REHAB SOLUTIONS, PLLC
840-2888 PH ** 840-4245 FAX
PATIENT INFORMATION

PLEASE READ CAREFULLY & FILL OUT IN FULL - IF YOU HAVE ANY QUESTIONS, PLEASE ASK

Patients full name_____

Date of Birth_____SSN_____

Guardian Name (if patient is a minor)_____

Address_____City_____State_____Zip_____

Home phone_____Cell_____Work_____

Emergency Contact (name, phone & relationship)

_____

Place of Employment_____

Employment address_____

Phone_____Supervisor_____

Spouse Name_____Date of birth_____

Cell_____Work_____SSN_____

Place of employment_____Phone_____

Referred By_____

Reason for Therapy_____

Please Check YES or NO:

Is this Worker's Comp ☐YES ☐NO Date of Injury/Onset _____

Is this a Motor Vehicle Accident ☐YES ☐NO Date of Injury _____

Do you have an attorney ☐YES ☐NO If yes, please include name, address, & phone

_____

Are you presently being seen by Home Health ☐YES ☐NO

Have you had Home Health services in the past 6 mnths ☐YES ☐NO

Were you injured at school or school event ☐YES ☐NO

Do you have school accident insurance ☐YES ☐NO (please give us the info upon admission)

PLEASE PRESENT ALL INSURANCE AT THE TIME OF ADMISSION. WE WILL FILE ONLY THE INSURANCE PRESENTED TO US*******

OUTPATIENT MEDICAL HISTORY

Patient name_____

Do you now have or have you ever had any of the following: (please check)

- ☐ Diabetes
- ☐ Sensitivity to Heat
- ☐ High Blood Pressure
- ☐ Sensitivity to Cold
- ☐ Heart Disease
- ☐ Allergies
- ☐ Heart Attack
- ☐ Hernia
- ☐ Pacemaker
- ☐ Seizures
- ☐ Cancer _____
- ☐ Currently Pregnant
- ☐ Frequent Headaches
- ☐ Total Hip Replacement
- ☐ Total Knee Replacement
- ☐ Kidney Problems
- ☐ Metal Implants
- ☐ Nervous Disorders
- ☐ Circulatory Disorders
- ☐ Previous Surgery _____

If yes to any of the above, please explain & give approximate dates:

_____

Have you had previous therapy for this condition ☐ YES ☐ NO
what facility and when_____

What treatment was given _____

Are you presently taking any medication ☐ YES ☐ NO
If yes, please list & for what condition_____

_____

By signing, I acknowledge and agree that the information provided is true and correct.

Signature_____Date_____

REHAB SOLUTIONS
OUTPATIENT THERAPY ADMISSION AGREEMENT

Patient Name_____

CONSENT FOR TREATMENT

I, _____hereby voluntarily consent to outpatient therapy services as ordered by my physician, my physician's assistant, designess or consultants. I am aware that medicine is not an exact science and I ackowledge that no guarantees have been made as to the results of treatment (s).

RELEASE FROM RESPONSIBILITY FOR LOSS OF VALUABLES

I, _____hereby understand that personal items considered valuable and other personal items should be left at home. REHAB SOLUTIONS, PLLC will not be responsible for loss.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I, _____authorize REHAB SOLUTIONS,PLLC designee to release to the insurance herein specified, Health Care Financing Adminstration or to any other insurer or agency concerned with the payment of my charges, and all information including copies of medical records and any medical information relating to the admission, which are deemed by the insurers or other agencies, to be required in the processing applications for financial coverage for services rendered during admission. I also authorize these intermediaries to pay direct to REHAB SOLUTIONS, PLLC.

I, _____hereby authorize REHAB SOLUTIONS, PLLC and its representatives to contact my physicians, other healthcare providers, my employer, and those involved in my employment to obtain medical records pertaining to my injury/medcial condition.

ASSIGNMENT OF INSURANCE BENEFITS

I, _____hereby assign all rights, benefits & interest in all plans of health insurance cases/claims arising from my condition, whether against an insurance company, corporation, individual, or any other entity to REHAB SOLUTIONS, PLLC. I hereby authorize payment directly to REHAB SOLUTIONS, PLLC of Worker's Compensation coverage, medical coverage, company liability coverage, individual liability coverage or any other benefits/claims otherwise payable to me. I understand that I am ultimately financially responsible for payment of all coverage if not otherwise paid. I further understand that any amount paid in excess of charges will be refunded as appropriate to the third party payor or patient guarantor.

FINANCIAL RESPONSIBILITY AGREEMENT

I, _____understand that I am financially responsible to REHAB SOLUTIONS, PLLC for any services rendered to me, on my behalf, or at my request by REHAB SOLUTIONS, PLLC, regardless whetherany insurance coverage exists which may pay all or part of any amounts owed to REHAB SOLUTIONS, PLLC. All charges not covered or paid by insurance to include all deductibles, co-insurance & other charges not paid by insurance or third party payors are due & payable upon demand, except in cases where a contractual relationship requires otherwise. It is also agreed that in case of default of payment causing a balance to be placed in the hands of a collector or an attorney for collection of suit, all reasonable collection fees, reasonable attoryney fees, costs and other expenses will be paid by the undersigned.

I, _____hereby agree that as the policyholder or patient, I share the responsibility of obtaining verification of insurance coverage from the insurance company on the above patient for this admission. I further agree that in the event the insurance company denies wither all or part of their payment, on this account, I will pay the account in full upon demand.

_____ _____
Patient or Guardian Date

_____ _____
Authorized Representative of Rehab Solutions, PLLC Date

REHAB SOLUTIONS

NOTICE OF PRIVATE PRACTICES

I, _____ do hereby acknowledge receipt of REHAB SOLUTIONS Notice of Privacy Practices on _____.
date

_____
patient signature

Rehab Solutions, PLLC Summary Notice of Privacy Practices
Effective Date: April 14, 2003

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.

We understand that medical information about you and your health is personal. Rehab Solutions is required by law to maintain the privacy of your health information, to follow the terms of this Notice and to provide you with this Notice of our legal duties and privacy practices with respect to your health information. All staff and employees of Rehab Solutions, PLLC will follow this notice. A detailed Notice of our Privacy Practices is available upon request.

How Rehab Solutions, PLLC May Use or Disclose Your Health Information

Rehab Solutions, PLLC protects the privacy of your health information for some activities. We must have your written authorization to use or disclose your health information. However, the law permits Rehab Solutions, PLLC to use or disclose your health information for several purposes without your authorization, including but not limited to:

- For Treatment. We may use and disclose information obtained by Rehab staff to treat you.
- For payment. We may use and disclose your health information so that Rehab Solutions, PLLC may bill and collect payment from you, an insurance company, Medicare or other third parties.
- For Health Care Operations. We may use and disclose health information about you for health care operations. These uses and disclosures are necessary for your treatment and to operate Rehab Solutions, PLLC.
- As Required by Law. We will disclose health information about you when required to do so by federal, state or local law.
- To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Public Health Risks. We ma disclose health information about you for public health activities.
- Lawsuits and Disputes. We may disclose health information about you in response to a court order or subpoena, if you are involved in a lawsuit or legal dispute.
- For Specific Government Functions. We may disclose health information for the following specific government functions: military personnel, as required by military command authorities; in response to an appropriate request from law enforcement and for national security reasons.
- To Business Associates. To those companies that perform services on behalf of Rehab Solutions, PLLC, including transcription services, consultants and collection agencies.
- Other Uses of PHI. Other uses and disclosures of your PHI not covered by this notice or the laws that apply to us will be made only with your written authorization.

When Rehab Solutions, PLLC May Not Use or Disclose Your Health Information

- You have the right to request restrictions on certain uses and disclosures of your health information. Rehab Solutions, PLLC is not required to agree to a restriction that you request.
- You have the right to inspect and request a copy, for a fee, of your health information.
- You have the right to require that Rehab Solutions, PLLC amend your health information that you believe is incorrect or incomplete. Rehab Solutions, PLLC is not required to amend health information that is accurate and correct.
- You have a right to receive an accounting of disclosures for your health information we have made after April 14, 2003 for purposes other than disclosures for Rehab Solutions treatment, payment or health are operations, based upon your authorization to others and for certain government functions.

To Report a Problem or File a Complaint

If you believe your privacy rights have been violated, you can report a problem or file a complaint with the Secretary of the U.S. Department of Health and Human Services. There will be no retaliation or denial of treatment for filing a complaint.

Changes to This Notice of Privacy Practices

Rehab Solutions, PLLC reserves the right to change this Notice and post the changes. Upon request, we will provide a revised Notice to you:

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Tupelo, MS 38804
(662) 840-2888