



WELCOME TO THE HUMAN PERFORMANCE AND REHABILITATION CENTERS, INC.

Welcome to Human Performance and Rehabilitation Centers, Inc. The following information will give you a better understanding of our payment, insurance filing and information policies:

PAYMENT POLICY: Payment is requested at the time of service unless other arrangements are made prior to treatment. We accept cash, check, MasterCard, Visa or American Express and most Health savings and Flexible Spending Accounts.

INSURANCE: HPRC will file your primary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance. You are responsible for payment of that balance. If your insurance does not pay, you should contact the insurance company. This office will not negotiate the settlement of a disputed insurance claim.

MANAGED CARE CONTRACTS: HPRC is enrolled in numerous managed care and participating provider insurance programs. Please advise our staff if you are a member of this type program. All co-pays or estimated patient balances are due at time of service. Our participation is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim.

MEDICARE: The therapists at HPRC are participating Medicare providers. We will file your Medicare and one supplement if you provide us with the appropriate insurance information. You will receive a statement each month until your account is paid out. Pay only amounts in patient responsibility on your statement. Medicare will pay 80% of covered services after your deductible is met. You are responsible for your deductible and 20% of covered charges if your supplement does not pay timely. Medicare requires that you see your physician at least every 90 days while you are receiving therapy.

WORKERS' COMPENSATION: Please provide HPRC with the proper information required to verify coverage. Except for acute cases, treatment will not begin until we have authorization from your workers' compensation carrier.

NON-COVERED SERVICES: Some or all of the services provided to you may not be covered by your insurance. You will be responsible for payment of these services.

INFORMATION DISCLOSURE: Federal and state law allows us to use and disclose information about you for purposes of treatment, billing and receiving payment, and routine health care operations. In order to use or disclose information about you for any other purpose, we need your specific authorization. The "Notice of Privacy Practices" posted in our lobby explains how we use and disclose information. If you request, we will provide you with a copy of the Notice of Privacy Practices.

LEGAL CASES: We cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered.

IF YOU HAVE ANY QUESTIONS, SOMEONE FROM OUR BUSINESS OFFICE WILL BE GLAD TO ASSIST YOU.

CONSENT FOR TREATMENT & AUTHORIZATION: I do hereby consent to treatment by Human Performance and Rehabilitation Centers, Inc. I authorize HPRC to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to Human Performance and Rehabilitation Centers, Inc. when indicated on claim. I understand that I am financially responsible for the charges for services rendered.

Signed _____ Date _____

Relationship to Patient: _____

Witnessed By: _____



PATIENT INFORMATION SHEET

Referring Doctor _____ Primary Care Provider _____
What part of the body are we treating? _____

Personal Information

First Name _____ Middle Initial _____ Last _____ Nickname _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
SSN _____ - _____ - _____ DOB ____ / ____ / ____ Gender M____ F____ Marital Status Married ____ Single ____
Height ____ foot, ____ inches Weight _____ Are you disabled? Y____ N____ If yes, what is your disability _____

Employer _____ Occupation _____ Phone (____) _____
Emergency Contact _____ Relationship _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____

Can we communicate with you by Email? Yes / No Email address _____ (optional)

Insurance Information

Primary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB ____ / ____ / ____ Policy Holder's SSN _____ - _____ - _____
Policy Holder's Address (if different): _____

Secondary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB ____ / ____ / ____ Policy Holder's SSN _____ - _____ - _____
Policy Holder's Address (if different): _____

If this is an approved claim through Worker's Compensation, please answer the following:

Injury Date _____ Employer when injury occurred (if different) _____
Insurance Carrier Name _____ Contact/Adjuster _____
Claim Number _____ Adjuster's Phone (____) _____

Please complete this section if the patient is a Minor and/or covered under parent's insurance:

Mother's Name _____ Phone (____) _____ SSN _____ - _____ - _____
Address (if different) _____ Employer _____
Father's Name _____ Phone (____) _____ SSN _____ - _____ - _____
Address (if different) _____ Employer _____

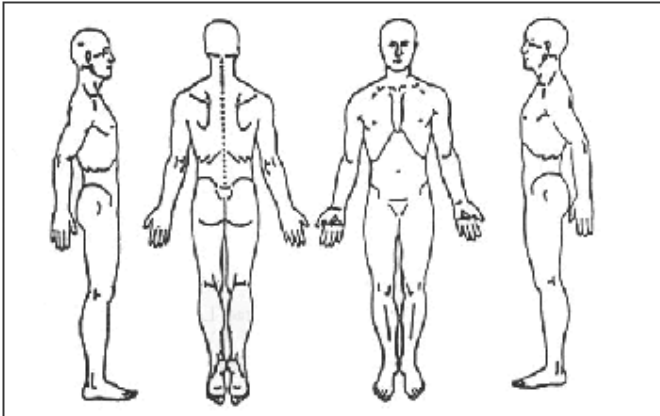
**Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.**

Signature: _____ Date: _____

Name:	Date:	Gender:	DOB:
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CURRENT INJURY: _____

Please mark below where your pain is located



Date started?		
Describe the onset and history of current condition		

Occupation?		
<input type="checkbox"/> Full Time	<input type="checkbox"/> Retired	<input type="checkbox"/> Not employed
<input type="checkbox"/> Part Time	<input type="checkbox"/> Disabled	
<input type="checkbox"/> Modified	<input type="checkbox"/> Full or Part Time Student	

Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

Over the past 6 months, have you been diagnosed with or are you currently experiencing any of the following symptoms?

<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Difficulty emptying bladder
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Kidney stones
<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Asthma	<input type="checkbox"/> Painful intercourse
<input type="checkbox"/> Dizziness	<input type="checkbox"/> COPD/ Emphysema	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Clumsiness or staggering	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Numbness
<input type="checkbox"/> Double vision	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Taste or smell change
<input type="checkbox"/> Falls to the ground	<input type="checkbox"/> Heart attack	<input type="checkbox"/> Skin turning yellow color
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Wheezing/ Coughing	<input type="checkbox"/> Rash/Itching or scaly patches
<input type="checkbox"/> Difficulty speaking	<input type="checkbox"/> Difficulty swallowing	<input type="checkbox"/> Hair or nail changes
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Abdominal pain or fullness	<input type="checkbox"/> Swelling in the arms or legs
<input type="checkbox"/> Night pain or sweats	<input type="checkbox"/> Constipation	<input type="checkbox"/> Liver or gallbladder Issues
<input type="checkbox"/> Muscle cramps	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Vomiting/ Nausea	<input type="checkbox"/> TB <input type="checkbox"/> Current <input type="checkbox"/> Past
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Appetite or weight change	<input type="checkbox"/> Allergies
<input type="checkbox"/> Open sores or wounds	<input type="checkbox"/> Change in bowel habits	Females:
<input type="checkbox"/> Dark red/purplish legs	<input type="checkbox"/> Blood in stool or urine	<input type="checkbox"/> Currently Pregnant
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Regular Menstrual Cycle
<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression	<input type="checkbox"/> Low urine output	<input type="checkbox"/> Menopausal Symptoms
<input type="checkbox"/> Abuse <input type="checkbox"/> Neglect	<input type="checkbox"/> Urinary infection	<input type="checkbox"/>

Have you had any of the following procedures?

- | | | |
|---|--|--|
| <input type="checkbox"/> Bypass Surgery | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Joint Replacement |
| <input type="checkbox"/> Cardiac Ablation | <input type="checkbox"/> Stent Placement | <input type="checkbox"/> Metal Implants |



Mental Health Background:

*Over the last 2 weeks, have you had thoughts that you would be better off dead? Yes No

IF NO to the above question, no need to answer 1&2 below. **IF YES** please answer 1&2 below questions:

- 1. Have you wished you were dead or wished you could go to sleep and not wake up? Yes No
- 2. Have you actually had any thoughts of killing yourself? Yes No

Please list your current medications, vitamins or supplements. (If your medications are written down, please allow us to scan into your chart) **Please specify blood thinners and NSAID's**

Please list any major surgeries (past 5 years) or pertinent to current condition

Please list any diagnostic tests you've had performed specific to current condition

- Biopsy
- Blood work/Lab Tests
- Bone Density Scan
- CT Scan
- EEG
- EMG
- Lower GI Study
- Motility Study
- MRI
- Nerve Conduction Study
- Swallow Study
- Upper Endoscopy
- Ultrasound
- X-Ray
- Other

Living Situation

- Single Story Home
- 2 Story Home
- Yes No Are there stairs at home?
- Other situation
- Ground Floor Apartment
- Upper Level Apartment
- Yes No Is there a handrail present?
- Assisted Living Facility
- Skilled Nursing Facility

Who do you live with?

- Spouse
- Spouse + Children
- Yes No Are others available to help if needed?
- Child(ren)
- Other Family Member
- Alone
- Other

What is your primary role at home?

- Caregiver for others
- Financial Provider
- Yes No Is the patient currently able to perform these roles?
- Housework
- Home Maintenance
- Yard Maintenance
- Other

Social Habits:

Smoker/Tobacco Products?	Current/Past Usage per Day?	Year stopped?
Coffee? Y / N Drinks/week?	Alcohol? Y / N Drinks/week?	Soft Drinks? Y / N Drinks/week?
Current or Prior Exercise Program?		Frequency/Duration?



ACKNOWLEDGEMENT OF NOTICE OF INFORMATION PRACTICES

(To be retained by Medical Provider)

I understand that Human Performance and Rehabilitation Centers, Inc. (referred to below as “the clinic”) will use and disclose **health information** about me in the course of providing treatment.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic’s ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written **Notice of Privacy Practices** that describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy of the most current version of the clinic’s Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will be provided with a copy of the Notice of Privacy Practices upon request.

By: _____
(Patient)

Date: _____

-OR-

By: _____
(Patient’s Representative)

Date: _____

Description of Representative’s Authority: _____