Patient Information

Appt. Date:______ & Time:_____

Last Name	First Name	Middle

Street Address	City	State	Zip

Social Security Number	Date of Birth	Sex M F	Home Number ( )	Cell Number ( )

Emergency Contact	Relationship to patient:	Telephone Number ( )

Referring MD	Referral to be: Fax___ Patient to bring___	Diagnosis:	Anyone coming into home? HH________ DC____________

Please list medications you are currently taking:

Primary Insurance Carrier		Secondary Insurance Carrier	
Contract Number	Group Number	Contract Number	Group Number
Policy Holder's Name (if other than patient)	DOB	Policy Holder's Name (if other than patient)	DOB
Relationship to patient: □Spouse □Parent □ Guardian □Self □Other		Relationship to patient: □Spouse □Parent □ Guardian □Self □Other	

Office Use only

WC's □ Yes □No Billing Address____

Carrier:	Phone #	Fax #	Case Number

Case Managers Name:	Approved number of treatments:
Place of Employment:	Injury Date:

Please read the following & sign/date at the bottom of the page

As the responsible party, I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby assign all medical benefits to which I am entitled to APRS (Alabama Physical Rehabilitation Service, Inc.) In the event my account becomes delinquent and is therefore in default of payment; I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection agency service fees, Attorney fees, all court cost and additional legal fees associated with the recovery of this debt. I hereby authorize APRS to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of APRS as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability of such treatment except acts of negligence. I agree that if I have a change of insurance coverage during the course of my treatment at APRS and neglect to inform APRS of the change, I will be held responsible for any/all charges or any charges denied by my insurance company.

_______________________________________ ____________________

Patient and/or Guardian Signature Date

Revised: 04/25/2013

PLEASE TURN OVER & COMPLETE BACK

Are you currently seeing a chiropractor? ___Yes ___No

How did you hear about our clinic? _______________

Medical History

Reason For Today's Visit:______________________________

Is this a injury/accident related to: Job __ Car __ Home __ Other______________________________

Injury Date:______________________ | Surgical Date:______________________

What makes it better:______________________________

What makes it worse:______________________________

Social History

Work Status: Employed: Yes_ No_ Full time__ Part time__ | Student_ Homemaker_ Retired_ Disabled_

Marital Status: Married __ Single __ Divorced __ Widowed __ or is patient a child __

Live with: Spouse __ Family__ Alone __ Friend __ | Smoke: Yes __ No __ Drink: Yes __ No __

Men: Do you have: Prostate Disease Yes __ No __ Urinary Incontinence Yes __ No __

Women: Do you have: Pelvic Inflammatory Disease __ Problem Periods __ Endometriosis __

Incontinence __ Currently Pregnant __ Complicated Pregnancies __ Other OB/GYN Problems __

Have you had an injury result due to a fall in the past year? Yes ___ No ___

Have you had two or more falls in the past year? Yes ___ No ___

Please check all that apply

Allergies __ Anemia __ Anxiety __ Arthritis __ Asthma __ Cardiac Condition __ Cardiac Pacemaker __

Cancer __ Chemical Dependency __ Circulation Problems __ Depression __ Emphysema/Bronchitis __

Dizzy Spells __ Fractures __ Gallbladder Problems __ Hepatitis __ High Blood Pressure __ Vision Problems __

Kidney Problems __ Metal Implants __ Multiple Sclerosis __ Parkinson __ Seizures __ Speech Problems __

Hearing Problems __ Strokes __ Thyroid Disease __ Tuberculosis __

If you did not bring a list of medications you are currently taking, please ask for a medication sheet from the front office staff. Thank You

JERRY L. KLUG, PT
Alabama Physical Rehabilitation Service, Inc.
1475 1st Avenue S.W.
Jacksonville, Al. 36265
256-435-9386

Patient Rights and Responsibilities

Alabama Physical Rehabilitation Service, Inc. recognizes that each patient is an individual with unique health care needs, psychosocial, spiritual and cultural values. It is our goal to provide that highest quality of care to each of our patients. Alabama Physical Rehabilitation Service, Inc. is committed to patient and family involvement in care.

Patient Rights:

You have the right to receive information regarding you medical condition and treatment.

You have the right to accept or refuse medical treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.

You have the right to personal privacy and confidentiality of personal information within the limits of the law.

You have the right to access the information contained in your medical record during treatment and following discharge within the boundaries of the law.

You have the right to make complaints regarding the quality of care and/or personal treatment you have received. Complaints may be directed to your therapist or the operating officer.

You have the right to receive care in a smoke-free environment. Absolutely no smoking is allowed within the building. Smoking area is provided outside the building.

Patient Responsibilities:

You are responsible for providing information about your health history.

You are responsible for following the Plan of Treatment.

You are responsible for keeping scheduled appointments.

You are responsible for canceling in a timely manner if you can not keep your appointment.

You are responsible for payment of financial obligations for care and services rendered.

You are responsible for being considerate of the rights of other patients as well as office and clinic personnel.

I have read and understand the "Patient Rights and Responsibilities"

______________________________________ ____________________

Signature of Patient or Authorized Representative Date

revised: 03/10

Patient Information Consent Form

APRS (Alabama Physical Rehabilitation Service, Inc.) has made available to me the Notice of Information Practices. I Understand that Alabama Physical Rehabilitation Service, Inc. may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the company in writing. I also understand that APRS will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my health information for purposes as noted in APRS "Notice of Information Practices". I understand that I retain the right to revoke this consent by notifying the company in writing at any time. ** ***INITIAL*** ___________

Designated Individuals Authorization Form

I thereby authorize one or all of the designated parties listed below to request and receive the release of any Protected Health Information regarding my treatment, payment or administration operations related to treatment and payment. I understand that the identity of designated parties must be certified before the release of any information.

Name: ______________________ Relationship: ______________ Name: ______________________ Relationship: _____________

Name: ______________________ Relationship: ______________ Name: ______________________ Relationship: _____________

*****PATIENT SIGNATURE***: ______________________________________ DATE: ____________________

Insurance Information: As a courtesy to you, APRS will bill your insurance company. Please provide us with your insurance card and any additional information we may need. We recommend that you call your insurance company to verify your physical therapy coverage if there is any discrepancy between what our office has been informed and what you thought your coverage was. Our billing office is available to answer questions you may have regarding our billing procedures. **It is your responsibility to know your policy benefits and limitations.**

Payment Options: APRS accepts personal checks, cash, and credit cards. Insurance co-payments are due on each visit unless arrangements have been made. Any portion of your treatments that are not covered by your insurance becomes your responsibility and is due within 30 days. We do offer payment arrangements: please ask the individual whom takes you back on your first visit about out payment options.

Return Check Fee: A $35.00 fee will be charged to the patient for a check that is returned to us for insufficient funds.

Supplies: Supplies purchased by the patient for use in the home are payable in full at the time the patient receives the supply.

Scheduling: We will make every effort to schedule your appointments at your convenience. We are happy to reschedule your appointments when a conflict occurs.

No Shows: We ask you to show consideration by notifying our office at least 12 hours in advance, if possible, if you are unable to keep an appointment. If you fail to give us notice of cancellation there could a $25.00 cancellation fee billed to your account that is non-covered by insurance. *****INITIAL***: _____________

Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

1. Are you currently receiving Home Health Service (nursing, PT, OT, aides) in your home? __Yes __No
2. Have you received Home Health Services in the last 30 Days? __Yes __No If yes, with whom? _________
3. Have you received Outpatient Physical Therapy or Speech Therapy this year? __Yes __No

If you fail to notify APRS prior to receiving home health services from another agency while you are receiving services with APRS or if services are currently being provided at this time you will be held responsible for the allowable amount of all services/charges rendered by APRS. If you fail to notify us of other physical therapy visits received at another facility for the current year will be held responsible for the visits/charges that go over your limit set by your insurance company. Thank you for allowing us this opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

*****Patient/Legal Guardian Signature***: ______________________________________ Date: ______________