TOTAL REHAB SOLUTIONS

PATIENT INFORMATION

Today's Date _____

Name _____
First *MI* *Last*

Address _____ _____
Street *City* *State* *Zip*

Date of Birth: _____ **SS#** _____-_____-_____ **Gender** M / F **Marital Status** M S D W

BEST Contact Number _____ **E-Mail** _____

Guarantor/Insured/Responsible Party if other than self (person responsible for payment):

_____ _____-_____-_____ _____
Guarantor/Insured Name **Guarantor/Insured SS#** **Guarantor/Insured DOB**

HAVE YOU HAD PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH THERAPY, HOME HEALTH OR CHIROPRACTIC SERVICES THIS YEAR? IF YES, HOW MANY VISITS DID YOU COMPLETE? _____

How Did Injury Occur? _____

_____

Date of Injury _____

Date of Surgery _____

State Injury Occurred _____

EMERGENCY CONTACT INFORMATION

Contact Name _____

Relationship _____ **Phone #** _____-_____-_____

PHYSICIAN INFORMATION

Primary Care _____

Referring MD _____

EMPLOYER INFORMATION

Occupation _____

Employer _____

Work Phone _____

MEDICATION LIST

Medication Name	Dosage	Frequency

PAST MEDICAL HISTORY

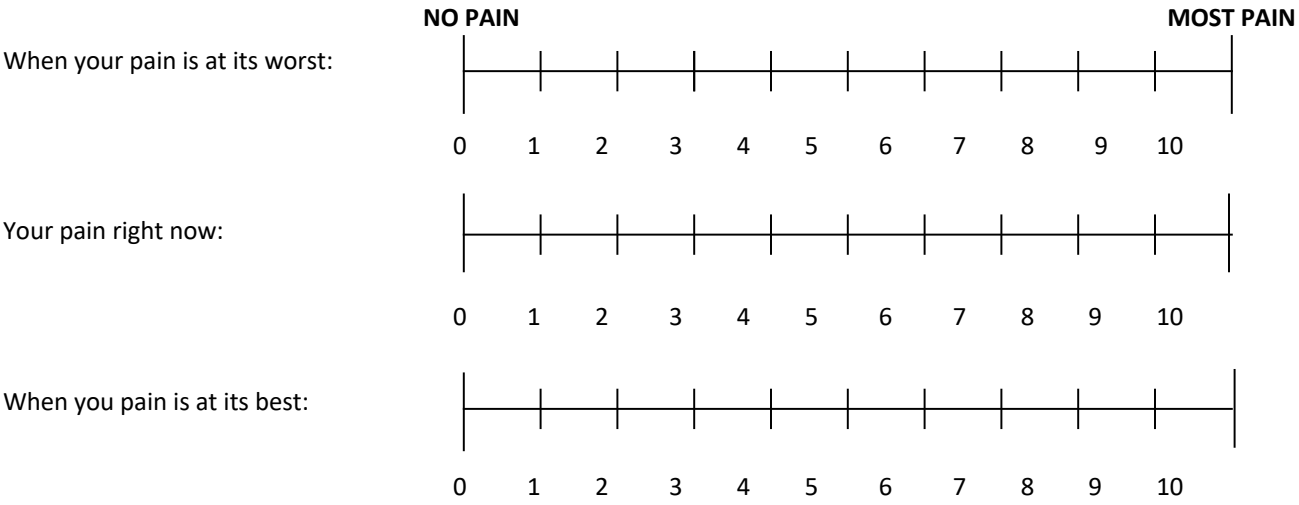
	YES	NO	COMMENT
Heart Attack / Congestive Heart Failure	___	___	_____
Irregular Heartbeat / Pacemaker	___	___	_____
Cancer	___	___	_____
Diabetes	___	___	_____
Seizures	___	___	_____
High Blood Pressure	___	___	_____
Current Pregnancy	___	___	_____
Metal Implants	___	___	_____
Ulcers	___	___	_____
Arthritis	___	___	_____
Breathing Problems	___	___	_____
Recent Weight Loss / Gain	___	___	_____
Allergies	___	___	_____
Headaches	___	___	_____
Bowel / Bladder Problems	___	___	_____
Active Smoker	___	___	_____
Depression/Anxiety	___	___	_____
Other Medical Conditions/surgeries: _____			

HISTORY OF PRESENT INJURY/ILLNESS

1. Have you had a previous episode of this problem?	Yes		No	
2. Are your symptoms getting:	Better		Worse	Same
3. Have you experienced any of the following recently?	Dizziness		Headache	Nausea
	Numbness		Tingling	Spasms
4. Do you have a current exercise or fitness program?	Yes		No	
5. Have you had physical therapy this year?	Yes		No	If Yes, What for? _____
6. Have you fallen in the last 12 months?	Yes		No	
If yes, how many times? _____				
Did the fall result in any injury? _____				
If yes, what was the injury? _____				
Why are the falls occurring? _____				
7. How are you sleeping?	Good	Fair	Poor	
8. What is your energy level?	Good	Fair	Poor	
9. How are your eating habits?	Good	Fair	Poor	

PAIN LEVEL DETAILS

Please mark on the line to indicate your pain level.

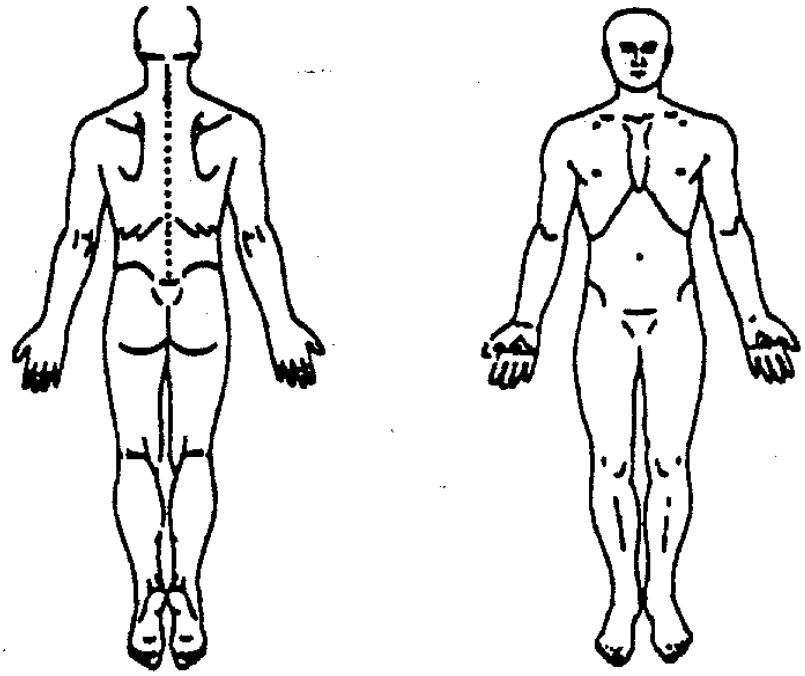


10. What makes your pain BETTER?
11. What makes your pain WORSE?

Pain Drawing:

Please be sure to fill this out accurately. Mark the area on your body where you feel the described sensation(s). Use the appropriate symbol(s), mark areas of radiating pain and include all affected areas.

Pain XXXXX Numbness +++++ Tingling ooooo



Patient Name (print): _____ Patient DOB: _____

CONSENT TO TREATMENT

By signing at the bottom of the page, I hereby authorize the professional staff at ***Total Rehab to*** examine and treat me with physical therapy for the injury I have been referred here for or referred myself to. I also give assignment and instruction for direct payment to ***Total Rehab.***

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO HEALTH PROVIDER

I hereby instruct the above-named insurance company/companies to pay by check made out to and mailed directly to: ***Total Rehab*** for professional or medical expenses allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. **THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.** This payment will not exceed my indebtedness to the above-mentioned assignee and I have agreed to pay, in a current manner, any balance of said professional fees for non-covered services and/or fees, over and above the insurance payment or as required by my insurance policy.

I understand that ***Total Rehab*** complies with HIPPA and will protect my Protected Health Information (PHI) and will use it as allowable by law in the treatment, billing and collection pertaining to my care until my case is closed and full payment is received. I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney for the purpose of securing payment under this policy of insurance or to any Medical Provider associated with my case to effectively treat me. The authorization is in effect until 90 days from the date the last bill is collected.

HIPPA REGULATIONS A photocopy of this Assignment shall be considered effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance under the HIPPA guidelines.

X_____ _____

Patient Signature Date

Patient Name (print): _____ Patient DOB: _____

NOTIFICATION CONSENT & AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

It may be necessary for our practice to contact you by automated phone calls, to leave a message, or by text. We like to leave messages when you are not directly available. To protect your privacy, it is our policy to leave limited information on a voicemail system, unless we have permission from you.

Please check applicable ways for us to notify you:

□ YES, call me on this phone number and leave a detailed voicemail: _____

□ YES, text me on this mobile number: _____

□ NO, I do not give consent for you to provide a detailed voice message or text message.

***Please list any individuals who we may discuss your Protected Health Information and/or billing information with:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

X_____ _____
Patient or Parent/Guardian Signature Date

MOTOR VEHICLE ACCIDENTS (MVA) and/or REPRESENTED BY AN ATTORNEY

(Only complete this section IF your case is related to an MVA and/or you are represented by an attorney.)

**I authorize Total Rehab to discuss, disclose and release all medical and/or billing records to my attorney listed below:

Attorney: _____ Attorney Phone #: _____

Address: _____ Accident Date: _____

_____

I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. Refusal to sign would affect Total Rehab 's ability to communicate with your attorney. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this PHI. I understand I have the right to revoke this authorization at any time, and I must do so in writing and present it to the Compliance Officer. Any revocation will not apply to information previously released.

X_____ _____
Patient or Parent/Guardian Signature Date

DRY NEEDLING CONSENT AND REQUEST FOR PROCEDURE

Dry Needling involves inserting a tiny monofilament needle in a muscle or muscles to release shortened bands of muscles and decrease trigger point activity. This can help resolve pain and muscle tension and will promote healing. This is not traditional Chinese Acupuncture but is instead a medical treatment that relies on a medical diagnosis to be effective.

DN is a valuable and effective treatment for musculoskeletal pain. Like any treatment, there are possible complications. While complications are rare in occurrence, they are real and must be considered prior to giving consent for treatment.

Risks: The most serious risk with DN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely require a chest x-ray and no further treatment. The symptoms of shortness of breath may last for several days to weeks. A more severe puncture can require hospitalization and re-inflation of the lung. This is a rare complication, and in skilled hands it should not be a major concern. Other risks include injury to a blood vessel causing a bruise, infection, and/or nerve injury. Bruising is a common occurrence and should not be a concern.

Patient's Consent: I understand that no guarantee or assurance has been made as to the results of this procedure and that it may not cure my condition. My therapist has also discussed with me the probability of success of this procedure, as well as the probability of serious side effects. Multiple treatment sessions may be required/needed thus this consent will cover this treatment as well as consecutive treatments by this facility. I have read and fully understand this consent form and understand that I should not sign this form until all items, including my questions, have been explained or answered to my satisfaction. With my signature, I hereby consent to the performance of this procedure. I also consent to any measures necessary to correct complications which may result.

Procedure: I, _____, authorize Total Rehab's clinicians to perform Dry Needling for my diagnosis.

Please answer the following questions:
Are you pregnant? Yes No
Are you immunocompromised? Yes No
Are you taking blood thinners? Yes No

DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTAND THIS FORM.
***You have the right to withdraw consent for this procedure at any time before it is performed.**

_____ _____ _____
Patient or Authorized Representative Date Time

_____ _____
Relationship to patient (if other than patient) (Patient name printed)

VERIFICATION OF INSURANCE BENEFITS

PRIMARY □ SECONDARY □ TERTIARY □

ACCOUNT#_____ PATIENT NAME _____ DOB _____

INSURANCE COMPANY _____ ID #: _____

POLICY HOLDER/INSURED: Name _____ DOB: _____ SSN: _____

BENEFITS QUOTED BY YOUR INSURANCE COMPANY—THIS IS NOT A GUARANTEE OF COVERAGE

□ **COPAY APPLIES:** Your insurance covers 100% after you pay your $_____ copay per visit

A copay is a flat dollar amount due from the patient at time of service.

□ **DEDUCTIBLE/COINSURANCE APPLIES:**

Your Deductible is $ _____, Deductible remaining to be met is $_____

A deductible is an amount you must pay FIRST for covered health care services before your health insurance kicks in to pay their portion and it is due from you at the time of services are rendered.

Once your deductible is met, your coinsurance responsibility is _____% of your insurance's allowable fee schedule**. A coinsurance is the percentage of costs a patient pays for medical expenses.**

Any differences processed by your insurance and the amount we collect will be invoiced to you once the claim has been processed. If you have any questions regarding your insurance benefits, please do not hesitate to ask for further details/explanations of your benefits.

***INSURANCE VISIT LIMIT:** # _____ *OR* MAX AMOUNT $ _____ ALLOWED PER: □ calendar year *OR* □ benefit period

***NUMBER OF VISITS/$ AMOUNT REMAINING:** # _____

-VISIT LIMIT IS FOR: □ PT/OT only □ COMBINED PT, OT, Speech, Chiropractic, Home Health, Hydro, Massage and/or Pulmonary)

HAVE YOU HAD HOME HEALTH OR PT THE PAST 6-12 MONTHS? YES ☐ NO ☐ If yes, how many? _____

Are you being seen in our office due to an auto accident or any other liability injury? YES ☐ NO ☐

MEDICARE 2026 DEDUCTIBLE: $283.00 * MEDICARE KX Threshold: $2,480.00

PART B Effective Date: _____ MEDICARE DEDUCTIBLE MET: YES☐ NO☐ $_____Amount Met

OPEN HH Episode: □ NO / □ YES **MCR:** PRIMARY ☐ SECONDARY☐ **HMO** □ NO / □ YES **HOSPICE** □ NO / □ YES **PT CAP USED: $**_____

Once your Medicare Deductible is met, Medicare covers 80%. If you have a secondary insurance, we will be glad to file the 20% coinsurance portion with your insurance carrier to request payment for the remaining balance. If you do not have a secondary insurance: you will be billed the 20% coinsurance balance as soon as we are notified by Medicare.

THIS SECTION IS FOR OFFICE USE ONLY

Insurance Verification Call Reference #: _____ Date of verification: ____/_____/_____
Name of Representative _____
Insurance effective date: _____ Is a primary care referral required? □ Yes □ No
Is there a separate copay for the evaluation? □ Yes □ No **If yes, copay eval amount? $_____**
Are the following CPT codes covered? 97016 □ Yes □ No / 97033 □ Yes □ No / 97140 □ Yes □ No
Are there any modality limitations? If yes, provide details:
Precertification/Auth required: □ Yes □ No **If yes, provide submission instructions: _____
Authorization #: _____ Expiration Date: _____# of Visits Approved: _____

PAYMENT IS DUE AT TIME OF SERVICE

SUPPLIES ARE NOT COVERED BY INSURANCE – THESE MUST BE PAID IN FULL BY THE PATIENT

WE VERIFY AND BILL YOUR INSURANCE AS A COURTESY TO YOU. BY SIGNING BELOW, YOU ACKNOWLEDGE THAT YOU WERE INFORMED OF THE BENEFITS QUOTED TO OUR OFFICE BY YOUR INSURANCE COMPANY. YOU ALSO UNDERSTAND THE PORTION OF YOUR ACCOUNT THAT YOU WILL BE RESPONSIBLE FOR ACCORDING TO THIS STATEMENT. THIS IS NOT A GUARANTEE OF PAYMENT FROM YOUR INSURANCE COMPANY—CLAIMS WILL BE PROCESSED DEPENDING ON STATUS OF COVERAGE AND POLICY TERMS. ACCORDING TO THIS STATEMENT, ANY CHANGES MADE BY YOUR INSURANCE COMPANY WILL BE YOUR RESPONSIBILITY AND WILL BE BILLED TO YOU. IN THE EVENT YOUR ACCOUNT BECOMES DELINQUENT, YOU WILL BE RESPONSIBLE FOR ALL REASONABLE COST ASSOCIATED WITH THE COLLECTION OF THIS DEBT, INCLUDING BUT NOT LIMITED TO COLLECTION SERVICE FEES, ALL COURT COSTS AND ANY ADDITIONAL LEGAL FEES ASSOCIATED WITH THE RECOVERY OF THIS DEBT. ANY BALANCES OVER 30 DAYS FROM THE LAST DATE OF SERVICE WILL BE CONSIDERED PAST DUE. ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE OR BY THE END OF THAT WEEK IN WHICH THE SERVICES ARE RENDERED.

_____ _____

SIGNATURE OF PATIENT (OR LEGAL GUARDIAN) **DATE**