PATIENT'S INFORMATION

Date: _____

Patient Name: _____
Last Name *Suffix* *First Name* *MI*

Permanent Mailing Address: _____

Physical Address: _____
If different than mailing

Home Phone: _____ Cell Phone: _____ DOB: _____

Social Security #: _____ E-Mail: _____ Marital Status _____

Race: _____ Ethnicity: ☐ Hispanic ☐ Not Hispanic Language: _____

Sex: ☐ M ☐ F Gender Identity: ☐ Female-to Male/ Transgender Male ☐ Male-to-Female/ Transgender Female ☐ Non-Binary/ Genderqueer ☐ Others

Employer Name: _____ Employer Phone: _____

Employer Address: _____

Preferred Pharmacy: _____ Pharmacy Location: _____

Emergency Contact: _____ Relationship: _____ Phone: _____
Leave blank if none

Primary Care Physician:_____ Referring Physician/Facility: _____

PCP City:_____ Referring City: _____

PCP Phone: _____ Referring Phone: _____

INSURANCE INFORMATION

Is this visit due to one of the following? ☐ Worker's Comp ☐ Liability ☐ Motor Vehicle Date of Injury: _____

Primary Insurance Co.: _____ Relationship to Subscriber: _____
If patient is not the subscriber complete the following.

Subscriber's Full Name: _____ SSN: _____

Subscriber's Address: _____

Subscriber's Sex: ☐ M ☐ F DOB: _____ Employer: _____

Subscriber's Employer Address & Phone: _____

Secondary Insurance Co.: _____ Relationship to Subscriber: _____
If patient is not the subscriber complete the following.

Subscriber's Full Name: _____ SSN: _____

Subscriber's Address: _____

Subscriber's Sex: ☐ M ☐ F DOB: _____ Employer: _____

Subscriber's Employer Address & Phone: _____

PARENT/GUARDIAN INFORMATION

If patient is a minor.

Father's Name: _____
Last Name *Suffix* *First Name* *MI*

Father's Mailing Address: _____

Father's Home Phone: _____ Cell Phone: _____

Father's DOB: _____ Father's SS#: _____

Father's Employer: _____

Employer Address: _____ Phone: _____

Mother's Name: _____
Last Name *Suffix* *First Name* *MI*

Mother's Mailing Address: _____

Mother's Home Phone: _____ Cell Phone: _____

Mother's DOB: _____ Mother's SS#: _____

Mother's Employer: _____

Employer Address: _____ Phone: _____

LAFAYETTE Rehabilitation Services
A UNITY HEALTHCARE PARTNER

Have you been a patient here before? ☐ Y ☐ N If yes, for ☐ the same or ☐ a different problem?

Primary Care Physician: _____ Therapy evaluations will be copied to your PCP (Do not send)

Have you had any other therapy this calendar year? ☐ Y ☐ N If yes, for: ☐ Physical ☐ Occupational ☐ Speech

For what body region(s) are you seeking treatment? (Please circle) ☐ Neck ☐ Mid-Back ☐ Lower
☐ Shoulder ☐ Elbow ☐ Hand ☐ Wrist ☐ Hip ☐ Knee ☐ Ankle ☐ Foot ☐ Other: _____

When did your symptoms start? _____ Can you identify a cause for your symptoms: ☐ Y ☐ N

If related to an injury, what kind? (Please circle) ☐ Auto ☐ Work ☐ Athletic ☐ Liability ☐ Other: _____

Have you retained an attorney as a result of this injury? ☐ Y ☐ N If yes, name: _____

If this is a work injury, employer name: _____

Have you had surgery related to this diagnosis? ☐ Y ☐ N If yes, when? _____

Check your *AVERAGE* level of pain: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
No pain Emergency Room

Does your pain move/radiate anywhere? ☐ Y ☐ N If yes, where? _____

Have you had any changes in your bowel/bladder/sexual function due to these symptoms? ☐ Y ☐ N

Have you ever had an allergic reaction to: ☐ Latex ☐ Band-Aids ☐ Cortisone ☐ Gel ☐ Lotion ☐ Beeswax

Have you fallen in the last year? ☐ Y ☐ N How many times? _____ Did you get hurt? ☐ Y ☐ N

Do you live alone? ☐ Y ☐ N Do you have a friend/family member to help you if needed? ☐ Y ☐ N

Do you smoke/use tobacco products? ☐ Y ☐ N Is there a chance you could be pregnant? ☐ Y ☐ N

1411 S. Creasy Lane, Suite 100 | Lafayette, IN 47905 | Phone: 765.447.5552 | Fax: 765.449.1054
3451 Wyndham Way, Suite D | West Lafayette, IN 47906 | Phone: 765.446.5250 | Fax: 765.446.5208
www.lafayetterehabilitation.com

LAFAYETTE Rehabilitation Services
A UNITY HEALTHCARE PARTNER

Please list all medications you are currently taking, including prescription, over the counter, & supplements:

Use back of this page if necessary. If you have a written list with you, our receptionist can make a copy for you.		
Medication Name	Dosage/Frequency	Reason for Taking

Please list any relevant surgeries, including when they were performed (month and/or year):

_____

_____

_____

Is your general health (please check one): ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Very Poor

What other medical problems do you or have you had?

☐ High Blood Pressure	☐ Diabetes	☐ Osteoarthritis	☐ Stroke	☐ Heart Disease
☐ Depression/Anxiety	☐ Cancer	☐ Rheumatoid	☐ Heart	☐ Lung Problems
☐ Parkinson's Disease	☐ Asthma	☐ Kidney Failure	☐ Gout	☐ Blood Clots
☐ Osteopenia/Osteoporosis	☐ Seizures	☐ Hard of Hearing	☐ HIV/AIDS	☐ Hard of Hearing
☐ Alzheimer's/Dementia	☐ Pacemaker	☐ Other:		

AUTHORIZATION STATEMENT

I authorize and consent to treatment at Lafayette Rehabilitation Services (LRS).

I authorize release of my medical records to my physician, insurance company, employer, rehab nurse, and any other party that may have an interest in payment of my rehabilitation.

I acknowledge that I have access to a copy of LRS's notice of privacy practices that describes my rights and LRS's duties with respect to my protected health information.

Patient Signature: _____ Date: _____

Guarantor's Signature: _____ Date: _____

Therapist Signature: _____ Date: _____

1411 S. Creasy Lane, Suite 100 | Lafayette, IN 47905 | Phone: 765.447.5552 | Fax: 765.449.1054
3451 Wyndham Way, Suite D | West Lafayette, IN 47906 | Phone: 765.446.5250 | Fax: 765.446.5208
www.lafayetterehabilitation.com

Dizziness Handicap Inventory

Date: _____

Patient Name: _____ Date of Birth: _____

The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness.

Item	Answer each question below as it pertains to your dizziness or unsteadiness only. Check: **Y**-yes **N**-no or **S**-sometimes		Y	N	S
1	Does looking up cause your symptoms?	P	☐	☐	☐
2	Do you feel frustrated?	E			☐
3	Do you restrict your travel for business or recreation?	F	☐	☐	☐
4	Does walking down an aisle of the supermarket increase your symptoms?	P	☐	☐	☐
5	Do you have difficulty getting into or out of bed?	F	☐	☐	☐
6	Do your symptoms significantly restrict your participation in social activities such as going out to dinner, the movies, dancing, or to parties?	F	☐	☐	☐
7	Do you have difficulty reading?	F	☐	☐	☐
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your symptoms?	P	☐	☐	☐
9	Are you afraid to leave your home without having someone accompany you?	E	☐	☐	☐
10	Are you embarrassed in front of others?	E	☐	☐	☐
11	Do quick movements of your head increase the symptoms?	P	☐	☐	☐
12	Do you avoid heights?	F	☐	☐	☐
13	Does turning over in bed increase your symptoms?	P	☐	☐	☐
14	Is it difficult for you to do strenuous housework or yardwork?	F	☐	☐	☐
15	Are you, afraid people may think you are intoxicated?	E	☐	☐	☐
16	Is it difficult for you to walk by yourself?	F	☐	☐	☐
17	Does walking down a sidewalk increase your symptoms?	P	☐	☐	☐
18	Is it difficult for you to concentrate?	E	☐	☐	☐
19	Is it difficult for you to walk around your house in the dark?	F	☐	☐	☐
20	Are you afraid to stay at home alone?	E	☐	☐	☐
21	Do you feel handicapped?	E	☐	☐	☐
22	Do your symptoms place stress on your relationships with family members or friends?	E	☐	☐	☐
23	Are you depressed?	E	☐	☐	☐
24	Do your symptoms interfere with your job or household responsibilities?	F	☐	☐	☐
25	Does bending over increase your symptoms?	P	☐	☐	☐
			x4	x0	x2
		=			
		TOTAL			

P _____ E _____ F _____

Perception of having a handicap: ☐ 100-70 = Severe ☐ 69-40 = moderate ☐ 39-0 = low

UNITY HEALTHCARE, LLC
DISCLOSURE AND RELEASE AUTHORIZATION

CONSENT TO TREAT: I request and give consent to my Unity Healthcare, LLC ("Unity") healthcare professional to provide and perform such medical/surgical care, therapy, tests, procedures, drugs, and other services and supplies as my healthcare professional, in their professional judgment, deems necessary or beneficial. I acknowledge that no representations, warranties, or guarantees as to the results or cures have been made to me or relied upon by me.

NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been offered a copy of the Unity Notice of Privacy Practices and understand that my protected health information ("PHI") may be used by Unity as described in such Notice.

OWNERSHIP DISCLOSURE: I acknowledge that Unity and indirectly, Unity's physicians, have an ownership interest in Unity Surgical Center ("USC"), and InnerVision Advanced Medical Imaging Center ("InnerVision"). I understand that I am free to determine which facility to utilize for health care services, and neither Unity nor my physician shall discriminate in the care provided to me should I desire to use a facility other than USC and InnerVision.

RELEASE OF MEDICAL INFO AND AUTHORIZATION TO PAY INSURANCE BENEFITS: I authorize Unity and my healthcare professional to release information from my medical records to my insurance carrier(s), governmental agency, or my employer in the case of work-related injuries or services for the purpose of processing claims for medical/workers compensation benefits and state on such claims that my signature is on file. I request that my insurance company(s) honor my assignment of insurance benefits applicable to the services and pay all assigned insurance benefits directly to my healthcare professional on my behalf.

FINANCIAL AGREEMENT: I understand and agree to all the following:

a. All accounts are the full responsibility of the patient and/or the patient's responsible party guarantor.
b. No conditional payments accepted, and payments with attempted conditions will be applied to any amounts owed.
c. Unity will assist me in obtaining insurance benefits when those benefits are assigned to my/the patient's healthcare professional. I have provided complete information regarding my/the patient's primary and secondary health insurance, as applicable.
d. I am responsible for making sure insurance payments are processed and paid promptly to my healthcare professional. In addition, I must provide my prompt payment of any amount owed to Unity that is deemed "Patient Responsibility" under my insurance contract (for those payors with which Unity is a participating healthcare professional or "in-network"). Otherwise, it is my responsibility if my insurance does not cover such services or Unity is a non-participating healthcare professional or "out-of-network".
e. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts. I agree that reasonable attorney fees shall be interpreted as 40% of any balance due at the time the account is sent to an attorney or collection agency for collection, or $300.00, whichever is greater.
f. Tippecanoe County, Indiana, shall be the preferred venue for any legal action related to this financial agreement, and I agree to waive my right to a trial by jury.
g. This financial agreement is being entered into individually and as an authorized agent for my spouse, if any. This financial agreement may be assigned by Unity to an attorney who purchases Unity's delinquent accounts, and the terms of this agreement shall remain binding.
h. A fee may be charged for any appointments not canceled at least twenty-four (24) hours in advance or missed for any other reason. These are generally not payable by insurance. I am responsible for these fees.
i. Unity Immediate Care (UICC) is not a participating provider with or under the Indiana Medicaid program. As a result, any medical or related services provided by the UICC will not be covered or paid by the Medicaid program.

OTHER PROVIDERS: I understand that in addition to the attending physician, other healthcare professionals, such as radiologists and pathologists, and other providers, such as laboratories and other medical professionals, may be involved in my care and may separately bill me for their services.

INDIANA LAW AND JURISDICTION: I understand that I am being provided treatment in the State of Indiana, and I agree that if I should have any claim with regard to my care or treatment, such will be decided in accordance with Indiana law and such action will be brought and decided in a Court in the State of Indiana.

NOTICE OF NONDISCRIMINATION: Unity complies with applicable Federal civil rights laws and does not discriminate based on race, color, national origin, age, disability, sex, or gender identity.

MEDICARE CERTIFICATION: (IF APPLICABLE) I certify that the information given by me, or by Unity on my behalf, in applying for payment under Title XVIII of the Social Security Act is correct. I authorize my treating healthcare professional to release information from my medical record to the Social Security Administration and/or Medicare program or its intermediaries or carriers, or the Professional Standards Review Organizations for the purpose of the processing of claims for medical benefits and state on such claims that my signature is on file. I request that payment of such authorized benefits be made directly to Unity or my treating physician on my behalf.

Please read and initial each of the following statements before signing this form. By initialing you indicate that you have read, understand and agree to each.

_____ AUTOMATED CONTACT: I authorize Unity and its affiliates and agents to use automated messages to contact me at the e-mail and phone numbers I have provided. These messages will provide information to me, such as *appointment information*, *closure messages*, *health services*, or *account information*. These may come in the form of a text message, automated call (whether a cell phone or a landline), or e-mail and will be left at the number or e-mail provided to any Unity healthcare professional. If I receive treatment from multiple Unity healthcare professionals, I may receive multiple messages referencing appointments/services from each office. I understand that I have the right to opt-out of any of these contact methods at any time, either by an opt-out within the message or by speaking to a Unity representative. Any opt-out request to a Unity healthcare professional will remove that contact method from ALL Unity Healthcare, LLC healthcare professionals. I understand I can later request to opt back into automated messages by speaking to a Unity representative.

_____ PHOTO CONSENT: My healthcare professional may request photos. I consent to have my photographs taken by my healthcare professional or designated associate if required and permit the use of photographs for identification, medical records, education, and lectures.

My signature below constitutes my acknowledgment and agreement that I have read and understand the consent, notices, disclosure, and other information provided.

Patient/Parent/Guardian

Print Patient Name: _____ Signature: _____ Date: _____

LAFAYETTE Rehabilitation Services
A UNITY HEALTHCARE PARTNER

ATTENDANCE/DISCHARGE POLICY

Patients will be discharged from Physical and Occupational therapy services when any of the following conditions are present:

Three (3) no shows

- 3 scheduled appointments are missed without notifying the clinician or the front office by the start of the scheduled appointment.

Less than 50% attendance

- Attendance is 50% or less of scheduled appointments during any four-week period

Medical necessity of treatment is no longer indicated

- Services are no longer medically necessary based upon standards of practice

All goals met as identified in initial or current evaluation

Late arrivals

- Arriving late to an appointment may impact if and how much your therapist can do for you to achieve the optimal benefit of treatment.
- Arrival 10 minutes late or more for a 30-minute appointment may mean your therapist is unable to see you.
- Arrival 20 minutes late or more for a 60-minute or longer scheduled appointment may mean your therapist is unable to see you.
- If you arrive late for your appointment. The appointment will end at its normally scheduled end time, unless determined otherwise by the therapist.

Cancellations by the therapist will not count as a missed appointment.

There will be a $30.00 charge for any no-shows or for cancellations with less than a 24-hour notice prior to the scheduled appointment.

Therapists are responsible for enforcing the attendance policy. Exceptions to the attendance policy may be determined by the therapist. Exceptions may be subject to review or approval by the department supervisor or director.
I understand and agree to the above policy. The phone number for **Unity Campus location is 765-447-5552** and The **West Lafayette location number is 765-446-5250.**

_____ _____

Patient or Guarantor Signature Date Therapist Signature Date

1411 S Creasy Lane, Suite 100 l Lafayette, IN 47905 l Phone: 765-447-5552 l Fax: 765-449-1054

3451 Wyndham Way, Suite C l West Lafayette, IN 47906 l Phone: 765-446-5250 l 765-446-5208

UNITY HEALTHCARE, LLC
HIPAA RELEASE OF INFORMATION

Name: _____ Patient Number: _____ DOB: _____

Due to HIPAA rules and regulations, we are not permitted to discuss your medical information with anyone, including your family, without your consent or unless an exception to the rule applies (e.g. provider-to-provider discussions related to your treatment or to collect payment).

If you want to allow us to communicate with any person, please complete the following. You may change your mind at a later date.

Please list individuals (other than providers) we may speak with regarding your care:

Name:	Relationship:	Phone:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

A photocopy of this authorization shall be considered as valid as the original. **This Release of Information will remain in effect until terminated by the patient in writing.**

Patient Signature: _____ Date: _____