



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 _____

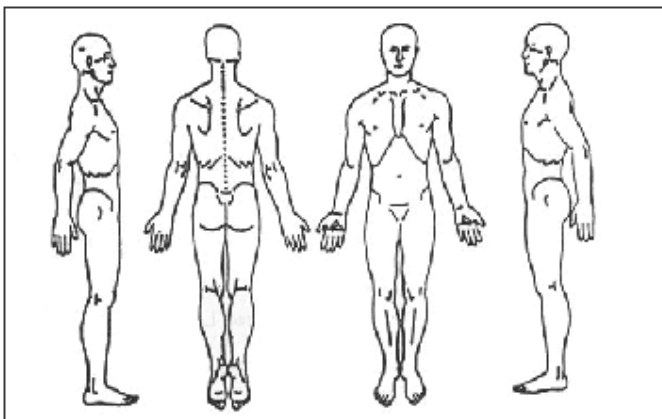
**Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.**

Signature: _____ Date: _____

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

CURRENT INJURY: _____

Please mark below where your pain is located



Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

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

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

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



Please list any other symptoms or conditions not listed:

Have you had any of the following procedures?

- Bypass Surgery, Cardiac Ablation, Pacemaker, Stent Placement, Joint Replacement, 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, 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, Ground Floor Apartment, Upper Level Apartment, Assisted Living Facility, Skilled Nursing Facility, Are there stairs at home?, Is there a handrail present?, Other situation

Who do you live with?

- Spouse, Spouse + Children, Child(ren), Other Family Member, Alone, Other, Are those checked available to help if needed?

What is your primary role at home?

- Caregiver for others, Financial Provider, Housework, Home Maintenance, Yard Maintenance, Other, Is the patient currently able to perform these roles?

Social Habits:

Table with 3 columns: Smoking/Tobacco Use, Alcohol Consumption, Caffeine Consumption, and Exercise Program. Includes frequency and duration options.