Back-in-Action REHABILITATION, S.C.

Patient Name:
DOB:
Acct #:
Date:

Please confirm the following mailing address. If corrections are necessary, please note them on this form.

Patient address: _____ _____ _____, _____

____ Address is correct **_____ Corrections are necessary**

Do you consent to Back-in-Action Staff communicating with you via text? Yes No

AUTHORIZATION TO TREAT / RELEASE OF MEDICAL INFORMATION and ASSIGNMENT OF BENEFITS

I hereby authorize Back-in-Action Rehabilitation to provide treatment, release information pertaining to my treatment for insurance purposes, and/or receive direct insurance payments otherwise payable to me for services rendered. I understand that I am financially responsible for payment of all services including charges not covered by my insurance. I also acknowledge I have had full opportunity to read and consider the contents of the Privacy Notice. I understand that, by signing this form, I am confirming my written permission for the disclosure of my protected health information, as described in this form.

Signature_____ Date_____

Other than your doctor, how did you hear about us? (Check all that apply)

Newspaper/Radio
- ☐ The Reporter/Action Ad
- ☐ Tri-County News
- ☐ Other Newspaper
- ☐ Great 98
- ☐ Sunny 97.7
- ☐ Other Radio Station

Online
- ☐ Social Media
- ☐ Back in Action Website
- ☐ Google
- ☐ Other Online Source

Other
- ☐ Billboard
- ☐ Seminar
- ☐ Drove by/Building Sign
- ☐ Insurance
- ☐ Doctor
- ☐ Other_____

☐ If you heard about us through a friend or relative, may we have their name so we may thank them?

EMERGENCY CONTACT INFORMATION

Name:_____

Relationship:_____

Phone #:_____

Back-in-Action REHABILITATION, S.C.

Patient Health History Questionnaire

To ensure you receive a complete and thorough evaluation, please provide us with the important background information requested on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

NAME: **DOB**: **Date**:

OCCUPATION, including activities that comprise your workday: _____

LEISURE ACTIVITIES, including exercise: _____

AGE: _____ **HEIGHT**: _____ **WEIGHT**: _____

ALLERGIES: List any medications you are allergic to:_____

Are you latex sensitive? YES NO — List any allergies we should know about: _____

Do you smoke? YES NO — Do you have a pacemaker? YES NO

Do you drink Alcohol? YES NO — How many alcoholic beverages do you drink per week? _____

Do you take blood thinners? YES NO — Do you have any implants? YES NO

Have you had a recent illness (explain if yes)? _____

FOR WOMEN: Are you currently pregnant or do you think you might be pregnant? YES NO

Have you recently experienced any of the following (check all that apply)?

☐ Fatigue	☐ Numbness or tingling	☐ Constipation	
☐ Fever/chills/sweats	☐ Muscle weakness	☐ Diarrhea	
☐ Nausea/vomiting	☐ Dizziness/lightheadedness	☐ Shortness of breath	
☐ Weight loss or gain	☐ Heartburn/indigestion	☐ Fainting	
☐ Falls	☐ Difficulty swallowing	☐ Cough	
☐ Balance difficulty	☐ Changes in bowel or bladder function	☐ Headaches	☐ No to all

Have you ever been diagnosed as having any of the following conditions?

☐ Cancer	☐ Lung disease	☐ Depression/Anxiety	
☐ Heart Problems	☐ Tuberculosis	☐ Chemical dependency	
☐ High Blood Pressure	☐ Asthma	☐ Bone or joint infection	
☐ High Cholesterol	☐ Rheumatoid arthritis	☐ Diabetes	
☐ Circulation Problems	☐ Other arthritic conditions	☐ Osteoporosis/Osteopenia	
☐ Angina/Chest pain	☐ Bladder/urinary tract infection	☐ Multiple Sclerosis	
☐ Blood clots	☐ Kidney Problem/infection	☐ Epilepsy	
☐ Stroke	☐ Sexually transmitted disease/HIV	☐ Ulcers	
☐ Anemia	☐ Pelvic inflammatory disease	☐ Liver disease	
☐ Pneumonia	☐ Hepatitis	☐Other_____	☐ No to all

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

☐ Cancer	☐ Diabetes	☐ Tuberculosis	
☐ Heart disease	☐ Stroke	☐ Thyroid Problems	
☐ High blood pressure	☐ Depression	☐ Blood Clots	☐ No to all

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to harm you in any way? **YES NO**

Please list any surgeries or conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	REASON FOR SURGERY/HOSPITALIZATION	DATE	REASON FOR SURGERY/HOSPITALIZATION
1.		4.	
2.		5.	
3.		6.	

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

☐ Aspirin ☐ Laxatives ☐ Antacid
☐ Tylenol/Acetaminophen ☐ Decongestants ☐ Vitamins/mineral supplements
☐ Advil/Motrin/Ibuprofen ☐ Antihistamines ☐ Other_____

Please list any PRESCRIPTION medication that you are taking (including pills, injections, and/or skin patches):

1._____ 3._____ 5._____
2._____ 4._____ 6._____

CURRENT SYMPTOMS: Briefly describe your symptoms: _____

When did your symptoms start (approx date)? _____ How? (Was there an injury)? _____

Have you previously been treated for this condition? YES NO By whom? _____

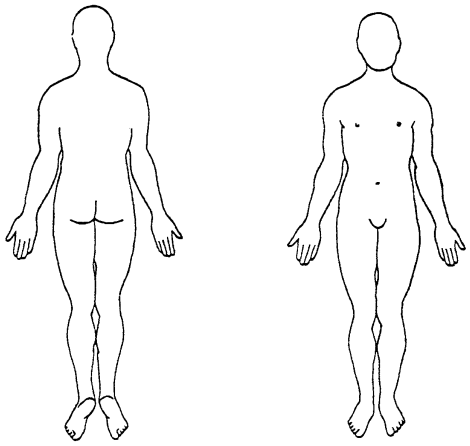
What is your personal goal for therapy? _____

What makes your symptoms worse? _____

What makes your symptoms better? _____

No symptoms 0 1 2 3 4 5 6 7 8 9 10 **Need to go to the hospital**

Body Chart: Please color in any areas where you feel symptoms on on the chart to the right



Using the 0-10 scale above, rate the level of symptoms that you have (had):
Currently: _____
Average in last 24 hours: _____
Average pain in last week: _____

How often do you experience your symptoms?

☐ **Constantly (76-100% of time)** ☐ **Frequently (51-75% of time)** ☐ **Occasionally (26-50% of time)** ☐ **Intermittently (0-25% of time)**

My symptoms are (check one):

☐ **getting better** ☐ **not changing** ☐ **getting worse** ☐ **fluctuating**

How much have your symptoms interfered with your usual daily activities? (both work outside of the home and housework)

☐ **Not at all** ☐ **A little Bit** ☐ **Moderately** ☐ **Quite a bit** ☐ **Extremely**

In general, would you say your overall health right now is…

☐ **Excellent** ☐ **Very Good** ☐ **Good** ☐ **Fair** ☐ **Poor**

Identify up to three important activities that you are unable to do or are having difficulty with as a result of your problem.

1._____
2._____
3._____

Therapist use only
1. PSFS rating _____
2. PSFS rating _____ PSFS Avg _____
3. PSFS rating _____

_____
Patient Signature Date

Unable to perform activity 0 1 2 3 4 5 6 7 8 9 10 **Able to perform activity at same level as before your injury or surgery**

Therapist use only

_____
Therapist Signature Date

Back-in-Action REHABILITATION, S.C.

Patient Name:
DOB:
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Date:

Thank you for choosing Back-in-Action Rehabilitation as your therapy provider. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have been advised to develop this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Insurance**. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. **Consent to Treat**. You are authorizing Back-in-Action Rehabilitation to provide treatment, release information pertaining to your treatment for insurance purposes, and/or receive direct insurance payments for services rendered. You acknowledge that no guarantees have been made as a result of any therapy treatments or evaluations administered or prescribed by our clinic, nor can they be. You understand that although you may be discharged from treatment, it is your responsibility to seek follow-up care when necessary and that your condition may continue to require maintenance therapy.
3. **Maintenance Therapy**. Maintenance therapy is particularly applicable to patients with chronic, stable conditions where skilled supervision and intervention is no longer required and further clinic improvement cannot reasonably be expected for continuous ongoing care. Most insurances do not cover maintenance therapy. This can be discussed with your therapist, to explore other options such as private pay.
4. **Co-payments and deductibles**. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. When a deductible is applicable, we ask for a payment of $50 to be paid at each visit. The payment will be applied to your deductible after insurance processes the claim. Copayment amounts can vary by coverage, and the staff will inform you of your copay amount. Payments can be made by cash, check or credit card.
5. **Non-covered services or items.** Please be aware that some of the services, or therapy items, you receive may not be covered by insurers. You must pay for these services in full at the time of visit.
6. **Proof of insurance.** All patients must complete our patient information form before seeing the therapist. We must also obtain a copy of your insurance card. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of the claims.
7. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.
8. **No Insurance**. We will provide therapy services on a cash only basis if you request. Payment must be made at the time of your visit.

9. **Credits on Account.** If any excess funds remain in your account, you hereby authorize Back-In-Action Rehabilitation to apply any excess funds to any other outstanding accounts you may have with Back-In-Action Rehabilitation.
10. **Returned Checks.** A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.
11. **Nonpayment & Collections.** You are required to remit the balance due on your account when services are rendered. Any portion of your bill which has remained unpaid for six months after the date of initial billing may be turned over to an attorney or collection agency. If your account is referred to an attorney, all additional attorney fees and collection expenses will become your obligation to pay. Account balance is due in full, partial payments will not be accepted unless otherwise negotiated.
12. **Missed appointments/Late Cancellations**. Our policy is to charge *$25 for missed appointments* not canceled within a reasonable amount of time (24-hour notice). These charges will be your responsibility and billed directly to you; they are not covered by insurance. Please help us to serve you better by keeping your regularly scheduled appointment. When cancelling your appointment, you must inform the staff of the reason for cancellation – if deemed to not be an emergency, your account will be charged $25 for the missed appointment.
13. **Privacy Notice.** By signing below, you are acknowledging that you have had full opportunity to read and consider the contents of our Privacy Notice.
14. **Medical Records.** Payment of reasonable costs will be necessary if you request photocopies of your medical records and reasonable time will be afforded to the clinic to respond to such requests. Costs are updated annually pursuant to Wis. Stat. §146.83.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our policies. Please let us know if you have any questions or concerns.

By signing below, you certify that you have read the entire document, understand its contents and significance, accept responsibility for payment, and agree to abide by its guidelines:

DATED this _____ day of _____, 20_____.

Signature: _____

If patient is a minor or unable to consent, complete and sign the following:
Patient is unable to sign because (provide reason) _____

Signature: _____

Person signing on behalf of patient Relationship to patient