THRIVE rehabilitation Physical Therapy

This information is considered confidential. We need this information because we care enough to want to know and your answers will help us determine if therapy can help you. If we do not sincerely believe your condition will respond satisfactorily, we will not accept your case. In order for us to understand your condition properly, write as neat and accurate as possible while filling this form.

Patient Information:

Last Name: _____ First Name: _____ Sex: _____

Date of Birth: _____ SS#: _____-_____-_____

Address: _____ City: _____ State: _____

Zip Code: _____ Work#: _____ Home#:_____

Email: _____ Mobile#:_____

Marital Status: [ ] Single, [ ] Married, [ ] Divorced, [ ] Widowed, [ ] Domestic Partner

Emergency Contact: _____ Phone#:_____

Doctors Information:

Referring Physician: _____ Phone #: _____

Diagnosis: _____ Date Last Seen by Doctor: _____/_____/_____

If PCP is same as Referring please check [ ]

Primary Care Physician: _____ Phone #: _____

Health Insurance Information: Is this policy [ ] Medicare, [ ] Medicaid, [ ] HMO

Health Insurance Co. Name:_____ Group :_____

Primary ID#:_____ Is this policy: []Self, []Spouse, []Parent

Insured Parent/Spouse Name:_____ Their DOB:_____/____/_____

Check if insured address is same [ ]. Insured Address:_____

City:_____ State:_____ Zip Code:_____

Secondary Health Insurance:_____ Group :_____

Primary ID#:_____ Is this policy: [ ] Self, [ ] Spouse, [ ] Parent

Insured Parent/Spouse Name:_____ Their DOB:_____/____/_____

Check if insured address is same [ ]. Insured Address:_____

City:_____ State:_____ Zip Code:_____

What is the Major reason(s) for this visit:_____

How long have you had this current problem? #_____Weeks, #_____Months, #_____Years

Was this injury cause by an: [ ] Auto Accident, [ ] Work/ Employment Accident, [ ] Other

How did you hear about us: [ ] Internet, [ ] Walk-in, [ ] Doctor, [ ] Staff Member, [ ] Other

Patient/or Guardian Signature:_____ Date:___/___/____

Current Condition(s)/Chief Complaint(s): Date of injury or when you first noticed injury:_____

Where did injury first occur: [ ] At work, [ ] At home, [ ] Motor Vehicle Accident, [ ] Recreation

Did you have to go to the hospital: **[]** Yes**, []** No. **IF** so which?_____

Were you discharged same day: **[]** Yes**, []** No Were injuries found:_____

Did the hospital take: **[]** X-rays, **[]** CT Scan, **[]** MRI, **[]** Other. Do you have copies: **[]** Yes**, []** No

Has any one examined you for this condition before? First treatment:____/____/_____

If so who did you see?_____

Did the doctor take: **[]** X-rays, **[]** CT Scan, **[]** MRI, **[]** Other. Do you have copies: **[]** Yes**, []** No

All other treating doctors:_____

Please explain how injury occurred:_____

_____

_____

_____

Since symptoms began they are: **[ ]** The same **[ ]** worsening **[ ]** improving

What activities make your symptoms better (treatment, positions, heat/ice, etc.)?

_____

_____

What activities make your symptoms worse (treatment, positions, heat/ice, etc.)?

_____

_____

What specific activities are you unable to perform or are difficult because of your symptoms?

_____

_____

	Inactivity										Intense Exercise
Prior physical activity:	0	1	2	3	4	5	6	7	8	9	10

Please list your normal/pre-injury recreational activities or hobbies:

_____

_____

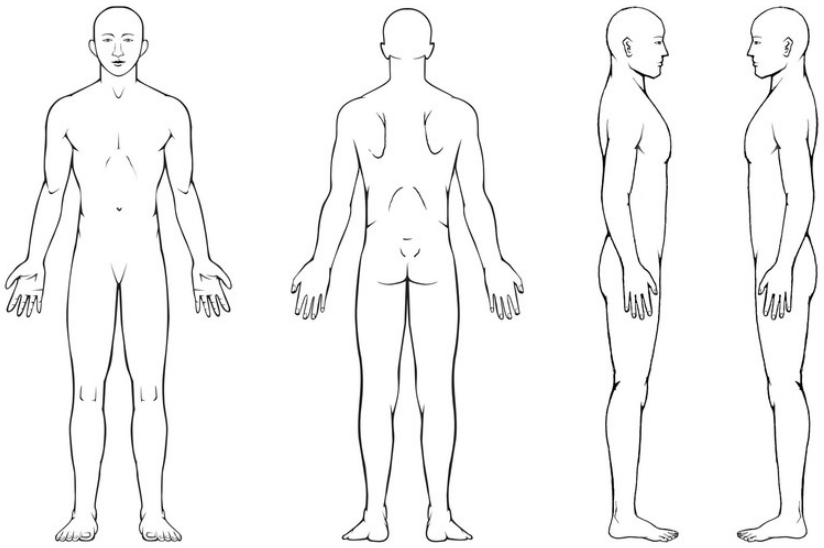
Please rate the following:	No Pain										Excruciating
Pain at its worst:	0	1	2	3	4	5	6	7	8	9	10
Pain at its best:	0	1	2	3	4	5	6	7	8	9	10
Pain currently:	0	1	2	3	4	5	6	7	8	9	10

Patient/or Guardian Signature:_____ Date:___/___/____

Using the diagram below, please indicate the location of symptoms listed

(+++ Sharp pain) (—— Numbness) (OOO Pins & Needles) (///Dull pain)

(xxx Burning pain) (zzz Deep ache) Other :_____



Injury History

Identify any other past or present injury(s) that the doctor should know about:

_____

_____

_____

_____

_____

_____

When was the last episode:_____How did this injury occur:_____

Other forms of treatment tried: [ ] No [ ] Yes If yes, what type of treatment:_____

_____

Who provided the treatment:_____ How long

ago: _____What were the results:_____

_____

Patient/or Guardian Signature:_____ Date:___/___/____

Medical History

[ ] No Known Medical History To Affect Treatment

[ ] Alzheimer's
[ ] Cardiovascular Disease
[ ] Cauda Equina Syndrome
[ ] Cerebral Vascular Accident
[ ] Current Infection
[ ] Diabetes Mellitus Type 1
[ ] Diabetes Mellitus Type 2
[ ] Fibromyalgia
[ ] Fracture Or Suspected Fracture
[ ] High Blood Pressure
[ ] History Of Cancer
[ ] Huntington's
[ ] Immunosuppression
[ ] Lupus
[ ] Muscular Dystrophy
[ ] Obesity
[ ] Osteoarthritis
[ ] Rheumatoid Arthritis
[ ] Parkinson's
[ ] Traumatic Brain Injury

Any Other conditions not listed on the form:

_____

_____

_____

_____

Medications

List Prescription, Non-Prescription Drugs, Vitamins and Supplements used in the past 2 months:

Name	Strength	Times per Day
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient/or Guardian Signature:_____ Date:___/___/____

Surgical History: Please list all surgical procedures below, (I.e. Spine, Cardiovascular, Bone, Brest, Gastrointestinal or any other surgeries). Try to include the surgery year performed:

Surgery	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family Medical History:

Does anyone in your immediate family (mother, father, siblings) have a history of Diabetes, High Blood Pressure, Cardiac Problems, Cancer, or any other hereditary conditions?

_____

_____

Social History	How often?			
Smoking: [ ] cigars [ ] pipe [ ] cigarettes	[ ] Daily	[ ] Social	[ ] Occasionally	[ ] Never
Alcoholic beverages:	[ ] Daily	[ ] Social	[ ] Occasionally	[ ] Never
Recreational drug use:	[ ] Daily	[ ] Social	[ ] Occasionally	[ ] Never

How does present problem affect hobbies, recreational activities, exercise regime?

_____

_____

_____

_____

Please list your goals/expectation of therapy:

1._____

_____

2._____

_____

3._____

_____

Patient/or Guardian Signature:_____ Date:___/___/____

Audio/ Visual Authorization

I hereby consent to be photographed while receiving treatment at Thrive Rehabilitation LLC. The term “photograph” includes video, Audio, Security Footage or still photography, in digital or any other format, and any other means of recording or reproducing images. This also includes the consent to use my name, likeness, quotes or phrases used directly resulting from my participation.

I hereby authorize the use of the photograph(s) by, or disclosure of the photograph(s) to Thrive Rehabilitation LLC. The use or disclosure of the photograph(s) for the following uses or purposes in order to assist scientific, treatment, educational, public relations, marketing, news media, and charitable goals, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization. I and my successors or assigns hereby hold Thrive Rehabilitation LLC, its employees, physician(s), and any other person participating in my care and their successors and assigns harmless from and against any claim for injury or compensation resulting from the activities authorized by this agreement.

I hearty understand this includes information that falls under the HIPPA laws and I understand that the use of my likeness, name and other protected health information may be used and not limited to the aforementioned uses above.

I understand that the information and likeness disclosed, or some portion thereof, may be protected by state law, federal law and/or the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). I further understand that, because ASPS is not receiving the information in the capacity of a health care provider or health plan covered by HIPAA, the information described above may no longer be protected by HIPAA and may be redisclosed by ASPS.

_____ _____

Patient / Parent/ Guardian Name DOB

Patient/or Guardian Signature:_____ Date:___/___/____

Payment Authorization

I hereby authorize payment to be made directly to Thrive Rehabilitation LLC, for all benefits which may be payable under a healthcare plan or from any other collateral sources. I authorize utilization of this application or copies therefor the purpose of processing claims and effecting payments, and further acknowledge that this assignment of benefits does not in any way relieve me of payment liability and that I will remain financially responsible to Thrive Rehabilitation LLC for any and all Services I receive at this office.

Signature of Thrive Staff member who witnessed signature and spoke to patient to verify complete understanding of this policy.

Staff Signature:_____ Date: ___/____/_____

_____ _____

Patient / Parent/ Guardian Name DOB

Patient/or Guardian Signature:_____ Date:___/___/____

NOTICE OF PRIVACY PRACTICE

This office is required to notify you in writing, that by law, we must maintain the privacy and confidentiality of your **P**ersonal **H**ealth **I**nformation. In addition we must provide you with written notice concerning your rights to gain access to your health information, and the potential circumstances under which, by law, or as **dictated by our office policy,** we are permitted to disclose information about you to a third party without your authorization. Below is a brief summary of these circumstances. If you would like a more detailed explanation, one will be provided to you. In addition, you will find we have placed several copies in report folders labeled **'HIPAA'** on tables in the reception. Once you have read this notice, please sign the last page, and return only the signature page (page 2) to our front desk receptionist. Keep this page for your records.

PERMITTED DISCLOSURES:

1. Treatment purposes- discussion with other health care providers involved in your care
2. Inadvertent disclosures- open treating area mean open discussion. If you need to speak privately to the doctor, please let our staff know so we can place you in a private consultation room.
3. For payment purposes - to obtain payment from your insurance company or any other collateral source.
4. For workers compensation purposes- to process a claim or aid in investigation
5. Emergency- in the event of a medical emergency we may notify a family member
6. For Public health and safety - in order to prevent or lessen a serious or eminent threat to the health or safety of a person or general public.
7. To Government agencies or Law enforcement – to identify or locate a suspect, fugitive, material witness or missing person.
8. For military, national security, prisoner and government benefits purposes.
9. Deceased persons–discussion with coroners and medical examiners in the event of a patient's death.
10. Telephone calls or emails and appointment reminders -**we may call your home and leave messages and send texts** regarding a missed appointment or apprize you of changes in practice hours or upcoming events.
11. Change of ownership- in the event this practice is sold, the new owners would have access to your PHI.

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued on the next page.

Patient/or Guardian Signature:_____ Date:___/___/____

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

YOUR RIGHTS:

1. To receive an accounting of disclosures
2. To receive a paper copy of the comprehensive "Detail" Privacy Notice
3. To request mailings to an address different than residence
4. To request Restrictions on certain uses and disclosures and with whom we release information to, although we are not required to comply. If, however, we agree, the restriction will be in place until written notice of your intent to remove the restriction.
5. To inspect your records and receive one copy of your records at no charge, with notice in advance in writing.
6. To request amendments to information. However, like restrictions, we are not required to agree to them.
7. To obtain **one copy** of your records at no charge, when timely notice is provided (72 hours)

COMPLAINTS: If you wish to make a formal complaint about how we handle your health information, please call Mario at (586)295-6411. If he is unavailable, you may make an appointment with our receptionist to see him within 72 hours or 3 working days. If you are still not satisfied with the manner in which this office handles your complaint, you can submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Ave. SW
Room 509F HHH Building
Washington DC 20201

I have received a copy of Thrive Rehabilitation's Patient Privacy Notice. I understand my rights as well as the practices duty to protect my health information, and have conveyed my understanding of these rights and duties to the doctor. I further understand that this office reserves the right to amend this 'Notice of Privacy Practice" at any time in the future and will make the new provisions effective for all information that it maintains past and present.

I am aware that a more comprehensive version of this "Notice" is available to me and several copies kept in the reception area. At this time, I do not have any questions regarding my rights or any of the information I have received.

_____ _____

Patient / Parent/ Guardian Name DOB

Patient/or Guardian Signature:_____ Date:___/___/____

Informed Consent

REGARDING: Physical Therapy/Rehabilitation, Modalities, and Therapeutic Procedures:

I have been advised that physical therapy and rehabilitation care, like all forms of health care, holds certain risks. While the risk are most often very minimal, in rare cases, complications such as sprain/strain injuries, irritation of a disc condition, and although rare, minor fractures, and possible stroke, which occurs at a rate between one instance per one million to one per two million, have been associated with Physical Therapy, medical massage, sauna use and any form of rehabilitation.

Treatment objectives as well as the risks associated with physical therapy/ rehabilitation and, all other procedures provided at Thrive Rehabilitation have been explained to me to my satisfaction and I have conveyed my understanding of both to the doctor. After careful consideration, I do hereby consent to treatment by any means, method, and or techniques, the doctor deems necessary to treat my condition at any time throughout the entire clinical course of my care.

Disclaimer: Thrive Rehabilitation LLC and the trademarked Thrive Logo with spine are in similar likeness to other LLC's. Thrive Rehabilitation LLC is not affiliated with any other practice, clinic, facility, MD, DO, DC, etc. in anyway financially or monetarily with any LLC's with similar names, logos, geographic area or presence. By signing below you fully understand that Thrive Rehabilitation LLC is its own entity even though you may have providers with similar likeness and or names the past, present, or future. Any bills from separate entities have no affiliation with Thrive Rehabilitation LLC and should be dealt with by that sole provider.

_____ _____

Patient / Parent/ Guardian Name DOB

Patient/or Guardian Signature:_____ Date:___/___/____

Cancelation Policy

Thrive Rehabilitation LLC provides each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient in order to minimize your wait time and assure your continuity of your treatment. Your consistent attendance of the planned treatment regimen is pertinent to your recovery.

While we are understanding that emergency(s) may occur in a rare instance, cancellations, especially last minute, along with patient no-shows, decrease our ability to accommodate the schedule of other patients. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. Your full cooperation is mandatory for the following policy:

- If you are more then 30 minutes late for your appointment and fail to notify us, treatment may be cancelled and a fee charged for missing the appointment
- A scheduled appointment MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE or a fee will be charged for that appointment
- Failure to show up for an appointment ("NO-SHOW") without notifying us will result in a fee being charged for that appointment. Furthermore, 2 consecutive no-shows will result in the cancellation of all remaining scheduled appointments.
- At week's end , ALL PATIENTS, regardless of insurance/third party payor, will be charged a **Fifty dollar ($50)** CANCELATION FEE for each late, late-cancelled, or no-show appointment. **THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.**
- **ALL CANCELATIONS/NO-SHOWS** will be documented in your medical record and appropriately reported to your physician and insurance/third party payor.
- Repeated failure to comply with this ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. This will require you to call for an appointment on each day you would like to receive therapy. We will do everything possible to accommodate you, as scheduling space permits.
- **NO CANCELLATION FEE WILL BE CHARGED if the missed appointment is made up within the same week it was scheduled, on a day that you do not have another appointment already scheduled.**

We believe that this policy is necessary for the benefit of all of our patients, so that we may continue to provide high quality treatment and service for everyone. For this reason we require a credit card on file from all patients regardless of insurance/third party payor. I understand the above policy and shall comply.

_____ _____

Patient / Parent/ Guardian Name DOB

Patient/or Guardian Signature:_____ Date:___/___/____

Credit Card Payment Authorization

Thrive Rehabilitation LLC requires a credit card to remain on file which will be automatically billed after 15 days of invoicing and receiving EOB. A$35.00 fee will be charged for declined payments if another form of payment is not provided with in 24 hours of notification of the declined payment. If a payment is declined Thrive Rehabilitation LLC may suspend services until payment is made. Thrive Rehabilitation will enforce the outlined cancellation policy on the credit card listed below.

Please indicate your current billing email address. Statement will be emailed to this email address at the end of each month.

Email:_____

I _____ authorize Thrive Rehabilitation LLC at the end of each month, for the previously rendered services.
Name on Card: _____
Billing Address: _____
_____

Credit Card Type:[] Visa, [] Mastercard, [] Discover , []AMEX

Credit Card Number: _____

Expiration Date:_____/_____ Card Identification Number:_____

I authorize Thrive Rehabilitation LLC to charge the credit card indicated on this authorization form according to the terms outlined above and per the signed cancellation policy. I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the business in writing of any changes in my account information or termination of this authorization at least 20 days prior to the next billing date. If the above noticed payment date falls on a weekend or holiday I understand that the payment may be executed on the next business day. This payment authorization is for the type of bill indicated above. I certify that I am an authorized user of this credit card and that I will not dispute the payment with my credit card company provided the transactions correspond to the terms indicated in the authorization form. This agreement may be modified by both parties in writing dependent on the individuals financial situation.

Signature of Thrive Staff member who witnessed signature and spoke to patient to verify complete understanding of this policy.

Staff Signature:_____ Date: ___/____/_____

_____ _____
Patient / Parent/ Guardian Name DOB

Patient/or Guardian Signature:_____ Date:___/___/____

THRIVE
rehabilitation
Physical Therapy

Authorization for Release of Medical Records and Communication

By signing this form, I authorize you to release confidential health information about me by releasing a copy of my medical records, a summary of my protected health information, and communication between the physician/person/ facility/entity listed below:

Patient Name:_____DOB_____
Last four of social security # _____
The information you may release subject to this signed release for is as follows:

TO BE COMPLETED BY PROVIDER*So we may collect only necessary information to your care.

[] Entire Medical Records	[] Care Plan	[] Imaging
[] Radiology Reports	[] Hospital Reports	[] Treatment Record
[] Operative Reports	[] Progress Notes	[]Medication Record
[] Pathology Reports	[] Lab Reports	

[] Other:_____

Release my protected health information **FROM** the following physician/person/ facility/entity and or those directly associated in my medical care

Name: _____

Fax#:_____

Release my protected health information **TO** Thrive Rehabilitation LLC

Email Records to: info@thriverehabmi.com
Fax Records to : (248) 566 - 0098
Mail Records to: Thrive Rehabilitation LLC
555 W. 14 Mile Rd, Ste B2
Clawson, MI 48017

This authorization is subject to written revocation at any time except to the extent the individual organization has already acted on authorization. If not previously revoked, the authorization will terminate one year from the date of the signature.

_____
Patient / Parent/ Guardian Name

Patient/or Guardian Signature:_____ Date:___/___/____