P.T. Services Rehabilitation, Inc.
Excellence in Motion

22020 W. State Route 51 · Genoa, OH 43430 · P: 419-855-8301 · F: 419-855-8302

# Welcome Letter and Attendance Policy

Welcome to P.T. Services Rehabilitation, Inc.!

On your first visit, a treatment plan will be set up, and goals established to help measure your progress. This Plan of Care will be sent to your referring physician. Please inform us of your next doctor's appointment so that we can accurately communicate your progress.

We will work with you and your physician to determine the appropriate frequency of your visits.

Please schedule and confirm your appointments with the front desk staff. If you must cancel an appointment, please provide a 24-hour cancellation notice. All other cancellations and no-shows are subject to a discretionary $30 charge.

Your attendance at therapy is crucial to successfully achieving your goals. Your attendance will be reported to your physician on our Plan of Care updates.

**You will be subject to discharge from treatment if you:**

- **Miss 3 consecutive visits without a phone call to cancel.**
- **Are not seen for therapy in 30 consecutive days.**
- **Attend less than 50% of your scheduled visits.**

**Please note: If you are more than 10 minutes late for your appointment, your treatment session may be adjusted.**

We give home exercises and instructions which you are expected to complete.

We are pleased to work with you toward your therapy goals.

**Thank you!**

I understand the above attendance policy.

**Patient/Caregiver Signature:**_____ **Date:** _____

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# Patient Information

**PLEASE PRINT** **Date:**_____

**Patient Name: Last** _____ **First** _____ **MI** _____

**Address: Street** _____ **P.O. Box**_____

**City** _____ **State** _____ **Zip** _____ **Phone: (**_____**)** _____**-**_____

**Cell Phone: (**_____**)** _____**-**_____ **Email Address:** _____

**SSN#:** _____**-**_____**-**_____ **Date of Birth:** ____/____/____ ☐ **Female** ☐ **Male**

**Race:**_____ **Marital Status:** _____

**Guarantor/Responsible Party:** _____ **Relationship:** _____

**Address:** _____ **Phone: (**_____**)** _____**-**_____

## EMPLOYMENT INFORMATION

**Employer:** _____ **Employer Contact:** _____

**City:** _____ **Work Phone (**_____**)** _____**-**_____

**Occupation & Duties:**_____

## EMERGENCY CONTACT INFORMATION

**Name: Last** _____ **First** _____

**Phone: (**_____**)** _____**-**_____ **Relationship:** _____

## PHYSICIAN/PROVIDER INFORMATION

**Referring Provider:** _____ **Phone: (**_____**)** _____**-**_____

**Primary Care Provider:** _____ **Phone: (**_____**)** _____**-**_____

## INJURY INFORMATION

**Date of Injury:** ____/_____/_____ **Employment Related:** ☐ **YES** ☐ **NO** **BWC Claim:** ☐ **YES** ☐ **NO**

**Have you received therapy/chiropractic services in this calendar year:** ☐ **YES** ☐ **NO**

**Are you receiving home care services:** ☐ **YES** **Name of Agency:** _____ _____ ☐ **NO**

**Auto Accident:** ☐ **YES** ☐ **NO**

## INSURANCE INFORMATION

**Primary:** _____ **Insured ID #:** _____

**S.S.#**_____**-**_____**-**_____

**Name of Insured:** _____ **Insured's Date of Birth:** ____/_____/_____

**Insured's Employer:** _____ **Relationship to Insured:** _____

**Secondary:** _____ **Insured ID #:** _____

**Name of Insured:** _____ **Insured's Date of Birth:** ____/_____/_____

**Insured's Employer:** _____ **Relationship to Insured:** _____

## FINANCIAL AGREEMENTS

**For and in consideration of services rendered or to be rendered to the above named patient by P.T. Services, Rehabilitation Inc. I agree, whether acting as an agent or patient, to pay the amount due this facility. I will make current payments as bills are rendered or I will assign my insurance benefits for direct payment to this facility, and I will pay copay amounts at the time service is provided and any uncovered differences upon receipt of a statement. I understand that I am financially responsible for all charges whether or not paid by said insurance. I have received and understand the attendance policy. I hereby authorize said assignee to release all information necessary to secure payment.**

**Patient Signature:**_____ **Date:** _____

**Witness:** _____ **Date:** _____

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# Notice of Privacy & Consent

- I understand that as part of my healthcare, P.T. Services Rehabilitation, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:
    - A basis for planning my care and treatment.
    - A means of communication among the many health professionals who contribute to my care.
    - A source of information for applying my diagnosis to my bill.
    - A means by which a third-party payer may verify that services billed were actually provided.
- I understand that I am given this notice prior to signing consent, and P.T. Services Rehabilitation, Inc. reserves the right to change their notice and practices upon a reasonable implementation and notification period. I understand that I have the right to object to the use of my health information, and I may restrict as to how my health information may be used or disclosed. However, P.T. Services Rehabilitation, Inc. is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron. In consideration of the statements above, please be advised that, P.T. Services Rehabilitation, Inc. has a legal obligation to protect your health information by following appropriate privacy practices.
- I hereby consent and authorize P.T. Services Rehabilitation, Inc. to administer treatment as ordered by the physician and deemed medically necessary by the therapist in the treatment of this patient.
- I understand that I will be given information regarding body region boundaries that are involved with my treatment.
- I hereby consent and authorize P.T. Services Rehabilitation, Inc. to use or disclose information pertaining to my health record for the purposes of: conducting appropriate rehabilitative treatment, seeking payment for services rendered, or performing required healthcare operations activities such as, but not limited to, medical chart reviews or case conferences.
- The undersigned hereby authorizes P.T. Services Rehabilitation, Inc. and its employees and agents, to notify the designated person below regarding my treatment and/or in case of emergency:

**Name:**_____ **Home Phone:**_____

**Address:**_____ **City:**_____ **State:**_____ **Zip:** _____

- I understand that by signing this release, I expressly consent to allowing P.T. Services Rehabilitation, Inc., to convey confidential and sensitive information regarding my care and treatment to the above named person(s) via text, email or voice mail. I hereby release P.T. Services Rehabilitation, Inc. and its employees and agents, from any liability associated with leaving such messages with this person set forth above.

**Signature:**_____ **Date**:_____

### Restricted Notification:

Please list the individuals that you do **not** want to receive any information regarding your care and treatment communicated by any means.

_____

_____

**This authorization is valid until such time as the patient revokes it.**

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# Social Needs Evaluation

**An illness, injury or pain changes a person's life in many ways. Check below any issues which you would like some assistance:**

### Daily Living Needs:

- ☐ Obtaining Meals
- ☐ Shopping
- ☐ Using Transportation Resources
- ☐ Managing Finances

### Social Changes:

- ☐ Family member(s) neglect/abuse
- ☐ Family member(s) too helpful
- ☐ Losing friends
- ☐ Being unable to get to work/school
- ☐ Having sexual/marital difficulties
- ☐ Unable to continue usual recreational activities
- ☐ Having legal problems due to illness

### Personal Changes:

- ☐ Feeling that the injury/pain is a kind of punishment
- ☐ Feeling concern about becoming a burden
- ☐ Feeling frustrated about slow progress
- ☐ Feeling that injury/pain keeps me from doing what I want to do
- ☐ Having negative feelings about my body
- ☐ Having negative feelings about equipment (i.e. walker, brace, wheelchair, etc.)
- ☐ Feeling worried about possible career change
- ☐ Feeling depression, hopelessness or anger

### Check the support systems that you currently have or use:

- ☐ Immediate Family
- ☐ Extended Family
- ☐ Friends
- ☐ Church
- ☐ Social Clubs
- ☐ Community Organizations
- ☐ Employee Assistance Program

**Do you feel need professional counseling services to address the above needs?** ☐ **YES** ☐ **NO**

**Patient Signature:**_____ **Date:** _____

**Witness:** _____ **Date:** _____

**Social Worker** (if need requested)**:** _____ **Date:** _____

# P.T. Services Rehabilitation, Inc. Notice of Privacy Practices

Effective April 14, 2003

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The terms of this Notice of Privacy Practices apply to P. T. Services Rehabilitation, Inc. and each of its subsidiaries, affiliates, and entities managed or controlled by P.T. Services Rehabilitation Inc., including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We arc required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by P.T. Services Rehabilitation, Inc. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, P.T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin, ·OH 44883.

**USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION**

**Authorization and Consent:** Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

**Uses and Disclosures for Treatment:** With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

**Uses and Disclosures for Payment:** With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

**Uses and Disclosures for Health Care Operations:** With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review. Business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

**Individuals Involved In Your Care:** With your written or oral agreement we may from time to time disclose your personal health information to designated family, friends, and others who arc involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Appointments and Services:** We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, P.T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin. OH 44883.

**Research:** In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

**Other Uses and Disclosures:** We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law.
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in recalls.
- To your employer when we have provided health care to you at the request of your employer.
- To a government oversight agency conducting audits, investigations, or civil criminal proceedings.
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

**RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION**

**Access to Your Personal Health Information:** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person.

**Amendments to Your Personal Health Information:** You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We arc not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if wc believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical rcords.

**Accounting for Disclosures of Your Personal Health Information:** You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

**Restrictions on Use and Disclosure of Your Personal Health Information:** You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

**Workers' Compensation:** For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

**Complaints:** If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, P.T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin, OH 44883. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

**FOR FURTHER INFORMATION:** If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, P .T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin, OH 44883.

Signature: _____ Date: _____
Patient (or representative)

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# Patient History

**Patient to complete the following questions:**

1. When did this problem begin: _____
   - Was it caused by a specific incident: ☐ YES ☐ NO
   - If yes, please explain:_____
   - Have you had this problem before: ☐ YES, when: _____ ☐ NO
2. Activities you are presently having difficulty with: _____
3. Activities that aggravate your problem(s): _____
4. Activities that relieve/improve your problem(s): _____
5. Recent falls: ☐ YES, when: _____ ☐ NO
6. When did you last see your doctor: _____ When is your next appointment:_____
7. Special tests: ☐ X-Ray ☐ CT ☐ MRI ☐ Hearing ☐ Swallow ☐ Other: _____
8. Have you had surgery for this problem: ☐ YES, when: _____ ☐ NO
9. Medications you are currently taking: ☐ See Attached / List: _____

   _____
10. Medication or skin allergies: ☐ See Attached / List: _____

    _____
11. Check if you have any of the following medical conditions:

| | | | |
|---|---|---|---|
| ☐ Broken Bones | ☐ Diabetes | ☐ Cancer / Type:_____ | ☐ Neurological Problems |
| ☐ Trauma | ☐ Heart Disease | ☐ Unexplained Weight Loss | ☐ Stroke |
| ☐ Metal Implants | ☐ Pacemaker Implant | ☐ Kidney Disease | ☐ Seizures |
| ☐ Total Joints | ☐ Circulatory Problems | ☐ Liver Disease | ☐ Bowel / Bladder Control |
| ☐ Rheumatoid Arthritis | ☐ High Blood Pressure | ☐ Infectious Disease | ☐ Depression / Anxiety |
| ☐ Osteoporosis | ☐ Migraine Headaches | ☐ Lung Disease | ☐ Other:_____ |
| ☐ Vision | ☐ Hearing | ☐ Ear Infections | |

12. Prior surgeries: _____
13. Recent hospitalizations: ☐ YES, when: _____ ☐ NO
14. Are you currently working? ☐ YES ☐ NO
    - Is this a work related injury? ☐ YES ☐ NO
    - Are you under restrictions? ☐ YES, explain:_____ ☐ NO
15. Females: Are you pregnant? ☐ YES ☐ NO
16. Any pregnancy/delivery complications? ☐ YES, explain:_____ ☐ NO
17. Goals for therapy:_____

**Patient Signature:**_____ **Date:** _____

**PT/OTR Signature:** _____ **Date:** _____