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 heal 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: ______________________________

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:____ Date:________________________

(Patient)

-OR-

By:____ Date:________________________

(Patient's Representative)

Description of Representative's Authority:____

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 <u>Worker's Compensation</u>, 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 _________________________________

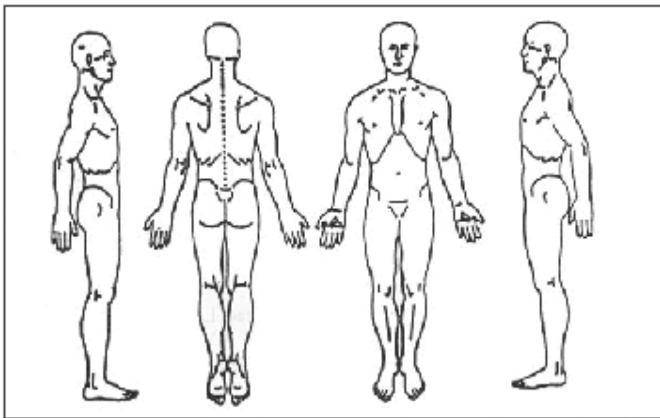
Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.

Signature: ____ Date: ______________________________________

Name:	Date:	Gender:	DOB:
Email:	Cell Phone:		

CURRENT INJURY: ____

Please mark below where your pain is located



Date started?		
Describe the onset and history of current condition ____________________________________ ____________________________________		
Occupation?		
□ Full Time	□ Retired	□ Not employed
□ Part Time	□ Disabled	
□ Modified	□ 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?

□ Abnormal Bleeding	□ DVT/ blood clot	□ Multiple Sclerosis
□ Abuse □ Neglect	□ Falls to the ground	□ Muscle Cramps
□ Angina (chest pain)	□ Fibromyalgia	□ Heart Attack □ Heart Disease
□ Anxiety	□ Frequent UTI	□ Numbness
□ Arrythmia	□ Gastroesophageal reflux dis.	□ Osteoarthritis
□ Asthma	□ Glaucoma	□ Osteoporosis
□ Bipolar Disorder	□ Gout	□ Psoriatic Arthritis
□ Blood Clotting Disorder	□ Hard of Hearing □Hearing aid	□ PVD(Peripheral Vascular Dis)
□ Bowel Incontinence	□ Hepatitis □ B □ C	□ Rheumatoid Arthritis
□ Cancer Type:	□ Hiatal Hernia	□ Scoliosis
□ Cellulitis	□ High Blood Pressure □Low	□ Seizure Disorder
□ Closed Head Injury	□ High Cholesterol	□ Shortness of Breath
□ Colitis	□ HIV/AIDS	□ Sleeping Disorder
□ Congestive Heart Failure	□ Hypothyroidism □ Hyper	□ Tuberculosis □Current □ Past
□ COPD	□ Irritable Bowel Syndrome	□ Urinary Incontinence
□ Chron's Disease	□ Kidney Stones	□ Allergies: ________________:
□ CVA (stroke)	□ Liver or gallbladder issues	**FEMALE:**
□ Depression	□ Lymphedema	□ Currently Pregnant
□ Diabetes Type1 □ Diabetes 2	□ Migraine Headaches	□ Regular Menstrual Cycle
□ Dizziness □Clumsiness	□ MRSA	□ Menopausal symptoms

Please list any other symptoms or conditions not listed:

____

Have you had any of the following procedures?

□ Bypass Surgery □ Pacemaker □ Joint Replacement
□ Cardiac Ablation □ Stent Placement □ Metal Implants

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

Living Situation

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

Who do you live with?

□ Spouse □ Child(ren) □ Alone
□ Spouse + Children □ Other Family Member □ Other
Are those checked available to help if needed? □ Yes □ No Comment: __________________

What is your primary role at home?

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

Social Habits:

Smoker/Tobacco Use? □ Yes □No Packs/day:	□Frequency □Occasionally □ Rarely □Never	Past Smoker? □ Yes □ No Year stopped?
Do you consume alcohol?	□Frequency □Occasionally □ Rarely □Never	Drinks/week? Drinks/time?
Do you consume caffeine? □ Coffee □ Soda □ Energy drinks		Drinks/day___ Days/wk ___
Current or Prior Exercise Program?		Frequency/Duration?