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: _____

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 _____

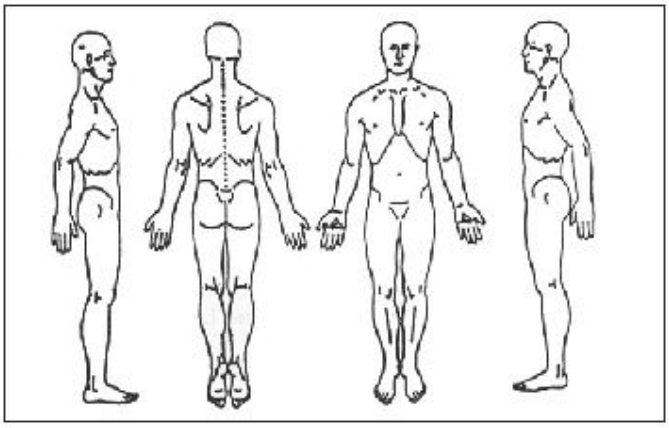
Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.

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?
□ Full Time □ Retired □ Not employed □ Part Time □ Disabled □ Modified □ 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?

□ 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?