Welcome to Team Rehab

Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____Cell Phone:_____
PCP:_____

Employer: _____Address: _____
Phone Number: _____

If Student/Minor, Person Responsible for the Bill:
Name: _____
Address:_____ Phone: _____

Have you had any Physical Therapy in 2017? Yes _____ No _____
Approximately how many visits? _____
This helps our staff accurately track how many visits your insurance allows.

Primary Insurance _____ID #:_____
Group #:_____ Subscriber:_____
Relationship to Subscriber: _____Date of Birth: _____
Employer:_____

Secondary Insurance:_____ ID #:_____
Group #:_____ Subscriber:_____
Relationship to Subscriber: _____Date of Birth: _____
Employer:_____

Auto or Workers Compensation
Auto Date of Injury:_____ W/C Date of Injury:_____
Claim #:_____Contact:_____
Company:_____ Address:_____
Phone:_____ Fax:_____

Team Rehab Insurance Specialists will verify the insurance benefits of all new patients. While we are happy to assist with insurance verifications and authorizations, we are NOT responsible to know or keep current with the status of your copay, deductible, and co-insurance responsibilities. Your insurance plan contract is an agreement between you and your insurance company. We recommend that you contact your insurance company if you have any questions about the accuracy of the information our insurance specialists have received.

_____ _____

Patient Signature Date

Team Rehab, 22 Eagle Road, Danbury, CT 06810
Financial Policy

General Policies

_____ **Initial** I, _____ authorize the staff of Team Rehab, P.C. to perform such procedures as may be deemed necessary for me or my minor child.

_____ **Initial** I authorize Team Rehab, P.C. to release information necessary to process this claim to my insurance carrier, Medicare, Workers Compensation, and Auto. I hereby assign to Team Rehab, P.C. all payments for medical services rendered to me or my dependents.

_____ **Initial** I understand that Team Rehab, P.C. will assist in obtaining prior authorization for medical treatment. I realize that my insurance contract is between me and my insurance company. It is my responsibility to understand my benefit plan including copay, coinsurance, and deductibles, and requirements such as referral or prior authorization. Any gaps in authorization or non-payment of services for which Team Rehab can legally transfer the balance to the patient will be my responsibility to pay. This includes denials of payment due to reaching my maximum benefit limit, Med Pay exhaustion, Medicare Therapy Cap when a signed Advanced Beneficiary Notice has been obtained, and other denials unrelated to routine contractual adjustments between Team Rehab and your carrier.

_____ **Initial** **HIPAA:** I have reviewed and understand the HIPAA policies posted in the waiting room and I understand that I may request a copy if I so choose.

Payment Policies

_____ **Initial** **Copays/Late Payments:** I understand that all copays and deductibles will be paid at the time of the service. If payment is not received at the time of the service, a $10 charge will be added to the copay/deductible amount for each date of service. Each month, I will receive a statement of services which is due and payable within 30 days of services rendered. If my payment is late and I do not communicate with the billing staff, an interest charge will accrue at the rate of 1.5% per month beginning 60 days following the date that services were rendered. After 90 days, my account will be placed in collections, and I am responsible for any court costs and related collection fees incurred.

_____ **Initial** **Insurance Card:** I understand that if I do not present my insurance card or Team Rehab is unable to verify my coverage, I am responsible for the payment of services rendered to me.

_____ Initial **Insurance Coverage:** I understand that if my insurance terminates or changes during my treatment and I do not notify Team Rehab in a timely manner, I am responsible for payment of the visits during the non-coverage period.

_____ Initial Returned Checks: I understand that all returned checks will be subject to an additional $25.00 service fee.

_____ Initial **Missed Appointments:** I understand that I am responsible for any missed appointments that were not cancelled within 24 hours. I am aware that Team Rehab charges $50.00 for follow up physical therapy visits, new evaluations are charged at $75.00, physician visits are charged at $75.00, and new evaluations with the doctor will be charged at $125.00.

_____ Initial **Billing:** I understand that Team Rehab outsources their insurance and patient billing. I am aware this may cause a delay in payment and processing. I am aware that if my bill does not reflect my payment or may indicate my bill is past due, I will communicate this to the billing staff at Team Rehab.

I hereby have read and understand the Financial Policy. I guarantee payment of all charges incurred for me/my minor child's account.

_____

Patient Name Responsible Party Signature Date

Welcome to Team Rehab. The purpose of this questionnaire is for your therapist to better understand your problem(s). Please answer the following questions to the best of your ability. Thank you!

General Health — Please Circle

1. Have you had any illnesses within the last 3 weeks (e.g. colds, influenza, bladder or kidney infection)? If yes, please list — Yes No
2. Have you noticed any lumps or thickening of skin or muscle anywhere on your body? — Yes No
3. Have you had any unexplained weight gain or loss in the last month? — Yes No
4. Do you smoke or chew tobacco? — Yes No
   If yes, how many pack/day? _____
   For how many months or years? _____
5. Do you have a pacemaker, transplanted organ, or metal implants? — Yes No
   If yes, explain_____
   _____
   _____
   _____

Medical Testing

Please see attached sheet for Medication Information

1. Have you had any x-rays, sonograms, computed tomography (CT) scans, magnetic resonance imaging (MRI), or lab work done recently? — Yes No

   _____
   _____

2. Please list any previous operations and the date(s):
   Operation — Date
   _____
   _____
   _____

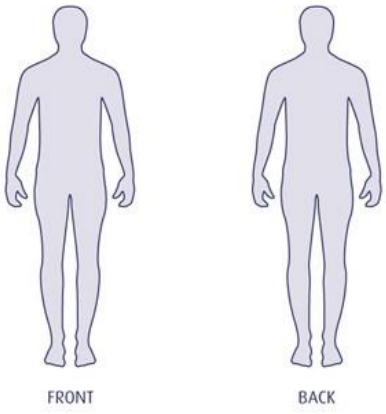
Work Environment

1. Occupation: _____
2. Does your job involve:
   [ ] Prolonged sitting (e.g. desk, computer, driving) [ ] prolonged standing (e.g. sales clerk)
   [ ] Prolonged walking (e.g. mill worker, delivery service) [ ] Lifting, bending, twisting, climbing, turning
3. Do you use any special supports: [ ] back cushion, neck cushion
   [ ] back brace, corset
   [ ] other kind of brace or support for any body part

4. History of falls: [ ] I have no falls [ ] I have just started to lose my balance/fall

[ ] I fall occasionally [ ] Certain factors make me cautious (e.g. curbs, ice, stairs)

To better understand your symptoms, please answer the following questions as best as possible:
Indicate in the diagram where you feel your symptoms



Describe your current symptoms (e.g. sharp, achy, etc.)
_____
_____
_____
_____

Did your symptoms begin due to a specific event?
[ ] car accident [ ] fall [ ] slowly without injury [ ] work related

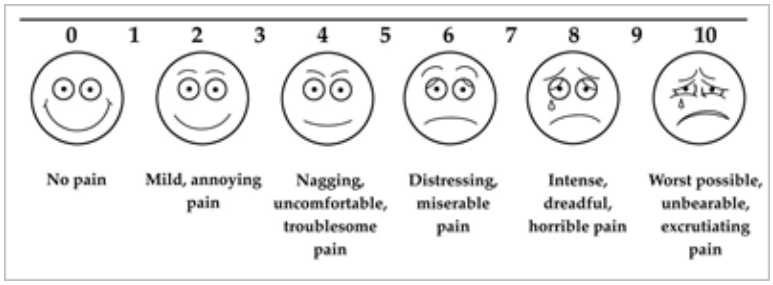
If other, please describe:
_____
_____
_____

Have your symptoms changed since the initial onset or injury? [ ] Yes [ ] No
If yes, please describe _____
_____

Please list things that make you feel better (e.g. activity, positions, ice, heat, etc.)
_____
_____
_____

What aggravates your symptoms?
_____
_____
_____
_____

Visual Analog Scale



Please rate your pain using the pain scale below:

Now _____

Average Pain_____

Worst Pain _____

Team Rehab, P.C.
22 Eagle Road
Danbury, CT 06810

Name : _____
Date : _____

Please provide your doctor and/or physical therapist with a **complete** list of any prescriptions, over-the-counter medicine, herbals, and vitamin/mineral/dietary (nutritional) supplements you are presently taking. Please notify our staff if you make any changes.

Name	Dosage	Frequency	Method of Administration (Oral, Inject, etc.)