



### Patient Information

Patient's Name: (Last \_\_\_\_\_ (First) \_\_\_\_\_ (MI) \_\_\_\_\_ Sex: M F  
 Date of Birth \_\_\_\_ Social Security # \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Telephone # \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
 Emergency Contact/Relationship/Telephone # \_\_\_\_\_  
 Referring Physician \_\_\_\_\_ **Primary Care Physician** \_\_\_\_\_  
 If related to an injury, what kind: Auto Work-Related Accident Athletic Other  
 Date of Injury \_\_\_\_\_  
 Employer \_\_\_\_\_ Address \_\_\_\_\_ Telephone # \_\_\_\_\_

**If under 18** Parent Responsible \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Telephone # \_\_\_\_\_ Employer \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

#### Insurance

Primary Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Insured's Employer \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 ID# \_\_\_\_\_ Group # \_\_\_\_\_

**MEDICARE PATIENT CERTIFICATION:** I certify the information given by me in applying for payment under Title XVII of Social Security Act is correct. I authorize the physician who treats me, to release information from my medical records to the Social Security Administration and/or Medicare program or its intermediaries or carriers or the Professional Standards Review Organization for processing of claims for medical benefits. I request that payment of authorization benefits be made directly to the physician treating me, on my behalf.

**TERMS AND CONDITIONS FOR INSURANCE AUTHORIZATION/ASSIGNMENT, AND FINANCIAL AGREEMENT. PLEASE READ CAREFULLY AND SIGN IN ORDER TO RECEIVE TREATMENT/SERVICES.**

**ALL PROFESSIONAL SERVICES ARE CHARGED TO THE PATIENT/EXCEPT FOR WORKERS COMPENTATION.** We will make every attempt to file and work with all insurance carriers on behalf of the patient to reduce the balance. Any insurance payment made on the patient's behalf on such bills will reduce the amount owed. All payment arrangements must be made in advance of services being rendered. IF DEEMED NECESSARY, we may process a credit check with the Credit Bureau of Indiana. All balances are due within 30 days of patient billing date, which is not covered by insurance.

I acknowledge and accept full responsibility for all services rendered. I agree to pay any service charge or interest (1.5% mo. 18%yr.) that may be assessed to any balance over 30 days past service date. In the event of default, I understand the balance due may be placed with a collection agency and I agree to pay 35% collection fee. In the event of legal action, I agree to pay reasonable attorney fees and court costs. I agree to pay any cancellation or no-show fees.

I give Lafayette Rehabilitation Services, permission to forward my medical records to my insurance company, employer rehab nurse, physician(s) and another party that may have an interest in payment of my rehabilitation. I hereby agree to all of the above terms and conditions, unless I am an approved Workman's Compensation patient which I agree to these same terms with the understanding that it is not my responsibility to cover the costs incurred for rehabilitation unless denied approval by my employer.

Signature \_\_\_\_\_ Date \_\_\_\_\_



**LAFAYETTE REHABILITATION SERVICES, INC.  
SPORTS AND INDUSTRIAL THERAPY**

**ACKNOWLEDGMENT OF RECEIPT OF PRIVACY NOTICE**

By signing below, I acknowledge that I have received Lafayette Rehabilitation Services, Inc.'s Notice of Privacy Practices ("Notice").

\_\_\_\_\_ Date \_\_\_\_\_  
Signature (Patient or Authorized Representative)

\_\_\_\_\_  
Printed (Patient or Authorized Representative)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgment
- An emergency situation prevented us from obtaining acknowledgment
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Unity Healthcare

## Acknowledgement of Receipt of Notice of Privacy Practices

I have received the Practice's Notice of Privacy Practices and understand that my protected health information maybe used by the Practice as described in the notice.

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT HISTORY

Work Related? Yes No Motor vehicle accident? Yes No

Are you currently working? Yes No What kind of job? \_\_\_\_\_

**Have you had any of the following medical tests?** X-rays CT scan MRI Arthrogram

Discogram Injections Bone Density Test/Scan Blood tests EMG/NCV

Other \_\_\_\_\_ Date of test(s) \_\_\_\_\_

Results: \_\_\_\_\_

**Are you presently taking any of the following medications?** Anti-inflammatory Pain pills

Muscle relaxer Hormone replacement Blood thinner Insulin Other \_\_\_\_\_

**Have you had treatment in the past for this problem?** Yes No

If yes, what type? Injections Chiropractic Physical/Occupational therapy Other \_\_\_\_\_

Did the treatment help? \_\_\_\_\_

Have you been pregnant? Yes No N/A Number of pregnancies \_\_\_\_\_

**My pain is** constant intermittent **What makes it worse?** Sitting Walking Standing

Reaching Looking up Bending Breathing deeply Lifting Repetitive motions Squatting Stairs

Other \_\_\_\_\_

**Pain rating: Lowest 0 1 2 3 4 5 6 7 8 9 10 Highest**

**What makes the pain better?**

Medicine Ice/Heat Rest Changing positions Other \_\_\_\_\_

Does your problem prevent you from sleeping? Yes No

Can you lay on the affected side? Yes No

Any dizziness? Yes No

Any numbness or tingling? Yes No

Any headaches? Yes No

Do you have an attorney? Yes (who) \_\_\_\_\_ No

## ATTENTION MEDICARE PATIENTS

Beginning January 2010 Medicare has implemented a Therapy Cap of \$1860.00.

Physical Therapy & Speech language pathology are considered one. Occupational Therapy is separate.

**If you have received Therapy outside of Lafayette Rehabilitation Services in 2010 we need to know the following.**

I have received therapy at another facility in 2010. YES or NO

What kind of therapy? Circle below

PHYSICAL      SPEECH      OCCUPATIONAL

What is the name of the facility where these services were provided?

\_\_\_\_\_

Telephone number: \_\_\_\_\_

How many visits did you receive? \_\_\_\_\_

### FALL RISK SCREENING

Have you fallen in the past year? YES or NO

If yes, how many times have you fallen? \_\_\_\_\_

Did you sustain an injury when you fell? YES or NO

Patients Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Thank you for your cooperation. We will keep you informed if and when you are coming close to reaching your maximum therapy benefits with Medicare.