THERAPY PROS
PHYSICAL RESPIRATORY OCCUPATIONAL SPEECH

Welcome to Therapy Pros! In order to serve you properly, we will need the following information. **(Please Print)**
All information will be strictly confidential.

Patient's Name	Sex M F	Birth Date _____/_____/_____ Age_____	Marital Status Single [ ] Married [ ] Widowed [ ] Divorced [ ]
Residence Address City State Zip		Home Phone:	Patient's Social Security #
Person Financially Responsible for this account	Self Spouse	Responsible Party's Birth date _____/_____/_____	Responsible Party's Social Security #
Responsible Party Drivers License Number State: Number		Occupation	How Long at Current Employer?
Name of employer Address or ___ Not Applicable		Business Phone	Occupation
Reason for Visit:	Referred by: (include phone number)		
Person to Contact in Case of Emergency:	Relationship to Patient	Phone	
Medicare Yes [ ] No [ ]	Medicare #	Medicaid Yes [ ] No [ ]	Medicaid #	Effective Date
Medicare Secondary Insurance Name Address		Policy #	Group #
Workers' Compensation? Yes [ ] No [ ] Motor Vehicle? Yes [ ] No [ ] **If Yes-put W/C or MVA carrier below:**	Date of Accident	Treatment authorized by	Claim #	W/C or MVA Insurance Phone #
Primary Insurance Company Address			Is Insurance Through Your Employer? Yes [ ] No [ ]
Subscriber Name	Subscriber Birth Date	Policy #	Group #
Secondary Insurance Name Address		Policy #	Group #

Lifetime Assignment of Benefits / Information Release / Authorization to Treat:

I authorize payment of medical benefits to **Therapy Professionals** for any services furnished. I understand that I am financially responsible for any amount not covered by my insurance carrier. I authorize you to release to my insurance company or its agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

I also authorize the Interdisciplinary Team to perform the treatments or procedures approved by my referring physician. I acknowledge that no guarantees, either expressed or implied, have been made to me regarding the outcome of any treatments and/or procedures. I fully understand that it is impossible to make any guarantees regarding the outcome of any medical treatment or procedure.

I have received a copy of my Patient Rights and Responsibilities.

_____ _____

Patient, Parent or Guardian Signature (if child is under 18 years old) Date

THERAPY PROS
PHYSICAL RESPIRATORY OCCUPATIONAL SPEECH

Patient Name: _____ Age: _____ DOB: _____

Referring Physician: _____ Primary Care Physician: _____

Reason for seeking assistance from Therapy Pros:

_____

When (roughly what date) did your present condition begin?

_____

Are you currently taking any Medications? YES NO; **if yes** which ones?

_____

Have you had any diagnostic studies (X-ray, MRI, etc.)? YES NO; **if yes** what type and when?

_____

Do you have pain? YES NO; **if yes**, rate your pain using the following scale:

0 1 2 3 4 5 6 7 8 9 10

No pain minor pain moderate pain severe pain -- take me to the hospital

Where is your pain located? _____

Can you describe the pain? (Examples: aching, burning, deep, shooting, itching, constant)

_____

Do you now or have you ever had any of the following?

Arthritis	Yes	No	Gout	Yes	No
High Blood Pressure	Yes	No	Sensitive to Heat/Ice	Yes	No
Heart Disease	Yes	No	Allergies	Yes	No
Heart Attack	Yes	No	Hernia	Yes	No
Pacemaker	Yes	No	Seizures	Yes	No
Diabetes	Yes	No	Metal Implants	Yes	No
Headaches	Yes	No	Dizzy Spells	Yes	No
Stomach or Kidney Problems	Yes	No	Balance Problems	Yes	No
Nervous Disorder	Yes	No	Vision Problems	Yes	No
Hearing Problems	Yes	No	a Concussion	Yes	No
Bowel/Bladder Problems	Yes	No	Numbness/Tingling	Yes	No
Respiratory Problems	Yes	No	Surgery	Yes	No
Cancer	Yes	No	Other_____		

If YES to any of above, please explain & give approximate dates:

_____

Do you have any allergies? YES NO If yes, to what? _____

Could you be/are pregnant? YES NO

Do you smoke cigarettes? YES NO Do you drink alcohol? YES NO

Smoking/Drinking History: _____

How has your current injury affected your daily life activities (work, self-care, extra-curricular activities)? _____

What are your goals? What do you plan on accomplishing by working with us?

_____

_____ _____

Patient, Parent or Guardian Signature Date

THERAPY PROS
PHYSICAL RESPIRATORY OCCUPATIONAL SPEECH

Attendance Policy

In order to receive the most benefit from rehabilitation, it is important that you follow the treatment plan prescribed by your physician and therapist and attend all sessions on a regular basis.

We ask that you give us at least 24 hours notice if you must cancel your appointment. Cancellations made with less than 24 hours notice and/or missed appointments will result in a **$35 charge**, which will be billed directly to you. Insurance companies will not cover missed appointment charges.

Please be advised that 3 missed appointments (with no prior notice given) will result in being discharged from therapy. Our therapists must adhere to this policy and they cannot make any exceptions unless an emergency situation prevents attendance.

We appreciate your cooperation and thank you in advance for understanding.

The above information has been read by and explained to me. **I understand my responsibility for the payment of any charges for cancelled or missed appointments**.

Client/Guardian: _____ Date: _____

THERAPY PROS
PHYSICAL RESPIRATORY OCCUPATIONAL SPEECH

Summary of Patients' Rights and Responsibilities

We are committed to serving you with compassion, care, skill, and respect. As one of our patients, you have choices, rights and responsibilities.

You have the *RIGHT*:

- to be treated with dignity and respect;
- to know the names and professional status of people serving you;
- to privacy;
- to confidentiality of your records;
- to receive accurate information about your health-related concerns;
- to know the effectiveness, possible side effects and problems of all forms of treatment;
- to participate in choosing a form of treatment;
- to receive education and counseling;
- to consent to, or refuse, any care or treatment;
- to select and/or change your health care provider;
- to review your medical records with a clinician;
- to amend your medical records; and,
- to information about services and any related costs.

You also have the *RESPONSIBILITY*:

- to seek medical attention promptly;
- to be honest about your medical history;
- to ask about anything you do not understand;
- to follow health advice and medical instructions;
- to report any significant changes in symptoms or failure to improve;
- to respect clinic policies;
- to keep appointments or cancel in advance;
- to seek non-emergency care during regular business hours; and,
- to provide useful feedback about services and policies.

Client/Guardian: _____ Date: _____

THERAPY PROS
PHYSICAL RESPIRATORY OCCUPATIONAL SPEECH

AUTHORIZATION FOR THE USE AND DISCLOSURE OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Specific description of information that may be used/ disclosed:

   All individually identifiable health information in the patient's medical record.

2. The information will be used/disclosed for the following purpose(s):

   To provide appropriate treatment, to bill appropriate insurance carrier, and to share information with referring physician.

3. Persons/organizations authorized to use or disclose the information:

   Therapy Professionals

4. Persons/organizations authorized to receive the information:

   *Referring physician, Billing company, Other*_____

5. If the purpose of this authorization is to disclose health information to another party based on health care that is provided solely to obtain such information, and I refuse to sign this authorization, the facility reserves the right to deny that health care.

6. I understand that I may inspect or copy the information used or disclosed.

7. I understand that I may revoke this authorization at any time by notifying the facility in writing, except to the extent that action has been taken in reliance on this authorization.

8. I understand I have a right to request/receive a Notice of Privacy Practices from the facility.

_____ _____

Signature of patient or patient's representative | Date

_____ _____

Printed name of patient or patient's representative | Relationship to patient, or representative's authority to act for the patient, if applicable

A copy of this signed form will be provided to the patient.