Date:___________

New Patient Information

Name: ____ Date of Birth: ___________________
E-mail Address: __________________________ Primary Care: __________________________
Reason for Therapy: ____

□ Speech Therapy □ Occupational Therapy □ Physical Therapy

History of Current Issue:

Are you currently taking any medications (prescription and/or over the counter medicines)?
Please, specify:

Have you had any of the following diagnostic, medical or rehabilitative services for this issue? Check the appropriate box or boxes:

□ Chiropractor
□ Massage Therapy
□ Speech Therapy
□ Occupational Therapy
□ Physical Therapy
□ General Practitioner
□ MRI
□ Neurologist
□ Orthopedist
□ Podiatrist
□ X-Rays
□ Emergency Room
□ Inpatient Rehab
□ Myelogram
□ Other

Do you now or have you ever had any of the following? Please check appropriate box or boxes:

□ Asthma, Bronchitis, or Emphysema
□ Anemia
□ Heart Attack or Surgery
□ Coronary Heart Disease or Angina
□ Dizziness or Fainting
□ Emotional/Psychological Problems
□ Falls
□ Hernia
□ High Blood Pressure
□ Shortness of Breath / Chest Pain
□ Diabetes I or II
□ Thyroid Disorder/Goiter
□ Cancer / Chemotherapy / Radiation
□ Infectious Diseases
□ Bowel or Bladder Problems
□ Numbness or Tingling
□ Severe or Frequent Headaches
□ Osteoporosis/ Osteopenia
□ Neck / Shoulder Injury/Surgery
□ Sleeping Problems/Difficulties
□ Blood Clot / Emboli (DVT/PE)
□ Epilepsy / Seizures
□ Pacemaker
□ Joint Replacement of ______________
□ Currently Pregnant / Trying to Conceive
□ Neurological Condition
□ Allergies, Specify: __________________
□ Elbow / Hand Injury
□ Vision or Hearing Difficulties
□ Stroke / TIA
□ Kidney Problems
□ Back Injury / Surgery
□ Ankle / Foot Injury / Surgery
□ Knee / Hip Injury/Surgery
□ Arthritis/Swollen Joints
□ Unintentional Weight Loss/Energy Loss
□ Tobacco / Cigarette Use
□ Other, Specify:_____________________

Please list any additional information about your health or any medical conditions you have not listed above:

What are your expectations or goals for therapy?

I have truthfully answered these questions about my medical history and condition and provided information about my current medications and medical care.

____

Signature

____

Date

Patient Privacy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have read and fully understand Infinite Rehab and Wellness may use or disclose my personal health information, without limitations, for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided, patient trend studies and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Infinite Rehab and Wellness will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Infinite Rehab and Wellness has taken action relying on this consent.

_____ Initial here that I have read, agree with, and understand the above statements.

Informed Consent to Treatment

Physical, Occupational, and Speech Therapy involves the use of many different types of physical evaluation and treatment. The patient should understand that a Physical, Occupational and Speech Therapy diagnosis are not a medical diagnosis by a physician or based on radiological imaging and that health plan or insurer might not cover such services.

As with all forms of medical treatment, there are benefits and risks involved with physical, occupational, and speech therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict the patient's response to a certain modality or procedure. It is impossible to predict an individual patient's reaction to a particular treatment, nor can it be guaranteed that the treatment will help the condition the patient is seeking treatment for. There is also a small risk that the treatment may cause pain or injury, or may aggravate previous existing conditions. The patient has the right to ask the treating therapist what type of treatment he/she is planning based on medical history, diagnosis, symptoms and testing results. The patient may ask the therapist about the potential risks and benefits of a specific treatment. The patient has the right to decline any portion of the treatment at any time before or during the treatment session.

I acknowledge that an Infinite Rehab and Wellness therapist has explained my treatment program, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical, Occupational, or Speech Therapy as outlined to me, and wish to proceed.

____

Signature

____

Date

Financial Responsibility

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. I, the patient, is responsible for charges incurred, regardless of insurance coverage. If Infinite Rehab and Wellness has a contract with the patient's insurance carrier, Infinite Rehab and Wellness will file the claim for patient's services. If the insurance company denies payment for no referral, non-covered services, deductible, etc, I understand that I am responsible for all balances due.

I understand, in some instances, all or some of the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance. I understand that it is my responsibility to understand my insurance benefits and comply with the requirements of the policy.

_____ Initial here that I have read, agree with, and understand the above statements.
_____ I give Infinite Rehab & Wellness authorization to keep my credit card on file

Appointment Times and Scheduling

All appointments are expected to last 45-60 minutes in length. Infinite Rehab and Wellness will at minimum contact the patient or caregiver the day before appointment to confirm appointment time. Infinite Rehab and Wellness respects patient's time and makes every effort to arrive on schedule. However, because an employee cannot anticipate what every person will need, or if medical emergencies arise, he/she will take whatever time is necessary to give each and every patient the best care that is needed. As Infinite Rehab and Wellness employees make home visits, one cannot foresee challenges in parking, heavy traffic, or unforeseen road conditions. For this reason therapists will give a window between fifteen to thirty minutes before or after the appointment time of arrival. If therapist is running more than thirty minutes late then patient will be called and notified and given the opportunity to reschedule without a cancellation / no show fee.

_____ Initial here that I have read, agree with, and understand the above statements.

Cancellations and Missed Appointments

In the event that the patient is unable to keep an appointment please contact your therapist as quickly as possible. Visits that are cancelled only 2 hours prior to visit time or are not cancelled at all will be billed $25 due to scheduling / traveling inconveniences. E-mail is a suitable means to communicate visit cancelation if message is sent twenty-four hours prior to visit start time. In the case of a true medical emergency, the cancellation fee will be waived.

_____ Initial here that I have read, agree with, and understand the above statements.

Patient Media Release

I hereby grant permission to the staff of Infinite Rehab and Wellness to use images, likenesses, audio or any other data (heretofore referred to as "Media") obtained through my treatment for instructional, educational, promotional, or research purposes. This included all photos, videos, audio recordings, charts, graphs, analysis or any other data obtained by or submitted to the staff of Infinite Rehab and Wellness in the course of my treatment. The Media may be used in any professional manner that Infinite Rehab and Wellness deems necessary and I understand that the Media belongs to Infinite Rehab and Wellness and I will not receive any compensation or payment in connection to their use.

I assume the risks involved in releasing this information and release Infinite Rehab and Wellness and it's employees and contractors from any and all liability that could arise from the use of this Media.

_____ Initial here that I have read, agree with, and understand the above statements.

_____ Initial here that I wish to opt out of media

Insurance Benefits and Financial Responsibility

Patient Name:_______________________________________

Insurance Verification Date: ________________

Primary Insurance:____________________________________

Deductible: _____________ Deductible remaining: $___________

Out of Pocket: $__________ Out of pocket remaining $_____________

Co-pay: $______

Co-insurance: _____% Patient Responsibility: _____%

Visits Per Year: ______ Visits remaining: ______

Physical Therapy Rate: $125 per visit

Plan of Care estimate: _______ visits a week for _______ weeks

Patient Estimated cost: $_______ per visit $________ Plan of Care total

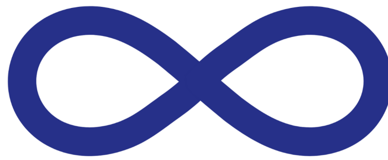
My insurance benefits have been explained to me and I understand that I am responsible for the remaining balance not reimbursed by my insurance company. I acknowledge that I am to make full payment within 30 days of receiving the invoice via cash, check, credit card, and HSA/FSA to Infinite Rehab and Wellness.

____

Patient Signature

____

Date



Private Pay Rates

Session Duration	Cost	8 Session Package	12 Session Package
60 min	$125	$950/month ($118.75/visit)	$1350/month ($112.5/visit)
30 min	$75	$570/month ($71.25/visit)	$810/month ($67.5/visit)

***Payments accepted: Cash, Check, Credit Card, HSA, & FSA**

I understand the cost of service and I agree to pay _______ monthly/weekly/visit with the knowledge that visits are to be used within 30 days and they do not transfer to the next month unless the therapist has to cancel or the missed visit is reported within 24hrs.

30 day cycle: _________________ to _________________

There is no contract and services can be canceled at any time with a prorated refund of unused visits due to terminal illness, hospitalization or loss of life.

I consent to receive physical therapy and/or wellness services provided by Infinite Rehab and Wellness.

____

Signature

____

Date