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 _____

Employer's Name: ________________________________ Occupation: _____________________________

Physician's Name: _________________________________ Diagnosis: ______________________________

Injury: Work or Auto related? ________ Allergies or Medical Precautions: ______________________

Emergency Contact: __________________________________ Phone#:_______________________

Insurance Information:

Insurance Co. Name: ____Policy#:_______________________

Address: _______________________________ City: _________________ State: _____ Zip Code: ________

Insured's Name: _____________________________ SS#:______-_____-_______ DOB: ___________

Address: _______________________________ City: ________________ State: _____ Zip Code: _________

Insured's Employer's Name: ____

Auto/Work Comp Patients: Date of Injury:________________

Insurance Co. Name: ____________________________________Claim#:___________________________

Adjuster Name:____ Phone#:____________________________

Adjuster Fax#:_____________________ Adjuster Address:_______________________________________

Attorney Name:_____________________________________ Attorney Phone#______________________

Case Manager Name:________________________________ CM Phone#____________________________

Who can we thank for your referral today?____

Dear Patient: 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 physical 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, please be as neat and accurate as possible while completing this form.

Patient 's Signature:____ Date:___/___/____

Current Condition(s)/Chief Complaint(s):

Date of injury or date when you first noticed symptoms: _____/_____/_____

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

[ ] Other:____

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?

____

____

What was your prior level of physical activity?

Inactivity — Daily Intense Exercise

0 1 2 3 4 5 6 7 8 9 10

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

____

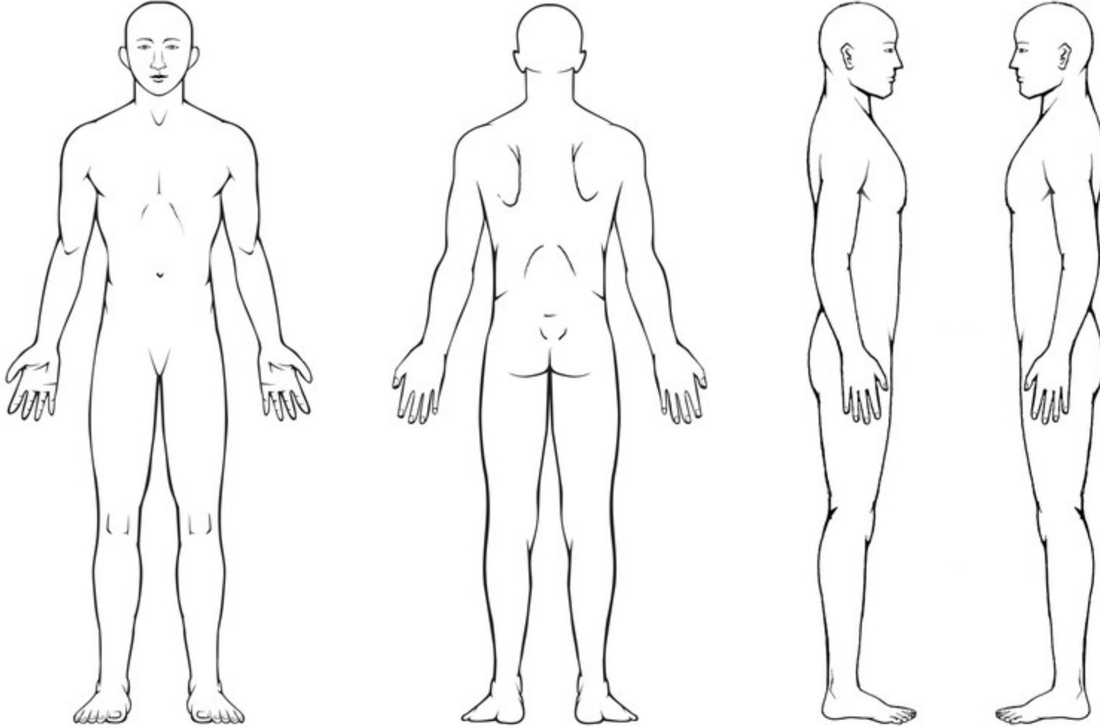
____

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

THRIVE rehabilitation

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

+++	Sharp pain	----	Numbness	000	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:

____

____

Have you experienced a similar problem in the past? [ ] No [ ] Yes If yes, how many times_______

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:____

____

Activities of Daily Living

Identify how your current condition is affecting your ability to carry out your daily activities

Activities:	No difficulty	Minimal difficulty	Difficult but can do	Significantly limits	Unable
Sleep	0	1	2	3	4
Sit to Stand	0	1	2	3	4
Climbing Stairs	0	1	2	3	4
Prolonged Standing	0	1	2	3	4
Prolonged Sitting	0	1	2	3	4
Prolonged computer use	0	1	2	3	4
Driving	0	1	2	3	4
Household chores	0	1	2	3	4
Sweeping/ Vacuuming	0	1	2	3	4
Laundry/ Dishees	0	1	2	3	4
Walking	0	1	2	3	4
Lifting children	0	1	2	3	4
Reading/ Concentration	0	1	2	3	4
Bathing	0	1	2	3	4
Dressing	0	1	2	3	4
Grooming	0	1	2	3	4
Pet care	0	1	2	3	4
Yard Work	0	1	2	3	4
Carrying Groceries	0	1	2	3	4

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

Other: ____

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

____

____

____

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.____

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 thereof for 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.

______________________________ ______________

Patient's Name DOB

______________________________ ______________

Patient signature Date

______________________________ ______________

Thrive Rehabilitation 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.

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
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

Patient initials: **________-retaining page 1 of 2**

NOTICE REGARDING YOUR RIGHT TO PRIVACY continued....

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's Name DOB

____ ______________

Patient signature Date

____ ______________

Witness Date

Patient initials: ________**-retaining page 2 of 2**

THRIVE rehabilitation

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's Name DOB

______________________________ ____________

Patient signature Date

______________________________ ____________

Witness Date