



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/ Male-to-Female/ Non-Binary/ Others
Transgender Male Transgender Female Genderqueer

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: _____

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

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?

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Stroke	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Depression/Anxiety	<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatoid	<input type="checkbox"/> Heart	<input type="checkbox"/> Lung Problems
<input type="checkbox"/> Parkinson's Disease	<input type="checkbox"/> Asthma	<input type="checkbox"/> Kidney Failure	<input type="checkbox"/> Gout	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Osteopenia/Osteoporosis	<input type="checkbox"/> Seizures	<input type="checkbox"/> Hard of Hearing	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Hard of Hearing
<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> 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: _____

Neck Index

ACN Group, Inc. Form NI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your neck condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ⓪ I have no pain at the moment.
- ① The pain is very mild at the moment.
- ② The pain comes and goes and is moderate.
- ③ The pain is fairly severe at the moment.
- ④ The pain is very severe at the moment.
- ⑤ The pain is the worst imaginable at the moment.

Sleeping

- ⓪ I have no trouble sleeping.
- ① My sleep is slightly disturbed (less than 1 hour sleepless).
- ② My sleep is mildly disturbed (1-2 hours sleepless).
- ③ My sleep is moderately disturbed (2-3 hours sleepless).
- ④ My sleep is greatly disturbed (3-5 hours sleepless).
- ⑤ My sleep is completely disturbed (5-7 hours sleepless).

Reading

- ⓪ I can read as much as I want with no neck pain.
- ① I can read as much as I want with slight neck pain.
- ② I can read as much as I want with moderate neck pain.
- ③ I cannot read as much as I want because of moderate neck pain.
- ④ I can hardly read at all because of severe neck pain.
- ⑤ I cannot read at all because of neck pain.

Concentration

- ⓪ I can concentrate fully when I want with no difficulty.
- ① I can concentrate fully when I want with slight difficulty.
- ② I have a fair degree of difficulty concentrating when I want.
- ③ I have a lot of difficulty concentrating when I want.
- ④ I have a great deal of difficulty concentrating when I want.
- ⑤ I cannot concentrate at all.

Work

- ⓪ I can do as much work as I want.
- ① I can only do my usual work but no more.
- ② I can only do most of my usual work but no more.
- ③ I cannot do my usual work.
- ④ I can hardly do any work at all.
- ⑤ I cannot do any work at all.

Personal Care

- ⓪ I can look after myself normally without causing extra pain.
- ① I can look after myself normally but it causes extra pain.
- ② It is painful to look after myself and I am slow and careful.
- ③ I need some help but I manage most of my personal care.
- ④ I need help every day in most aspects of self care.
- ⑤ I do not get dressed, I wash with difficulty and stay in bed.

Lifting

- ⓪ I can lift heavy weights without extra pain.
- ① I can lift heavy weights but it causes extra pain.
- ② Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ③ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ④ I can only lift very light weights.
- ⑤ I cannot lift or carry anything at all.

Driving

- ⓪ I can drive my car without any neck pain.
- ① I can drive my car as long as I want with slight neck pain.
- ② I can drive my car as long as I want with moderate neck pain.
- ③ I cannot drive my car as long as I want because of moderate neck pain.
- ④ I can hardly drive at all because of severe neck pain.
- ⑤ I cannot drive my car at all because of neck pain.

Recreation

- ⓪ I am able to engage in all my recreation activities without neck pain.
- ① I am able to engage in all my usual recreation activities with some neck pain.
- ② I am able to engage in most but not all my usual recreation activities because of neck pain.
- ③ I am only able to engage in a few of my usual recreation activities because of neck pain.
- ④ I can hardly do any recreation activities because of neck pain.
- ⑤ I cannot do any recreation activities at all.

Headaches

- ⓪ I have no headaches at all.
- ① I have slight headaches which come infrequently.
- ② I have moderate headaches which come infrequently.
- ③ I have moderate headaches which come frequently.
- ④ I have severe headaches which come frequently.
- ⑤ I have headaches almost all the time.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Neck
Index
Score

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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: _____

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: _____



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 | Lafayette, IN 47905 | Phone: 765-447-5552 | Fax: 765-449-1054

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

**ATTENTION
MEDICARE PATIENTS**

Beginning January 2024 Medicare has implemented a Therapy Cap of **\$2330.00**.

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

If you have received therapy outside of Lafayette Rehabilitation Services in 2024 we need to know the following:

I **have** received therapy at another facility in 2024. Yes or No
I am **currently** under Home Health Care. Yes or No Discharge Date: _____

What kind of therapy?

Physical Occupational Home Health Speech

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

Telephone number: _____

How many visits did you receive? _____

MEDICARE PATIENT CERTIFICATON: I certify the information given by me in applying for payment under Title XVII of Social Security Act is correct. I authorize the clinician 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 clinician treating me, on my behalf.

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.