PATIENT INFORMATION

WHO REFERRED YOU HERE?_____ TODAY'S DATE_____ DATE REFERRED_____

METHOD OF PAYMENT: ☐ CASH ☐ CREDIT ☐ PRIVATE HEALTH-INS ☐ PERSONAL INJURY ☐ WORKERS COMPENSATION

PATIENT'S LAST NAME | PATIENT'S FIRST NAME | M.I | SOCIAL SECURITY #

DATE OF BIRTH | AGE | SEX: ☐ MALE ☐ FEMALE | MARITAL STATUS: ☐M ☐S ☐D ☐W

ADDRESS & UNIT/APARTMENT # | CITY | STATE | ZIP CODE

HOME TELEHONE # | WORK TELEPHONE # & EXTENSION | D.L. #

CURRENT EMPLOYER | CURRENT OCCUPATION

PATIENT'S PRIMARY DR (FOR THIS INJURY) | DR'S TELEPHONE # | CITY/OFFICE LOCATION

PATIENT'S ATTORNEY NAME (& LAW FIRM NAME) | ATTORNEY'S TELEPHONE #

ATTORNEY'S & LAW FIRM'S ADDRESS | CITY | STATE | ZIP CODE

FRIEND/RELATIVE TO NOTIFY IN CASE OF EMERGENCY | RELATIONSHIP TO PATIENT | FRIEND/RELATIVE'S TELEPHONE #

WORKERS COMPENSATION INFORMATION

DATE/S OF INJURY:_____ OCCUPATION AT TIME OF INJURY:_____

EMPLOYER AT TIME OF INJURY | EMPLOYER'S TELEPHONE #

EMPLOYER'S ADDRESS & SUITE | CITY | STATE | ZIP CODE

HAS INSURANCE ADMITTED INJURIES WORK RELATED? : ☐ YES ☐ NO (DENIED) ☐ PENDING, UNDER INVESTIGATION, ETC…

IF YES TO ABOVE, PLEASE LIST PARTS OF BODY ADMITTED:_____

PERSONAL INJURY INFORMATION

ARE YOU REPRESENTED BY AN ATTORNEY? ☐ YES ☐ NO HAS OTHER PARTY ADMITTED FAULT? ☐ YES ☐ NO

DATE OF ACCIDENT | NAME OF OTHER PARTY & THEIR INSURANCE | INSURANCE'S TELEPHONE #

OTHER PARTY'S INSURANCE ADDRESS | CITY | STATE | ZIP CODE

PRIMARY INSURANCE INFORMATION

INSURANCE TYPE: ☐ AUTO MED-PAY ☐ 3rd PARTY ☐ PRIV/PPO ☐ WORK COMP ☐ OTHER_____

PRIMARY INSURANCE COMPANY | INSURANCE ADJUSTER NAME | CALIM # OR GROUP/POLICY #

INSURANCE TELEPHONE # | ADDRESS | CITY | STATE | ZIP CODE

PRIAMRY INSURED'S COMPLETE NAME | INSURED'S ID# | INSURED'S SOCIAL SECURITY # | REALTIONSHIP TO PATIENT

HEALTH QUESTIONS

1) BRIEFLY DESCRIBE THE ACCIDENT AND/OR ONSET OF SYMPTOMS:_____

_____

_____

2) PLEASE LIST ALL PARTS OF THE BODY AFFECTED BY THIS INJURY/CONDITION AND CURRENT SYMPTOMS:_____

_____

3) PLEASE DESCRIBE ALL PRIOR TREATMENT AND DOCTORS SEEN AS A RESULT OF THIS INJURY/CONDITION:_____

_____

4) PLEASE LIST ALL TREATMENT TO THESE PARTS OF THE BODY, PRIOR TO THIS PARTICULAR INJURY/CONDITION:_____

_____

5) WAS ANY OF THIS PRIOR TREATMENT CLAIMED AS WORK RELATED? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:_____

_____

6) HAVE YOU EVER HAD:

☐ HEART PROBLEMS	☐ ALCOHOLISM	☐ GALLBLADDER PROBLEMS	☐ DIZZINESS/FAINTINESS
☐ HIGH BLOOD PRESSURE	☐ RADIATION TREATMENT	☐ CEREBRAL PALSY	☐ ARTHRITIS
☐ LOW BLOOD PRESSURE	☐ TONSILS REMOVED	☐ SCARLET FEVER	☐ GOUT
☐ CIRCULATORY PROBLEMS	☐ EPILEPSY	☐ MALIGNANCIES	☐ ADENOIDS REMOVED
☐ RHEUMATIC FEVER	☐ KIDNEY PROBLEMS	☐ ASTHMA	☐ A.I.D.S. OR H.T.L.V.
☐ HEPATITIS	☐ NERVOUS PROBLEMS	☐ CHRONIC SINUS PROBLEMS	☐ LIVER PROBLEMS
☐ DIABETES	☐ TUBERCULOSIS	☐ CHRONIC EAR PROBLEMS	☐ VENEREAL DISEASE/HERPES
☐ ALLERGIES/HAY FEVER	☐ EXCESSIVE BLEEDING	☐ ANEMIA	☐ BROKEN/FRACTURED BONES
☐ SHORTNESS OF BREATH	☐ ULCER PROBLEMS	☐ CHRONIC FATIGUE	☐ TORN LIGAMENTS
☐ SKIN CONDITIONS	☐ ATHLETES FOOT	☐ NAUSEA OR CRAMPS	☐ DISLOCATED JOINTS

7) PLEASE LIST ALL MEDICAL CONDITIONS / HEALTHCOMPLICATIONS / PHYSICAL LIMITATIONS NOT LISTED ABOVE:_____

_____

8) ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO IF YES, HOW MANY MONTHS:_____

9) PLEASE LIST ALL MEDICATIONS / DRUGS YOU ARE ALLERGIC TO:_____

10) PLEASE LIST ALL MEDICATIONS / DRUGS YOU ARE CURRENTLY TAKING:_____

11) HAVE YOU EVER BEEN HOSPITALIZED? ☐ YES ☐ NO IF YES, PLEASE DESCRIBE:_____

_____

12) PLEASE DESCRIBE YOUR USUAL EXERCISE HABITS / PROGRAMS AND PHYSICAL ACTIVITIES, INCLUDING WORK:_____

_____

ASSIGNMENT OF BENEFITS & FINANCIAL AGREEMENT

I HEREBY AUTHORIZE AND DIRECT ANY INSURANCE COMPANY TO PAY DIRECTLY TO THE MEDICAL PROVIDER ALL AMOUNTS DUE THE PROVIDER FOR MEDICAL SERVICES RENDERRED. I HEREBY AUTHORIZE THE RELEASE OF ANY AND ALL INFORMATION FROM ANY PART, INCLUDING MY ATTORNEY (WAIVING ATTORNEY/CLIENT PRIVILAGE), TO THE MEDICAL PROVIDER FOR THE SOLE PURPOSE OF REIMBURSMENT OF SERVICES RENDERRED BY AND REQUESTED FROM THE PROVIDER. I UNDERSTAND THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF MY MEDICAL EXPENSES, EXCEPT AS EXCLUDED PER ANY PROVIDER CONSTRACTS WITH MY INSURANCE AND AS EXCLUDED UNDER CALIFORNIA LAWS, INCLUDING WORKERS COMPENSATION LAWS. IF I AM FOUND RESPONSIBLE FOR ANY PORTION OF SAID SERVICES, I AGGREE TO PAY ALL COLLECTION EXPENSES INCURRED BY THE PROVIDER, AND INTEREST AT THE PREVAILING RATE FOR PAST DUE AMOUNTS. I HAVE READ OR HAD READ AND TRANSLATED TO ME, AND COMPLETELY UNDERSTAND AND AGREE TO ALL THE PROVISIONS CONTAINED HEREIN THIS DOCUMENT, AS WELL AS ALL OTHER DOCUMENTS SIGNED BY ME FOR THE PROVIDER, AND I ALSO AGREE TO ALL PROVISIONS CONTAINED THEREIN.

_____ ___/___/___ _____ ___/___/___

PATIENTS SIGNATURE (OR LEGAL GUARDIAN) DATE TRANSLATORS SIGNATURE DATE

_____ _____ _____

PRINT SIGNER'S NAME (IF OTHER THAN PATIENT) RELATIONSHIP TO PATIENT PRINT TRANSLATOR'S NAME

Dynamic Rehab Center
Patient Information Sheet

Patient Name _____ (M / F) DOB: _____ Age: _____

Home Address_____ City _____State:____ Zip _____

Home PH#:_____ Cell/Work/Other: _____

Email Address: _____

Referring Provider: _____ **SSN#:** _____

Married **Divorced** **Single** **Minor/Child** **Widowed** **Separated**

✓ **Have you had PT services this year**? _____

✓ **Are you currently receiving <u>ANY</u> home health services**? _____

Primary Insurance Company Name: _____

ID / Subscriber Number #: _____ Group#: _____

Name of **Responsible Party**, if different than Patient: _____

DOB: _____ SSN#: _____ Employer: _____

Private Health Insurance:
It is ***your*** responsibility to know the benefits and limitations of your particular insurance policy. For insurance companies that we do not contract with the services rendered with be your responsibility at the Usual & Customary rates for this area. **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.**

****Twenty-four hours notification is requested when canceling and appointment. Thank you!**

*I **authorize** the release of **any medical** or other information necessary to process claims on my behalf. I agree to be **fully responsible** for all lawful debts incurred by myself for services received from **Dynamic Rehab Center, Inc.** whether covered by insurance or not.*

I have read, understand, and agree to the above stated financial policies. I consent to therapeutic treatment and services rendered, which include those modalities and/or procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

Patients Signature: _____ **Date:** _____

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policies.

- ☑ **ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE**
- ☑ **We do not accept liens under any circumstances.**

Private Health Insurance

If you have a co-payment, it is **due** at the time of treatment. As a courtesy, we will bill your insurance company on your behalf for services provided to you. If for any reason your insurance company does not cover the treatment; **you** will be **financially responsible** for payment at the usual & customary rates. **Additionally**: if your insurance company makes payment to you (personally), and not to our office, due to contractual obligations, you are **ultimately responsible** for the amount **paid plus coinsurance.** *Verification of benefits is done as a **courtesy** and is **never a guarantee** of payment. Should you have any questions regarding your insurance coverage, we will gladly assist you; however, it is ***your responsibility*** to know the benefits and limitations of your particular insurance policy.

Your Personal Benefits:

Deductible _____Co-Insurance _____Co-Payment _____ Max Visits _____

OP Max _____ Coverage: 100%, 90%, 80%, 70%, 60%, 50%

Workers Compensation

You will be immediately responsible for costs if your workers compensation carrier denies the claim for any reason [i.e.: litigation or failure to file a claim]. Your case manager will be notified of any missed appointments, and may **jeopardize** your claim. Please contact the office, should you need to reschedule your appointment.

We reserve the right to discontinue treatment if you fail to comply with the policies stated above.

Twenty-four hours notification is **requested** when canceling an appointment. Thank you!

I have read, understand, and agree to the above stated financial policies. I **consent** to **therapeutic treatment** and services rendered here which include those modalities and/or procedures prescribed by my physician. I hereby state that the information I have provided is true and correct to the best of my knowledge.

Signature: Dated:

_____ _____