We would like to welcome you to Nirvana Sports Medicine and Rehabilitation Services, LLC and thank you for choosing our facility for your rehabilitation needs. We promise to do our very best to meet your needs and expectations. All of us share a common goal to assist you in returning to full function and we will do everything we can to help achieve that goal. The purpose of this introduction letter is to provide you with some helpful information as you prepare to begin your rehabilitation journey.

Prior to your evaluation today your primary insurance has been verified and if necessary authorization obtained. We have relayed to you what we feel is the pertinent information regarding your plan(s) and financial obligations. We, however, highly suggested that you call the Member Service department at your insurance company and verify personally what your responsibilities may be regarding copays, deductibles, referrals, etc. Please remember that benefits quoted are not a guarantee of payment per your insurance.

During your initial evaluation today your therapist reviewed your history, listened to your issue, concern, and goals, performed some special test and wrote up an evaluation and plan of care that will include exercises and other treatment modalities. This plan was discussed with you and will be forwarded to your referring physician. You have also been provided with a home exercise program to perform outside the clinic. In order for you to progress and meet your, and your physicians, goals, your cooperation in your program is greatly appreciated. We need for you to attend all the recommended scheduled appointments and not be late for your appointments. We understand that life emergencies happen but please call us and reschedule, please do not just not show up. This allows us to prepare and fill our schedules with other patients. We are also required to track your reschedule and missed appointments and those are reported back to your physician, carrier, and adjuster/case manager if a workers compensation claim. We do this because your rehabilitation benefits may be limited on number of visits or time and we want to make the best use of your, and everyone's, time and effort in reaching your greatest potential before that time expires. Lastly we ask that during your rehabilitation sessions, that you give us full effort and are honest and truthful. Each individual may respond differently to the rehabilitation sessions and we need to access your progression and adapt and change if need be.

At Nirvana Sports Medicine and Rehabilitation Services, we strive to focus our care on you, the patient. We want to promote a healthy lifestyle and instill great programs and techniques that carry over once you are discharged from our facility. We want you to know that we are always here for you, to answer your questions or concerns or to help you find other resources in our community.

If there is anything any of us can do to make your rehabilitation better, please do not hesitate to ask, you are our main concern. From all of us, thank you again for trusting us with your care.

Here's to your success!

Sincerely,
Glynn Stiles, LAT, ATC
Administrator

# NIRVANA SPORTS MEDICINE AND REHABILIATION SERVICES, LLC

## PATIENT CONSENT TO REHABILITATION SERVICES

Thank you for selecting Nirvana Sports Medicine and Rehabilitation Services, LLC as your provider for your rehabilitation (physical, occupational, speech therapy) needs, or any other rehabilitation needs or treatments as indicated by your referring physician or medical professional. Nirvana Sports Medicine and Rehabilitation Services, LLC is in compliance with Federal HIPAA Regulations and is committed to protecting your health information and privacy and our therapists and staff make every effort to ensure that your privacy and protected health information (PHI) is kept private.

1**. CONSENT TO TREATMENT**: I consent to rehabilitation and related services at Nirvana Sports Medicine and Rehabilitation Services, LLC as indicated by my referring physician or medical professional. In doing so, I understand and acknowledge that rehabilitation, and related services, is a “hands on” program that may consist of me performing physical and functional activities, and may involve bodily contact, touching, and/or direct contact with clinical personnel. I further understand, and consent, to being treated in a group setting and understand that due to the nature of the open setting of the therapy area that my treatment may be performed in the presence of other individuals and that it might be possible for other patients, family members, or friends and staff may overhear some trivial information relating to my treatment, diagnosis, and insurance benefits. I consent to possible disclosure of this inconsequential information to any other individuals who may be present in the therapy treatment area.

2. **TREATMENT OF MINORS**: I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

3**. LIABILITY**: I know and agree that Nirvana Sports Medicine and Rehabilitation Services, LLC is not responsible or liable for loss or damage to personal valuables, including but not limited to money, cell/mobile/smart phones and related electronics, jewelry, glasses, dentures, documents, clothing or other articles of value and I have been advised not to place these items outside of my reach.

4. **WAIVER AND RELEASE**: I hereby release, discharge and acquit Nirvana Sports Medicine and Rehabilitation Services, LLC, it’s agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to Fire/EMS service, Paramedic/EMT, physician or other urgent care services.

5. **AUTHORIZATION OF PAYMENT**: I hereby assign all benefits directly to Nirvana Sports Medicine and Rehabilitation Services, LLC and also authorize release of any medical records necessary, including via electronic transmittal, to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive; I will be financially responsible for payment.

6. **NONDISCRIMINATION POLICY:** As a recipient of Federal financial assistance, Nirvana Sports Medicine and Rehabilitation Services, LLC does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, gender, sexual orientation, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by Nirvana Sports Medicine and Rehabilitation Services, LLC directly or through a contractor or any other entity with which Nirvana Sports Medicine and Rehabilitation Services, LLC arranges to carry out its programs and activities.

7. **CONSENT TO PHOTOGRAPH**: I hereby give consent for Nirvana Sports Medicine and Rehabilitation Services, LLC to take pictures of myself and treatment being done to document my medical condition. I also acknowledge that the open areas of the facility are under video surveillance for my protection.

8. **NO FIREARM/WEAPONS OR TOBACCO USE:** I acknowledge and understand that Nirvana Sports Medicine and Rehabilitation Services, LLC, the interior facility and immediate surrounding exterior area are designated as firearm/weapon and tobacco free area and as such agree to leave all such items outside the facility.

I certify that I have read, understand, and consent to the information provided herein.

Patient/Guardian Signature ___________________________________

Witness Signature __________________________________________

# NIRVANA SPORTS MEDICINE AND REHABILIIATION SERVICES, LLC

## INSURANCE PAYOR QUESTIONAIRE FORM

Nirvana Sports Medicine and Rehabilitation Services, LLC will file with your insurance company according to the information that you provide. The accuracy of the provided information is highly important in order for your insurance to pay on your account. In order to ensure that we are filing the correct insurance, please answer the following questions.

1. Are you currently or have you had ANY type of Home Health Service? Yes No
   Home Health Agency:_______________________ Date Discharged:_________________

2. Was this injury/illness a work related incident? Yes No
   If yes, name of employer:___________________________________________________
   Employer phone:______________________ Contact Person:______________________
   Carrier's name:________________________ Claim Number:_______________________
   Are you currently employed? Yes No
   Name of current employer, if different:________________________________________

3. Was this injury related to an auto accident? Yes No
   Do you have an attorney representing you for your claim? Yes No
   Attorney's name: ________________________________ Phone:__________________________

   Is your auto insurance currently exhausted? Yes No
   Do you have a letter of exhaustion from your auto carrier? Yes No
   Do you have regular medical health insurance? Yes No
   Insurance Carrier's Name:___________________________________________________
   Phone Number:________________________ Policy ID:___________________________
   Primary Insured Name:______________________________________________________

4. Was this injury a result of a fall or other form of accident? Yes No
   If yes, please describe how and where accident happened:
   ______________________________________________________________________
   ______________________________________________________________________

5. Have you had therapy for this same condition within the last year Yes No
   If yes, name of facility:____________________________ Dates Seen:______________________

6. Is there anyone else involved in paying for your care? Yes No
   If yes, Name:_________________________________ Phone:____________________________

7. Are you currently on Medicare? Yes No

8. Who is your Primary Care Provider (PCP):_________________________ Phone Number:___________

_______________________________________ _______________________________________
Patient/Guardian Signature Relationship to Patient

_______________________________________ _______________________________________
Print Patient Name Date

## NIRVANA SPORTS MEDICINE AND REHABILITATION SERVICES, LLC

## PREFERRED CONTACT INFOMATION

I understand that Nirvana Sports Medicine and Rehabilitation Services, LLC will contact me for various reasons during my treatment and admission. In doing so, I prefer to be contacted in the following methods: (Check all that apply)

**Home Telephone**

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with family members or other persons living in the same household

**Work Telephone**

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ OK to leave message with secretary, assistant, or other individual who regularly answers the phone

**Cell Telephone**

- ☐ OK to leave message with detailed information
- ☐ Leave message with call-back number only
- ☐ Ok to send Text-Message with detailed information (for appointment reminders)
- ☐ Cell Phone Carrier is_______________________________________________

**Email** (Please specify email address) ______________________________________

- ☐ OK to send message with detailed information (for appointment reminders)
- ☐ I would not like to be contacted via email
- ☐ Cell Phone Provider is _______________________________________

**Other Method:**_____________________________________________________________

________________________________________      _________________________

Signature of Patient      Date

# Nirvana Sports Medicine and Rehabilitation Services
## Patient History Form

**Name:**______________________________**Contact Phone:**_______________**Date:**__________________

**Emergency Contact:**______________________________**Emergency Contact Phone:**_________________

**Email Address:**________________________________________**Date of Birth:**______________________

**Height:**______________**Weight:**________________**Date of Illness/Injury:**_______________________

**Your Pain Level (0-10):** **Current**:_______________**Best:**______________**Worst**:_____________

**What makes the pain better**:______________________________________________________________

**Location of Pain**:_______________________________________________________________________

**Have you fallen or lost your balance in the last year:** **Yes** **No**

**If yes, how many times?**________________ **Have you injured yourself as result?** **Yes** **No**

**Are you afraid of falling**? **Yes** **No** **Do you experience dizziness or vertigo? Yes** **No**

**Medical History** Do you have/had any of the following medical conditions?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| Heart Problems | ___ | ___ | Diabetes | ___ | ___ |
| High Blood Pressure | ___ | ___ | Active Tuberculosis | ___ | ___ |
| Pacemaker | ___ | ___ | Seizures | ___ | ___ |
| Urinary Incontinence | ___ | ___ | Cancer | ___ | ___ |
| Osteoporosis | ___ | ___ | Pregnant | ___ | ___ |

**Other Health Issues**:____________________________________________________________________

**List any Allergies you may have**:_________________________________________________________

**Please list the medications you currently take, include any over the counter medications:**

| Medication | Prescription (Yes/No) | Dose | Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**List any other surgeries, injuries, or major medical problems within the last 5 years**:

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_

**Describe your current physical complaint and how it happened and when**:

_____________________________________________________________________________________

_

_____________________________________________________________________________________

**Have you had ANY previous therapy for this problem**: **Yes** **No** **Was it helpful**: **Yes** **No**

_

_____________________________________________________________________________________

_

**What type of therapy did you have**:________________________

**Work/Employment Information:**

**What is your occupation**: ________________________________________________________________

**Employer**: _____________________________________________________________________________

**Describe your physical requirements of your job (how much you lift/carry, positions, time spent standing/sitting/walking**:________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

**What is your Present Work Status:**

___Working Full Time/Regular Duty
___Working Full Time/Modified Duty
___Not Working because of current injury
___Homemaker
___Retired
___Working Part Time/Regular Duty
___Working Part Time/Modified Duty
___Not Working for other reason
___Student
___Unemployed

**Do you need assistance in communicating with your employer: Yes No**

**Social Information:**

**Do you use an Assistive Device: (Please check all that apply)**

___Cane ___Walker, Rolling Walker or similar
___Wheelchair ___Motorized wheelchair
___Other_____________________________

**With who/whom do you live: (Please check all that apply)**

___Alone ___Spouse/Significant Other
___Child or children ___Other relative(s)
___Group setting ___Personal care attendant/assistant
___Other_____________________________

**What goals would you like to achieve in therapy**:

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**What activities have you had functional limitations in performing due to this injury:**

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

I have completed this history form and know it to be accurate to the best of my knowledge and ability:

___________________________________
**Patient Signature**

# NIRVANA SPORTS MEDICINE AND REHABILITATION SERVICES, LLC
# NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT AND RELEASE FORM

**Disclosure Authorization – For Release of Protected Health Information (PHI)**

I have been provided with, read, and fully understand **Nirvana Sports Medicine and Rehabilitation Services, LLC** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request at any time. I understand that **Nirvana Sports Medicine and Rehabilitation Services, LLC** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that that **Nirvana Sports Medicine and Rehabilitation Services, LLC** therapists and staff will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Nirvana Sports Medicine and Rehabilitation Services, LLC** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Initials: _______

**Communication of Health Information**
I give permission to **Nirvana Sports Medicine and Rehabilitation Services, LLC** to disclose and discuss any information related to my medical condition(s) with the following individuals:

Name: ______________________________________ Relationship: ______________________________
Name: ______________________________________ Relationship: ______________________________

Initials: _______

By signing this Authorization Form, I understand that I am giving my authorization to Nirvana Sports Medicine and Rehabilitation Services', LLC designated medical records custodians, database custodians, billing and collections personnel to use and/or disclose my Protected Health Information as described. I further acknowledge and understand that I may revoke this authorization at any time by notifying Nirvana Sports Medicine and Rehabilitation Services, LLC in writing of my intent to revoke this authorization except to the extent that Nirvana Sports Medicine and Rehabilitation Services, LLC has taken action on in reliance to this consent and previously disclosed. Unless revoked earlier, this authorization will expire 180 days after the signing of this authorization form.

_________________________________________ ____________________________
Signature of Patient or Personal Representative Date

_________________________________________ ____________________________
Printed Name of Patient Printed Name of Representative