Core Rehabilitation

Patient Medical History Form

Notice of Patient Rights & Responsibilities

Medical History Form

Name: _____ Age: _____ Date: _____

*** To ensure you receive a thorough evaluation we need complete medical history information. Please answer all questions to the best of your ability. Some questions may seem like they do not apply. Please answer them as they may be an important piece of the puzzle.**

Current Condition

1. Please describe your current physical complaints or problems?

2. Date current complaint began: ___/____/_____
3. Is this problem due to (check all that apply) Auto accident Work Injury Fall
4. Any falls in the last year Y / N How many? _____ Last Fall Date _____
5. Have you seen any other healthcare providers (Physician, dentist, chiropractor, massage therapist, etc) for this condition? Y/ N Who: _____
6. Have you had any tests for this condition? (Please check all that apply)
    a. □ X- rays □ MRI □ CT Scan □ Nerve Test □ Bone Scan □ Blood Work □ Other
7. Have you had any procedures for this condition? (Please check all that apply)
    a. □ Injections Location: _____ □ Surgery Type : _____
8. Current Level of Function (please rate your current level)
    a. Sitting Tolerance (minutes) <5 5-10 10-20 20-30 30-60 > 60
    b. Standing Tolerance (minutes) <5 5-10 10-20 20-30 30-60 > 60
    c. Walking Tolerance (minutes) <5 5-10 10-20 20-30 30-60 > 60
    d. Dressing/Bathing/Grooming (Limitation) None Mild Moderate Severe Unable
    e. Normal Daily Activities (Limitation) None Mild Moderate Severe Unable
    f. Normal Household Tasks (Limitation) None Mild Moderate Severe Unable
9. Functional Deficits (Please check all activities that you are having difficulty with)
    a. Sleeping Dressing Bathing Taking care of yourself
    b. Lifting Carrying Push/pull Reaching
    c. Sitting Standing Bending Squatting
    d. Walking Running Working Household Chores
    e. Exercise Stairs Other _____

Pain (0-10 with 0 = no pain and 10 = pain so bad need to go to hospital, please circle)

10. Right Now 0 1 2 3 4 5 6 7 8 9 10

11. At Best 0 1 2 3 4 5 6 7 8 9 10
12. At Worst 0 1 2 3 4 5 6 7 8 9 10

Medical History

13. Have you ever been diagnosed with or told you have (Check all that apply):
    a. □ Cancer Type: _____ □ Heart Problems
    b. □ High blood pressure □ High Cholesterol □ Pacemaker/defibrillator
    c. □ Circulation Problems □ Neuropathy □ Lung Problems
    d. □ Asthma □ Emphysema □ Thyroid Problems
    e. □ Multiple Sclerosis □ Rheumatoid Arthritis □ Other Arthritis
    f. □ Osteoporosis □ Tuberculosis □ Stroke
    g. □ Depression □ Anxiety □ Kidney Problems
    h. □ Anemia □ Epilepsy/Seizures □ Other _____
    i. □ Chemical Dependency (alcohol/drugs) □ Diabetes
        - **Women Only:** Are you pregnant or could you be pregnant? Yes No

Surgical History

14. Please list all surgeries and approximate date (year) of the surgery:

_____

_____

Symptoms

15. Do you have any of the following symptoms? (Please check all that apply)
16. □ Chest Pain/tightness □ Shortness of breath □ Trouble sleeping
17. □ Recent Weight Loss/Gain □ Nausea/Vomiting □ Extreme Fatigue
18. □ Weakness □ Fever/Chills/Sweats □ Numbness/Tingling
19. □ Blood in urine or stool □ Dizziness/Fainting/Blackouts □ Loss of appetite
20. □ Changes in bowel function □ Changes in bladder function □ Skin Rash
21. □ Cough □ Dribbling or leaking urine □ Heart Palpitations
22. □ Swelling or lumps anywhere □ Problems seeing or hearing □ Memory Loss
23. □ Confusion □ Difficulty swallowing/talking
24. Have you been admitted to a hospital in the last 3 months? Y N
25. If yes, why? _____
26. Please list any physicians (other than listed previously) that you have seen in the last 3 months with a brief description of reason for visit (ie. Dr. Smith –Flu, Dr. Jones-Heart)
27. _____

Medications

28. Please list all medications you are currently taking including vitamins and supplements:

29. If you have list we will make a copy. _____
30. _____
    _____
    _____
31. Have you ever smoked/chewed tobacco? Y/N How many packs per day? ___ Years ___
32. Do you exercise regularly? Yes No How many days per week? ____
33. In the last month have you been feeling down, depressed or hopeless? Yes No
34. In the last month have you been bothered by having little interest or pleasure in doing things? Yes No
35. Do you ever feel unsafe at home/work or has anyone hit you or tried to injure you in any way? Yes No

Medicare Patients

36. Are you currently receiving any health services in your home (nursing, home aid)? Y N
37. Have you had any other therapy (physical/occupation/speech) in the last year? Y N

Therapist Only

Heart Rate ___ BP ___/___ Height: ___ Weight: ____ BMI: ____ In WebPT

Therapist Signature: _____ Date: _____

Patient Consent & Financial Policy

I authorize Core Rehabilitation to furnish physical therapy treatment as indicated by their evaluation. In addition I authorize Core Rehabilitation to release any information including medical information that may be necessary to process medical claims on my behalf to related physicians, insurance carriers or attorneys.

Financial Policy & Assignment of Benefits

- I understand that I am responsible for paying my co-payments, co-insurance and deductibles at the time of service. I also understand that I am responsible for the remaining balance due after my insurance company makes payment. I understand that Core Rehabilitation will bill my insurance carrier for the services rendered based on coverage verified by my insurance

carrier. I understand that verification of benefits is **not a guarantee** of payment and my financial responsibility is subject to change.

- If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for the services rendered. If my insurance company does not make payments on my account within 60 days, I agree to take an active role in petitioning my insurance carrier to make appropriate payments on my behalf for the services rendered. If my insurance company does not make payments on my account within 75 days, I understand that I will be responsible for the balance due in full.
- Charges related to Workers Compensation injury shall be forwarded to your Workers Compensation Insurance carrier and you will not be held personally responsible for these charges. However, if you claim that you have workers compensation benefits and are then denied these benefits, you will be held personally responsible for the balance of all services rendered to you.
- I hereby request that my insurance carrier make payment directly to Core Rehabilitation for all services rendered. If my insurance carrier makes payments to me I agree to immediately pay these funds directly to Core Rehabilitation. I also authorize Core Rehabilitation to deposit any checks received on my account when made out to me.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, attorney fees and interest from the date of service in the amount of 18% per annum.

Your primary health insurance carrier has verified that you have a yearly deductible of $ _____ of which $_____ has been met. After your deductible has been met, your primary insurance carrier states it covers medical services at _____%. Your secondary insurance carrier will be billed for any balances on your account and has advised us they will cover ____ % of the remaining balance. You have a responsibility of $ _____ or _____% co-payment which is due at each visit.

- ❖ Verification of insurance benefits that are given by your insurance carrier is not a guarantee of benefits or payment and you are ultimately responsible for services rendered to you. The patient, legal guardian or parent (if the patient is under 18 years old) will be personally responsible for the co-payment and the deductible at the time of service.

Patient/Guardian _____ Date_____

Core Rehabilitation

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Core Rehabilitation is required by law to maintain the privacy of certain health care information about our patients. The law also requires health care providers like Core Rehabilitation give you a notice like this one and to follow its standards.

Core Rehabilitation and Your Protected Health Care Information

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As a part of our day-to-day activities, Core Rehabilitation may need to use and disclose (share) your protected health care information for several purposes without first getting your written approval. Those purposes include:

- Your treatment. For example, Core Rehabilitation might discuss your condition and medications with your pharmacist.
- Payment for your treatment. For example, Core Rehabilitation may need to discuss your condition and the treatments Core Rehabilitation provided to you with your insurance company.
- Core Rehabilitation operations. For example, appropriate Core Rehabilitation staff must discuss your condition in order to provide you proper treatment.
- Core Rehabilitation may contact you based upon your protected health care information. For example Core Rehabilitation may call to arrange your appointments, provide you with information about new medications, treatments, benefits and services that are available to you.
- Core Rehabilitation may provide information to government officials who oversee health care or are working on threats to public safety from unsafe products, diseases, abuse, neglect, domestic violence and other crimes.
- Core Rehabilitation may provide information to licensed researchers who are under strict rules regarding how they use and disclose protected health care information. Those researchers, as an example, may use the information about patients with your condition for a study to improve ways to combat diseases.

No other uses and disclosures of your protected health care information will occur without your written authorization. And, if you sign such an authorization, you have the right to cancel it at any time.

Rights Regarding Your Protected Health Care Information

Under the law, you have several rights that Core Rehabilitation is committed to upholding. Those rights include:

- The right to request restrictions on some of the ways Core Rehabilitation uses and disclosures your information. These restrictions can go beyond the restrictions already in the law. However, Core Rehabilitation may not always agree to implement these additional restrictions.
- The right to receive confidential communications. While Core Rehabilitation cannot promise to communicate in every possible way patients might request, we will work with you to find a practical way of communicating with you in strict confidence if you wish.

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- The right to inspect and get copies of your health care information held by Core Rehabilitation by making a request in writing. Core Rehabilitation, however, may charge a reasonable fee to cover only the cost of providing this information.
- The right to request that Core Rehabilitation amend or correct information about you. To make such a change, Core Rehabilitation will ask you to make the request in writing with a description of the reason you want your record changed. Core Rehabilitation may not always agree to such requests.
- The right to a list of Core Rehabilitation disclosures of your protected health care information that were not authorized by you and the disclosures that were unrelated to treatment, payment and Core Rehabilitation operations.

If you have any questions or complaints about the way Core Rehabilitation handles your protected health care information or if you believe your privacy rights have been violated, contact the Core Rehabilitation Privacy Officer at (863)678-0705 or in person. You can also contact the Secretary of the U.S. Department of Health and Human Services. Please note that there will be no retaliation against you for filing a complaint or making requests regarding your health care information, or for disagreeing with Core Rehabilitation related decisions.

Core Rehabilitation may need to change its privacy practices from time to time. Before making such changes, however, Core Rehabilitation will modify this Notice and begin distributing it to patients when they are treated by Core Rehabilitation. These new practices will then apply to all information held by Core Rehabilitation. At any time, anyone has a right to get a paper copy of the latest version of this Notice by asking the Core Rehabilitation's receptionist.

Core Rehabilitation

Privacy Officer

Notice of Privacy Practices

Acknowledgement of Receipt

I received a copy of Core Rehabilitation's Notice of a Privacy Practices. I understand that if Core Rehabilitation uses my personal health information in a manner that is different than described by the Notice, Core Rehabilitation must first get my permission in writing.

I am accepting this Notice on behalf of:

❑ Myself

❑ Another person as his or her personal representative (parent, guardian, family member etc.)

OTHERS PRIVACY RIGHTS AGREEMENT

- I understand that Core Rehabilitation Inc. provides care in an open clinic space.

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- I understand photography, videos, or any other recording devices are prohibited unless I receive permission from Core Rehabilitation Inc. prior to recording. I understand I am responsible for insuring family members, or any other person who arrives with me will abide by these prohibitions.
- I also agree that I will not willfully listen, talk about, or otherwise violate other patient's expectation of privacy, and will ensure that my friends, and family will do the same.

Signature of Patient/Personal Representative:

_____

Print Name of Personal Representative (*if applicable*):

_____

Date signed: _____

If you received this by mail, please return a signed copy to:

Attention Privacy Officer

Joseph P. Koloc MSPT, MBA Core Rehabilitation

1750 Longleaf Blvd, STE 5&6

Lake Wales, FL 33859

Appointment Policy

- Your physical therapist have prescribed ___ visits per week.
    - You **must attend** the number of visits per week prescribed by your Physical Therapist in order to get better.

- If you do not complete 100% of your visits you will not receive 100% of the benefits of treatment.
    - For example; if you only attend 2 out of 3 visits per week you can only expect to get 66% of the results.

- We take special care to arrange an appointment time so you receive the highest quality of care. Please respect your appointment time so that you receive the quality of care you need and our therapists are able to provide the same level of care to our other patients at their scheduled time.

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- If you have an emergency and can not make it to your scheduled appointment, call us ASAP. Have another time and day ready so you can re-schedule.
    - **We will reschedule all cancelled appointments** so you can maintain the prescribed frequency and meet your goals.

- If you miss your scheduled appointment, we will call you within the first 10 minutes of your scheduled time. We will schedule you for later that same day if possible, if not you **MUST** attend your next scheduled appointment.

- If you **do not show up to or reschedule** a missed appointment by the end of business that same day, you will be discharged. We only work with patients who are serious about treatment and committed to getting better.

At Core Rehabilitation we pride ourselves on getting excellent results for our patients. We will do everything possible to help you meet your goals but **we need your commitment** to make it happen.
I have read and agree to follow the above appointment policy in order to achieve my goals in therapy at Core Rehabilitation.

_____ _____

Patient Signature Date