Patient Information

Date:_____ Soc.Sec. #_____ Birthdate:_____

Name:_____ Sex:__M__F

First Last MI

Address:_____ City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Email:_____

Marital status

Single _____ Married_____ Long-Term Partne_____ Divorce_____ Widowed_____ Separated_____ Minor_____

Employer:_____ Business Phone:_____

Business Address:_____ Occupation:_____

Who should we thank for referring you? _____

In case of emergency, who should we contact? _____ Phone:_____

Health History

Height:_____ Weight: _____ Date of injury: _____

Medicare History (please check all that apply)

__Arthritis __Shortness of Breath __Cancer __High/Low Blood Pressure

__Diabetes __Heart Disease __Psychiatric Condition __Latex Sensitivity

Surgical History/Other Relevant Medical History:

_____

_____

Please List Medications with Dosages:

___ Brought List (Please check if applicable. If not, please utilize the space provided)

_____

_____

Assignment and Release: I hereby authorize payment directly to _____ for all insurance benefits otherwise payable to me for services rendered. I understand I am financially responsible for all changed, whether or not paid by insurance, and for all services rendered on my behalf. I authorize my physician and/or any provider or supplier of services in the office to release the information to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party:_____ **Date:**_____

Auburn Bay City Essexville

One Time Authorization Agreement

I,_____ Medicare Number_____
request that payment of authorized Medicare benefits be made either to me or on my behalf to Thomas M. Barba, MPT, for services furnished to me by that Physical Therapist. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services (formerly known as the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable for related services.

_____
Beneficiary Signature

_____
Date

Appendix F

Acknowledgment of Receipt of Notice of Privacy Practices

As part of my health care, Prohealth Rehabilitation, PLLC creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among The Company's personnel, and with medical personnel outside of the practice. I understand that this information serves as a sources of information for applying my diagnosis and surgical information to my bill.

I understand that this information can be used as a tool to asses the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for The Company that providers a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that The Company may change its Notice of Privacy Practice at any time and that current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that The Company is not required to agree to the restrictions requested. The procedures to request restriction on information use and disclosure is contained in the Notice of Privacy Practice.

I acknowledge that I have received or have been offered a copy of the Notice of Privacy Practice of Prohealth Rehabilitation, PLLC and agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative **Date** **Relationship to Patient**

_____

Printed name of patient
Effective date April 14, 2003
Revised date September 23, 2013

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Auburn Bay City Essexville

Patient Authorization Record

Initial Here	
	Authorization for Treatment ➢ I hereby give authorization for the performance of such rehabilitation procedures as permitted by the State of Michigan Statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.
	Authorization for Release of Information ➢ I agree that Prohealth Rehabilitation PLLC (Auburn PT) may provide information from my medical record to persons involved in my medical care. ➢ I authorize the release of medical information necessary to obtain payment of any benefits available to me to Prohealth Rehabilitation PLLC for services rendered. ➢ I agree that Prohealth Rehabilitation PLLC (Auburn PT) may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. ➢ I have read "Notice of Privacy Practices" mandated by HIPAA
	Authorization for release of Payment ➢ I authorize that direct payment of any benefits available to me be released to Prohealth Rehabilitation PLLC (Auburn PT) for services rendered.
	Patient Agreement ➢ I agree to pay Prohealth Rehabilitation PLLC (Auburn PT) charges for services rendered to me during my course of treatment. ➢ I am aware and agree to pay for any services that may not be covered by my health insurance. I am also aware that in the event my account is turned over to collections I will be responsible for court costs, attorney fees, and any other charged associated with collecting my debt.
	Cancellation Policy ➢ Prohealth Rehabilitation PLLC (Auburn PT) requires 24 hour advance notice for any cancellation. Three consecutive cancels/failures to show up may result in discharge of service.
	Medicare, Medicaid, and Similar Benefits ➢ I agree that the information given to Prohealth Rehabilitation PLLC (Auburn PT) in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Prohealth Rehabilitation PLLC (Auburn PT) may give Social Security Administration of is fiscal intermediary's information necessary to process claims.
	Workers Compensation ➢ I agree that the information given to Prohealth Rehabilitation PLLC (Auburn PT) in applying for benefits under Workers Compensation is complete and accurate. I agree that Prohealth Rehabilitation PLLC (Auburn PT) may give intermediary's information necessary to process claims.

_____

Patient Printed Name Patient Signature Date

_____ _____

Signature of Legal Representation/POA Witness Signature Date