

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____

SSN: _____ HOME PHONE: (____) _____

CELL PHONE: (____) _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

EMPLOYER: _____ PHONE NUMBER: (____) _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____

IS THIS A WORKMAN'S COMPENSATION CLAIM? YES NO
DATE OF INJURY? _____ CONTACT PERSON: _____

IS YOUR PRESENT INJURY THE RESULT OF AN ACCIDENT? YES NO
EXPLAIN: _____

ATTORNEY/INSURANCE CO: _____ PHONE: (____) _____

ADDRESS: _____ CITY: _____ STATE: _____

ZIP CODE: _____ CONTACT PERSON: _____

EMERGENCY CONTACTS (NOT LIVING IN YOUR HOME)

NAME: _____ PHONE NUMBER: (____) _____

NAME: _____ PHONE NUMBER: (____) _____

IF INSURANCE IS CARRIED BY SPOUSE, PARENT, OR GUARDIAN

PLEASE FILL IN THE SECTION BELOW:

PRIMARY INSURANCE

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: (____) _____ ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ RELATIONSHIP TO PATIENT: _____

SECONDARY INSURANCE

NAME: _____ DATE OF BIRTH: _____

PHONE NUMBER: (____) _____ ADDRESS: _____ CITY: _____

STATE: _____ ZIP CODE: _____ RELATIONSHIP TO PATIENT: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

I understand that Whitewater Valley Rehabilitation will release any medical information acquired in the course of my evaluation and treatment to any referring physicians and any workman's compensation case managers. This facility makes every attempt to maintain your confidentiality and will not forward any information without a signed release.

Signature

Date

AUTHORIZATION FOR PAYMENT

I hereby authorize and request my insurance company to pay directly to Whitewater Valley Rehabilitation, the amount due on my claim for rehabilitation services provided to me. I understand that I AM RESPONSIBLE FOR ANY AMOUNT OF MY BILL NOT COVERED BY MY INSURANCE CARRIER. In consideration of the services provided to me, I hereby guarantee payments in full of my account in accordance with the financial agreements made, if no such agreements are made, then payment shall be made in full within sixty (60) days of discharge. I agree that in the event of default in payment, reasonable costs of collection, equal to fifty (50) percent of the delinquent balance, and reasonable attorney fees may be added to the amount due on the account.

Signature

Date

LIABILITY ACKNOWLEDGEMENT

This is to verify that you have been aware that physical, occupational, or speech therapy techniques and exercises may cause an inflammatory response in joints, muscles, and surrounding tissues which you may not be directly treated for. It is normal to experience an increase in pain, discomfort, or soreness with exercise and therapy techniques due to inflammation from your current injury or surgery. You may also experience these symptoms even in body parts not directly being treated secondary to de-conditioning, lack of use, prior injuries or surgeries, or inflammatory conditions with which you have been diagnosed. In the event that severe increased pain arises in any body part, you are responsible for relaying this information and the manner in which it happened (i.e: home, work, recreation) to your therapist so your treatment program can be modified. We are not responsible for injuries occurring due to negligence of the patient or improper use of exercise equipment. Our goal is to make your rehabilitation at our facility a pleasurable learning experience, and with your help we will be able to accomplish this.

Signature

Date

Authorization for Release of Information:

I hereby authorize *Whitewater Valley Rehabilitation* to release any medical information acquired in the course of my evaluation or treatment to my:

- * Referring physician: _____
- * Family physician: _____
- * Attorney: _____
- * Case manger: _____
- * Other: _____

Whitewater Valley Rehabilitation makes every attempt to maintain your confidentiality and will not forward any information without a signed release.

Signature

Date

Whitewater Valley Rehabilitation
Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers, and conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this acknowledgement. I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may need to contact this organization at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

_____ *signature* _____ *date*

To our MEDICARE OR MEDICAID PATIENTS:

As an outpatient physical, occupational, and rehabilitation center, Whitewater Valley Rehabilitation is Medicare and Medicaid approved. We will bill Medicare and any secondary insurance you may have and you will not receive a bill from us until a payment from Medicare and/or your secondary insurance has been received. We do want you to be aware that it may take a while to get a response back from Medicare or Medicaid.

You may be responsible for any co-pay or deductible that your insurance does not pay. You may also be responsible for payment if Medicare therapy services are denied. **AS OF JANUARY 1ST, 2006, PHYSICAL AND OCCUPATIONAL THERAPY HAVE A LIMITATION OF \$1,740 EACH. YOU WILL BE RESPONSIBLE FOR ANY BALANCE OVER THE LIMIT.** Also, if you have had or are currently having home healthcare, please list the name of the facility here: _____. There are some exceptions to the Medicare rules. Please ask the receptionist if you have any questions.

If you have any questions at any time about your treatment, please feel free to contact Donna Stern at (765) 939-0820.

I have read and agree to all the above terms listed.

_____ *signature* _____ *date*

FINANCIAL POLICY

This is an agreement between Whitewater Valley Rehabilitation, as creditor, and the patient named on this form. In this agreement, the words "you," "your," and "yours" mean the patient. The word "account" means the account that has been established in your name to which charges are made and payments are credited. The words "we," "us," and "our" refer to Whitewater Valley Rehabilitation.

MONTHLY STATEMENT: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge (if any), and any payments or credits applied to your account during the month.

PAYMENTS: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid by the end of the month.

INSURANCE: Insurance is a contract between you and your insurance company. We are not a party to this contract. We will bill your primary insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a primary physicians' referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

REQUIRED PAYMENTS: Any co-payments or deductibles required by an insurance company must be paid at time of service.

RETURNED CHECKS: There is a fee of \$25.00 for any checks returned by the bank.

FINANCE CHARGE: A finance charge will be imposed on each item of your account which has not been paid within ninety (90) days of the time the item was added to the account. The finance charge will be computed at the rate of one and a half (1 1/2) per month or an annual percentage rate of eighteen (18) percent. The finance charge on your account is computed by applying the periodic rate (1.5) to the "overdue balance" of your account. The "overdue balance" of your account is calculated by taking the balance owed ninety (90) days ago, and then subtracting any payments or credits applied to the account during that time.

MISSED APPOINTMENTS: Patients who do not show up for an appointment, or cancel with less than 24 hours notice will be charged a \$30.00 fee.

PERSONAL INJURY: If you are being treated as part of a personal injury lawsuit or claim, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to personal injury case.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Signature

date

Vocational/Social Assessment Services

Patients Name: _____ **Date of Birth:** _____

***Purpose of Assessment:** To identify vocational, educational, social, and emotional needs to determine what services are needed to meet your overall treatment goals and to assist you with referrals to appropriate resources.*

1. Are there any areas in which you need assistance? (please check)

- | | |
|---|---|
| <input type="checkbox"/> Financial | <input type="checkbox"/> Emotional Problems |
| <input type="checkbox"/> Family/Relationship problems or conflict | <input type="checkbox"/> Employment/Career change |
| <input type="checkbox"/> Housing (including accessibility) | <input type="checkbox"/> Education/Training |
| <input type="checkbox"/> Chronic stress | <input type="checkbox"/> Adjustment to illness |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Other (please explain) |
- _____

2. Please complete the following:

Occupation: _____ Job Title: _____

Job Status (circle): Full time Part time Sick Leave Unemployed Retired

Patient's Signature (must sign): _____ **Date:** _____

Diagnosis: _____

Based on review of information social services follow-up is not indicated at this time.

Based on review of information social services follow-up is indicated at this time.

Findings/Recommendations/Interventions: _____

Betty McDivitt ACSW, LCSW

date

JOB DESCRIPTION QUESTIONNAIRE

Employer: _____ Length of Employment: _____

What is your specific Job Title: _____

How many hours do you work per day _____, per week _____, hours of over time _____?

Please circle the category below that best describes your job.

SEDENTARY: Lifting 10 pounds maximum.

LIGHT: Lifting 20 pounds maximum with frequent lifting and/or carrying objects weighing up to 10 pounds.

MEDIUM: Lifting 50 pounds maximum with frequent lifting and/or carrying objects weighing up to 25 pounds.

HEAVY: Lifting 100 pounds maximum with frequent lifting and/or carrying objects weighing 50 pounds or more.

VERY HEAVY: Lifting objects in excess of 100 pounds with frequent lifting and/or carrying objects weighing 50 pounds or more.

Do you incorporate any of these activities during your workday?

	YES	NO	HOW LONG/DISTANCE
a. Drive	_____	_____	_____
b. Walk	_____	_____	_____
c. Stand	_____	_____	_____
d. Sit	_____	_____	_____
e. Twist	_____	_____	_____
f. Bend	_____	_____	_____
g. Squat	_____	_____	_____
h. Kneel	_____	_____	_____
i. Reach	_____	_____	_____
j. Crawl	_____	_____	_____
k. Stairs	_____	_____	_____
l. Ladder	_____	_____	_____

Do you incorporate any pushing/pulling? YES ___ NO ___

If yes, please answer the following:

- What do you push/pull? _____
- How far? _____
- How much weight is involved? _____
- On what type of surface do you push/pull? _____
- Does the unit have wheels? YES ___ NO ___

Print Name