VALLEY REHAB CENTER

3609 Belmont Street

Bellaire, OH 43906

740-325-1120

Insurance Verification for Patient _____ Member _____

Member ID _____ Member DOB _____ Group # _____

Date _____ Person Spoken to _____ Reference # _____

Insurance Company _____

Policy Dates _____ Calendar Year Yes / No

Deductible _____ Met / Not Met Amount Remaining _____

Coinsurance _____

Co-Pay _____

Out of Pocket _____ Met / Not Met Amount Remaining _____

Visit Limit _____

Authorization Needed _____

Authorization Received _____

Send Claims to _____

Allowable Charges: 97001 _____ 97112 _____ 97032 _____

97140 _____ 97110 _____ 97035 _____ 97026 _____

97530 _____ 95992 _____

Health Saving Account _____

The above information has been reviewed with me. I agree to the physical therapy treatment prescribed. I realize that I am responsible for any remaining balances after my insurance has been processed. I agree to make timely payments for the remainder of the balance owed on my account.

Signature _____ Date _____

Completed By: _____

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Welcome to Valley Rehab Center

It is our goal to provide quality care designed to alleviate your pain and maximize your physical abilities. Today your therapist will evaluate you and tailor a treatment program to meet your individual needs. Together you will set realistic goals in an effort to facilitate your rapid recovery. We will work closely with you to meet these goals in a timely manner and will also teach you ways to care for yourself in order to prevent further injury or debilitation.

During your rehabilitation process, it is extremely important that you keep all of your appointments and follow the instructions given by your therapist. At Valley Rehab Center we are committed to providing personal one on one care. In order to keep that commitment we schedule our appointments in no less than 45 minute time blocks. This assures we have enough time to care for each of our patients. This, however, limits the number of appointment times available each day so please schedule in advance and please be courteous and notify us of the need to cancel at least **24 hours in advance** of a cancellation. We understand that "life happens" and it is sometimes necessary to cancel or change your appointment time. We want to accommodate you, but you must understand that appointment times are valuable and that missed appointment without prior notice prohibits us from seeing other patients in that time slot.

If you fail to cancel at least **24 hours prior** to your appointment time, or fail to show for a scheduled appointment, you will be assumed a **$25 missed visit fee**. This fee will be due at the time of your next scheduled visit. If you fail to return for additional therapy, this fee will be your final bill.

I have read and understand the cancellation policy.

Name _____ Date _____

Consent to Physical Therapy Evaluation and Treatment

I hereby consent to the evaluation and treatment of my condition by a licensed physical therapist employed by or under contract with Valley Rehab Center.

Name _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices for Protected Health Information

I acknowledge that I have received Valley Rehab Center's Notice of Privacy Practices of Protected Health Information.

Name _____ Date _____

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Assignment of Benefits

I do hereby consent to the recommended treatment by authorized personnel of Valley Rehab Center as may be dictated by prudent medical practice for my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

I, the undersigned or designated representative for the patient, do hereby assign all medical benefits of which I am entitled to Valley Rehab Center Inc., in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance.

After obtaining your insurance information, as a courtesy to our patients, our billing department will attempt to verify and explain your physical therapy benefits to you by your second or third visit to our clinic. However, please know that it is the patient's ultimate responsibility to know what their physical therapy benefits are by calling their insurance provider themselves or by asking our office manager to explain their physical therapy benefits to them. Once we have verified your benefits we will be very glad to review them with you so that you can make an informed decision about your treatment.

Thank you for allowing Valley Rehab Center to have the opportunity to serve you. If you have questions regarding the above information or uncertainty regarding your insurance benefits please ask for our assistance. Please sign and date this form to indicate you understand and agree to these conditions.

I do hereby authorize Valley Rehab Center to release all information necessary to secure payments of said benefits.

_____ Date _____

Patient or Legal Guardian

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Name _____ Age _____ Date of Birth _____

Address _____

City _____ State _____ Zip Code _____

Home Phone Number _____ Cell Phone Number _____

Email Address _____

Employer _____ Phone Number _____

Occupation _____ Social Security Number _____

If Client is a Minor, Name of Guardian _____ Relationship _____

Name of Person to Call in Case of Emergency _____

Phone Number _____ Address _____

City_____ State _____ Zip Code _____

Who referred you to our service? _____

Reason you are seeking physical therapy: _____

HIPPA Medical Release:

I authorize the release of information including diagnosis, treatment rendered to me and claims information to the following:

( ) Spouse _____ ( ) Children _____

( ) Other _____ ( ) My information is not to be release to anyone.

The release will remain in effect until terminated by me in writing.

Messages:

Please call: ( ) my home ( ) my work ( ) my cell ( ) other _____

If unable to reach me, you may: ( ) leave a detailed message ( ) leave a message to return your call.

Best time to reach me is: ( ) day ( ) evening ( ) between (time) _____

Signed _____ Date _____

Witness _____ Date _____

Name _____

Name of Primary Physician _____
Name of Referring Physician _____
When are you scheduled to return to your physician? _____
Have you seen anyone else for your condition?

( ) Physician/MD ( ) Chiropractor ( ) Podiatrist ( ) Orthopedic Surgeon
( ) Dentist ( ) Neurologist ( ) Physical Therapist ( ) Other _____

Past Medical History:

Have you ever had any of the following conditions? Check all that apply.

( ) High blood pressure ( ) Heart condition ( ) Stroke ( )Peripheral Neuropathy
( ) Osteoporosis ( ) Seizures/Epilepsy ( ) Vision Problems ( ) Diabetes
( ) Hearing Problems ( ) Fainting/Dizziness ( ) Emphysema ( ) Frequent or severe headaches
( ) Bowel/bladder issues ( ) Cancer ( ) Arthritis ( ) Asthma
( ) Other: _____

Have you had any falls in the past year?	YES	NO	If so, about how many? _____
Do you have a history of fractures?	YES	NO	Where? _____
Do you have any metal implants?	YES	NO	Where? _____
Do you smoke?	YES	NO	How much per day? _____
Do you exercise regularly?	YES	NO	How often? _____
Do you have any known allergies?	YES	NO	Please List: _____
Are you pregnant or think that you might be?	YES	NO	

Medications:

Please list any medications (prescribed or over the counter) or supplements that you are currently taking:

_____
_____

Surgeries: Please list all surgeries including dates: _____
_____

Diagnostic Tests: Please check and tests or procedures that have been done for your **current** condition.

( ) X Rays ( ) MRI ( ) CT Scan ( ) Bone Scan
( ) EMG ( ) Blood Work ( ) Bone Density ( ) Ultrasound

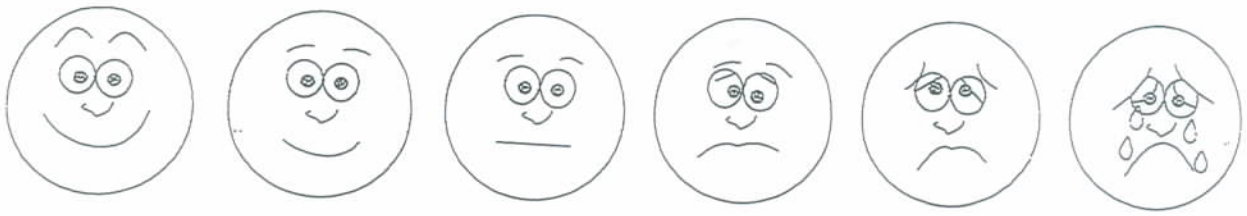
Current Condition:

What is the problem you are here for? _____
What is the date when the problem started? _____
Have you had similar symptoms before? _____
Have you had previous treatment for this condition? _____

Patient Signature _____ Date _____

Therapist Signature _____ Date _____

Faces Pain Scale



0	2	4	6	8	10
Very happy, no hurt	Hurts just a little bit	Hurts a little more	Hurts even more	Hurts a whole lot	Hurts as much as you can imagine (don't have to be crying to feel this much pain)

Please check all that may apply. My pain is worse:
in the morning / during the day / at night / constant / with activity / during rest
☐ ☐ ☐ ☐ ☐ ☐

On a scale of 0 to 10,
(0 being no pain and 10 being unbearable pain requiring hospitalization)
Please rate your pain at its best _____ and at its worse _____

Using the key provided, please draw the symbol representing your pain over the area of the body as it relates to your present condition.