ADVANCED TRAINING AND REHAB

Name: _____ **Date of Birth** _____
Last First Middle Initial

Gender: M F **Marital Status:**_____ **SS#:**_____

Email address:_____

Address:_____ **Home Phone:**_____
(street)

_____ **Cell Phone:** _____
(city, state, zip code)

Parent/Guardian:_____ DOB:_____ **Work Phone:**_____
** (if under age 17)**

Emergency Name and Contact #: _____

Employer's Name/Address: _____

Occupation:_____ **Referring Doctor:**_____

How did you hear about Advanced Training & Rehab? _____

WORKERS COMP, AUTO OR ATTORNEY INFORMATION _____ Non-Applicable

_____
_____
_____ Injury due to: ____Work ____Other ____Auto accident
Employer, Company or Attorney Name/Address Date of Injury _____
Contact Person _____ Off Work Dates: From___/____/____ To ____/____/____

INSURANCE INFORMATION

Have you had any visits to a Physical Therapist or Chiropractor this year? Y N If so, how many visits?_____

Primary Insurance _____ ID# _____Grp # _____
Insured's Name _____ Employer _____
Relationship to Insured _____ DOB _____

Second Insurance _____ ID# _____ Grp# _____
Insured's Name _____ Employer _____
Relationship to Insured _____ DOB _____

By my signature below, I authorize Advanced Training And Rehab to treat me. I understand I have the right to refuse this treatment. All medical expenses shall be my responsibility. I Agree to pay any additional charges related to the cost of collection (including but not limited to finance charges, interest, collection agency fees of 37% of the bill that are added to the total bill, reasonable attorney's fees and court costs). I authorize Advanced Training And Rehab to release any medical information necessary for the processing and payment of my bills to any insurance company or other third-party payer who is or may be responsible for paying for medical treatment. I further authorize release of copies to the referring physician or physicians consulted in regard to said treatment. I further authorize the use of said records for the purpose of Workmen's Compensation disclosure. I hereby assign, transfer, and set over to Advanced Training And Rehab all of my rights, title and interest to my medical reimbursement benefit under my insurance policy.

SIGNATURE _____ **DATE** _____
Patient or parent/guardian of minor child

ADVANCED TRAINING
AND REHAB

NOTICE OF PRIVACY PRACTICES

Dear Patient,

Advanced Training and Rehab has always protected the confidentiality of health information by sealing medical records and refusing to reveal your health information without your consent. Now state and federal laws also attempt to ensure the confidentiality of this sensitive information. This Notice of Privacy Practices will inform you of our privacy practices and your rights:

1. All staff have been trained to maintain confidentiality of your medical records.
2. If you are a parent or guardian of a minor, you have a right to the health record of the minor.
3. You have the right to limit who among family has access to your record by telling us who can receive such information by listing their name(s) / relationship below:

    a. _____

    b._____

    c._____

4. The law allows us to use your patient information for treatment, payment and administrative purposes without your consent.
5. You have a right to your medical record at any time by filling out a form available from the front desk staff.
6. The law does allow treating staff to discuss your treatment without your consent.
7. Your record is safeguarded from exposure to casual workers entering the office such as delivery and service personnel.
8. We will make every effort to ensure a confidential space for sensitive conversations between you and our staff.

These rules are to ensure your privacy while under our care. If you have any concern about this Notice of Privacy Practices please contact Jim Hofman, our designated privacy officer at 314-434-6060.

Thank you for choosing Advanced Training and Rehab for your Physical Therapy needs.

SIGNATURE _____ **DATE** _____

Patient or parent/guardian of minor child

FINANCIAL POLICY

Thank you for choosing Advanced Training and Rehab as your health care provider. We appreciate your trust and the opportunity to serve you. As a part of our service, we try to contain the ever-rising cost of health care. This will explain the reimbursement process and the patient's financial responsibility.

Insurance Filing

Under Federal regulations, questions concerning eligibility for benefits or coverage of medical treatment or supplies are not claims, and any information provided to you is as a convenience only. It is not a guarantee or determination of benefits and may not be appealed. Benefits will be determined after treatment when a claim is filed in accordance with the plan's procedures.

******I understand Advanced Training and Rehab cannot guarantee how insurance will process my claims, including, but not limited to, copays, deductibles, and number of visits my insurance covers. ******

_____ (INITIAL)

If the payer's rate is less than Advanced Training and Rehab's contracted rate with your insurance carrier, you will be responsible for the difference.

If insurance payment is not received within 90 days, the balance will automatically be transferred to patient responsibility; at that time, cash or checks will be accepted. If necessary, a payment plan may be established.

*Delinquent Accounts

If an account goes unpaid and is referred to a collection agency, then cost for the collection service is the patient's responsibility.

Non-Covered Services

Each insurance policy may contain clauses that it does not cover a particular service. This does not mean it is not a medically appropriate service, it simply means that this policy does not cover that service. Additionally, some insurance companies do not deem some treatments/visits as medically necessary even though a doctor has prescribed it. These services are the responsibility of the patient.

Also, some supplies needed may not be covered by your insurance. You will be advised of any such items and payment is expected at the time you receive the supplies.

Usual & Customary Rates

Every insurance company uses a table of what it considers "usual & customary rates." These rates are established using a wide geographic area and may not truly represent reasonable rates for this area. Our

practice is committed to providing the best treatment for our patients and we charge less than what is "usual & customary" for our area. Any "UCR" reduction taken by your insurance is the responsibility of the patient.

Copays/Deductibles/Coinsurance

*****Copays, Coinsurance and Deductibles are due at the time of service***.** If you have a deductible that must be met first, we collect your contracted rate toward your deductible at each visit. Please refer to your explanation of benefits the insurance company sends you to know exactly what is due toward your deductible for each date of service. Once claims process you may owe more than collected, please refer to your Explanation of Benefit; if so, we will bill the remainder at the end of your treatment.

Statements

Should you have any questions regarding your bill, you may contact the billing department of Advanced Training and Rehab at (314) 434-8680. Statements are sent monthly. If we are a participating provider in your insurance plan, your statement may not be mailed until after your insurance has paid its portion of your claim.

Workman's Compensation Claims

We will accept your claim that treatment is subject to a Work Comp claim. All claims will be verified and your Work Comp Carrier will be contacted within 48 hours. If, at any point, Work Comp denies the claim for services, the patient will become responsible. At that time, the patient's personal medical insurance may be filed or a payment plan established.

Auto Accidents/Liability/Litigation

Advanced Training and Rehab will accept these claims within these limits:

1. Patients must sign medical liens, directing the responsible party to pay Advanced Training and Rehab in full when the claim is settled.
2. A copy of your personal medical insurance will be kept on file. After denial, if a claim remains unsettled, the balance becomes the responsibility of the patient. Your medical insurance will be filed or a payment plan may be established, at the discretion of Advanced Training and Rehab.
3. The patient authorizes Advanced Training and Rehab to assert a lien or financial stake in the insurance proceeds by signing below.
4. The patient authorizes Advanced Training and Rehab to be paid directly by third party ins

By signing below, I verify that I have read and agree to the above policy.

Acknowledged By: _____

Note**: Parent must sign if the patient is age 17 or younger.**

Dated: _____

Witness: _____

ADVANCED TRAINING AND REHAB

Patient Medical History

****(information for Therapist use only – not intended for office use) ****

Name: _____

Height: _____ Weight: _____

Tobacco Use: **YES** **NO**

Referring Physician: _____

1. Have you had any visits to a Physical Therapist or Chiropractor this year? **YES** **NO**
2. If so, how many? _____
3. Are you currently taking any prescription or non-prescription medications? **YES** **NO**
4. List medications:

_____

_____

5. Please list any allergies: _____

6. Please circle any of the following Medical or Rehabilitative Services you have received for this injury/incident:

Chiropractor General Practitioner Neurologist Orthopedist

Podiatrist CT Scan X-rays MRI

7. Do you currently or previously have any history of the following items?

____Breathing difficulties
____Chest Pain
____High Blood Pressure
____Heart Attack or Surgery
____Pacemaker
____Stroke
____Blood clot/Emboli
____Diabetes
____Osteoporosis
____Vision or Hearing Difficulties
____Bowel or Bladder Problems
____Numbness or Tingling
____Severe or Frequent Headaches
____ Joint Replacement
____Pins or metal implants
____Cancer/Chemotherapy/Radiation
____Sleeping Difficulties
____Emotional/Psychological Difficulties

8. Please list any previous surgeries and dates: _____

_____

9. Is there any chance you may be pregnant or are currently expecting a child? **YES** **NO**

SIGNATURE _____ **DATE** _____

Patient or parent/guardian of minor child

ADVANCED TRAINING AND REHAB

Numeric Pain Scale

Instructions: Rate your ***major area of pain*** on a ***0 to 10+ Pain Rating Scale***. Write the number of your pain in the spaces provided; pain now, lowest pain over the last month, and the highest pain over the last month.

Listed by the numbers or number ranges are examples of how healthcare workers will expect someone to look, act, and function. During the evaluation, ***your ratings will be measured against these criteria*** to see how consistent your complaints are with your behaviors.

10+ = The Worst Pain That Anyone Can Possibly Feel
You would be in the hospital and are totally dependent on someone for your care.

10 = Pain Requiring Emergency Medical Care
The pain is so bad; you would seek immediate medical attention.

7-8-9 = Pain Causing You to Stay in Bed
You would be able to feed yourself, go to the bathroom, and bathe. But for anything else you would need help.

6 = Pain Causing You to Stay Home
You would be able to perform all of your own self-care, but your pain would not allow you to travel beyond very short trips to the store or the doctor.

3-4-5 = Pain Causing You to Alter Your Daily Routine
You would need to change the way you do normal tasks or to eliminate the hardest things you do.

1-2 = Mild Discomfort
You can complete all of your normal duties and chores, but with mild discomfort.

0 = No Pain or Discomfort

Your pain level ***at this very second***: _____

Your ***lowest*** pain in the last month: _____

Your ***worst*** pain in the last month: _____

My signature below indicates that I understand the above and have had the opportunity to ask questions.

_____	_____	_____	_____
Patient	Date	Worker	Date