Therapy Excel & Rehabilitation
Moving Forward Pain Free

THERAPY EXCEL AND REHABILITATION
PATIENT INTAKE FORM

Date:

Name: _____ Date of Birth:_____ Gender:____
Last First Middle *MM/DD/YYYY* M/F

Address:_____ Apt:_____ City:_____

State:_____ Zip Code:_____ Marital status: _____
single/married/divorced/widowed

Home #: ( )_____-_____ Cell #: ( )_____-_____ Work #: ( )_____-_____

Email:_____SSN: _____

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE NEXT SECTION.

Relation To Patient:_____

Name:_____ Date of Birth:_____
Last First Middle *MM/DD/YYY*

Address: _____ Apt:_____ City:_____

State:_____ Zip Code:_____

Home #: ( )_____-_____ Cell #: ( )_____-_____ Work #: ( )_____-_____

Emergency Contact:

Name:_____ Phone #: ( )_____-_____

Relationship:_____

INSURANCE INFORMATION:

Primary Insurance Company:_____ ID Number:_____
Group #:_____ Claim #: _____ Phone #: ( )_____-_____
Policy Holder Name:_____ Date of Birth:_____
Secondary Insurance Company:_____ ID Number:_____
Group #:_____ Claim #: _____ Phone #: ( )_____-_____
Policy Holder Name:_____Date of Birth:_____

Patient Signature:	*Guardian Signature (if applicable):*	*Date:*

Therapy Excel and Rehabilitation
8530 N Canton Center Rd, Canton MI 48187
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THERAPY EXCEL AND REHABILITATION
Patient Medical History Form

Name: _____ Date: _____

Height: _____ Weight: _____ Diagnosis: _____

Date of Onset: _____ Diagnostic Testing: _____
MRI/CT-SCAN/X-ray

Have you had any surgery for this? _____
Type of surgery: _____

Pain at Worst: Rate your worst pain

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Pain at Current: Rate your current pain

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

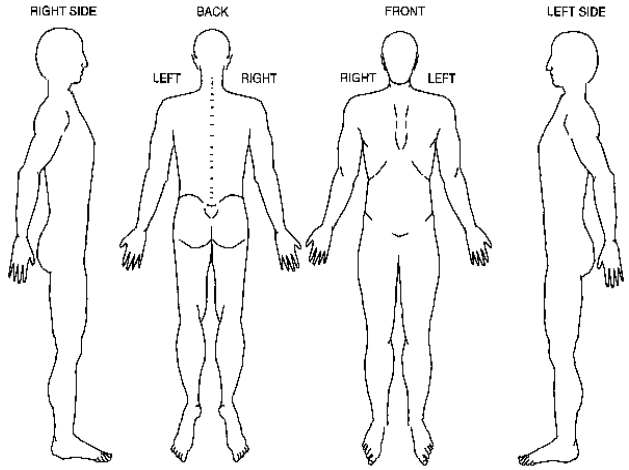
Pain at Lowest: Rate your lowest pain

0 1 2 3 4 5 6 7 8 9 10
No pain Worst pain

Aggravating Factor:
_____

Relieving Factor:
_____

Mark all applicable areas of pain:



Are you currently receiving Home Care at home? YES NO
Have you received Prior Physical Therapy for this? YES NO
If yes, how did it help? _____

Is an attorney involved in this case? YES NO

Treating Physician: _____ Phone #: ( ) _____-_____

Primary Physician: _____ Phone #: ( ) _____-_____

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Patient Medical History Form

Medical History:	**Yes**	**No**		**Yes**	**No**
Change in General Health?	___	___	Dizziness or Fainting?	___	___
Unexplained weight change?	___	___	Do you have a Pacemaker?	___	___
Difficulty sleeping?	___	___	Asthma?	___	___
Diabetes?	___	___	Cancer?	___	___
High Blood Pressure?	___	___	Hernia?	___	___
Osteoarthritis?	___	___	Epilepsy/Seizures?	___	___
Numbness or Tingling?	___	___	Anemia?	___	___
Ulcers/GERD/ Acid reflux?	___	___	Metal Implants?	___	___
Heart Disease?	___	___	Allergies: _____		
Kidney Disease?	___	___			
Liver Disease?	___	___			
Pregnant?	___	___			
Bowel/bladder?	___	___			

Other: _____

Prior Surgeries with date: _____

Are you currently taking any prescription or non-prescription medication? YES NO

NAME	DOSAGE	FREQUENCY

Patient Signature:	*Guardian Signature (if applicable):*	*Date:*

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THERAPY EXCEL AND REHABILITATION
CONSENT FOR CARE AND TREATMENT
(Please read before you sign)

CONSENT TO TREATMENT:
I, the undersigned, do hereby agree and give my consent for **Therapy Excel and Rehabilitation LLC**, to furnish medical care and treatment to _____ that is considered necessary and proper in diagnosing or treating his/her condition which may involve bodily contact, touching, and/or direct contact of a sensitive nature.

AUTHORIZATION BENEFIT ASSIGNMENT / FINANCIAL RESPONSIBILITY/RELEASE OF INFORMATION:
I authorize **Therapy Excel and Rehabilitation** to release to the insurance carrier any information needed for the payment of any claim. I authorize payment to **Physical Therapy and Rehabilitation** from my insurance carrier or third party payer.

I agree to pay any applicable co-payments at the time of service and coinsurance and/or deductibles as agreed between **Therapy Excel and Rehabilitation** and me. I understand that my insurance benefits may not cover all charges and that I am responsible for those charges not covered by my health insurance or third party payer. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

By my signature, I authorize **Therapy Excel and Rehabilitation**, to release all information necessary, including medical records to secure payment.

Cancellation Policies:

Please be on time for your appointment as this is important for successful treatment and recovery from your injury.

If you are more than 15 minute late to an appointment, **Therapy Excel and Rehabilitation** has the right to reschedule you or see you for remaining time.

24 hours notice of a cancellation must be given or a **$25 cancellation fee** will be charged.
If a patient **misses 3 consecutive appointment without calling**, **Therapy Excel and Rehabilitation** will cancel all future appointments and discharge the patient. We are not required to notify patient.

Patient Signature:	***Guardian Signature (if applicable):***	***Date:***

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THERAPY EXCEL AND REHABILITATION
HIPAA PRIVACY POLICY

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights:

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.

Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us at

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You can file a complaint with **the U.S. Department of Health and Human Services Office for Civil Rights** by sending a letter to **200 Independence Avenue, S.W., Washington, D.C. 20201,**
calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**

We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to: Share information with your family, close friends, or others involved in your care, Share information in a disaster relief situation, Include your information in a hospital directory

In these cases we never share your information unless you give us written permission: Marketing purposes, Sale of your information, Most sharing of psychotherapy notes.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you: We can use your health information and share it with other professionals who are treating you.

Run our organization: We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services: We can use and share your health information to bill and get payment from health plans or other entities.

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes.

Help with public health and safety issues

We can share health information about you for certain situations such as: Preventing disease, Helping with product recalls, Reporting adverse reactions to medications, Reporting suspected abuse, neglect, or domestic violence, Preventing or reducing a serious threat to anyone's health or safety.

Comply with the law: We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests: We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director: We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you: For workers' compensation claims, For law enforcement purposes or with a law enforcement official With health oversight agencies for activities authorized by law, For special government functions such as military, national security, and presidential protective services.

Respond to lawsuits and legal actions: We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities:

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice: We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Patient Signature:	*Guardian Signature (if applicable):*	*Date:*

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