Regional Rehab
Physical Therapy
Laser Center

465 Mariner Blvd. Spring Hill, FL 34609 Phone: 352-688-8066 Fax: 352-688-8540

PATIENT INFORMATION

Name:_____ **Today's date:**____/_____/_____
First M.I. Last

What is the main problem that brings you here today? _____

Date of Birth:_____ **Age:**_____ **Right handed**_____ **or Left handed**_____ **Do you take medicine for diabetes?** ☐ **yes** ☐ **no**

Have you had any falls in the past year? ____**yes** ☐ **no** **If yes, how many falls?** ____

OCCUPATION:_____**Social Security #** _____**(Workers Comp Only)**

Mailing Address:_____
Street City State Zip

Home phone: (_____)_____ **Cell phone:** (_____)_____ **Work phone:** (_____)_____

Email: _____ **Marital status:**_____

Emergency Contact:_____ **Relationship to you:**_____ **Phone number:**_____

Who is your primary care physician?_____ **Primary physician's phone number?**_____

Name of physician who referred you to physical therapy?_____

How did you hear about us? (examples: friend, newspaper ad, doctor referral) _____
_____

OUR POLICIES REGARDING CANCELLATIONS, NO-SHOWS AND TARDINESS

Your referring doctor and your therapist will prescribe a set frequency of treatment; following these instructions and showing up as scheduled for these visits is your most important job in achieving your goals.

CANCELLATION POLICY: We request 24 hours notice in the event of a cancellation; in the case of illness or an unexpected emergency, please call by 9:00 AM on the morning of an appointment, if possible.

NO-SHOW POLICY: There is a $25.00 charge for a no-show; this charge will not be covered by insurance and will have to be paid by you personally. When you don't show up for your appointment, 3 people are hurt:

1. **You, the patient, because you don't get the prescribed treatment you need**
2. **Other patients who could have been scheduled for treatment at that time if there had been proper notice**
3. **The therapist who now has an empty space on his/her schedule which could have been offered to someone else.**

TARDINESS POLICY: Please be on time. If you are more than 15 minutes late for your appointment, we will try our best to work you in; however, your treatment time may be reduced or your appointment cancelled because of the need for us to remain timely in our treatment of other scheduled patients. Repetitive tardiness may result in the discontinuation of treatment due to non-compliance.

I have read and understand these policies:

_____**Date:**_____
(Signature of Patient/Legal Guardian)

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PATIENT AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT OF BENEFITS

I hereby authorize Regional Rehab to release and request any protected health information in the course of my examination or treatment to any insurer or government agency providing benefits to me and from any of my medical providers. I further authorize payment directly to Regional Rehab of all benefits payable under the terms of my insurance policy and agree to pay any co-pay or coinsurance determined my responsibility by my insurance policy. ALL PRE-DETERMINED CO-PAYMENTS MUST BE PAID UPON SIGNING IN FOR YOUR APPOINTMENT.

Signature of Patient/Legal Guardian:_____ Date_____

CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR HIPPA AND COMPLIANT HEALTHCARE OPERATIONS

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my therapist, another healthcare provider, a health plan, my employer or a healthcare clearinghouse. This protected health information related to my past, present or future physical or mental health or condition identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Regional Rehab's Notice of Privacy Practices prior to signing this document and it is available upon request.

I consent to the use of disclosure of my protected health information by Regional Rehab for the purpose of evaluation or providing treatment to me, obtaining payment for my health care bills, or to conduct the health care operations of Regional Rehab. I understand that diagnosis or treatment of me by the professional staff is conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information issued or disclosed to carry out treatment, payment or health care operations of the practice. I have a right to revoke this consent, in writing, at any time, except to the extent that the staff of Regional Rehab may have taken action in reliance on this document.

Signature of Patient/Legal Guardian:_____ Date:_____

In conjunction with these privacy practices, you will need to complete the following:

1. Name of person(s) we may speak to regarding your health (i.e. spouse, child, etc. including phone number

Name:_____Relationship_____ Phone number:_____

Name:_____Relationship_____ Phone number:_____

2. May we leave a message regarding an upcoming appointment on your answering machine? ☐ yes ☐ no

Signature of Patient/Legal Guardian:_____Date:_____

CONSENT TO TREAT

I hereby indicate my consent to receive physical therapy treatment at Regional Rehab. I understand that the purpose of these treatments is to reduce pain and/or inflammation, enhance my recovery from an injury or illness, and to increase my functional activities. My participation is voluntary and I may withdraw at any time.

Signature of Patient/Legal Guardian:_____Date:_____