CENTER FOR BALANCE & REHABILITATION
NEW PATIENT INFORMATION

Patient name: ____
LAST FIRST MIDDLE

Date of Birth: ___________________ Age: ___________ Gender (please circle): Female Male

Responsible Party SS#:_____________________ **Email Address:** _____________________________
Required if patient is a veteran, minor and/or full-time student.

Address: ____ City: _______________ State: _______

Zip Code: _____________ **Marital Status** (please circle): Single Married Divorced Widowed

Cell Phone #: ____________________________ Work/Home Phone #: ___________________________

Employment (please circle): Full-time Part-time Retired Unemployed

Employer: _______________________________ Occupation: ________________________________

Emergency Contact Information

Name: ____________________________ Phone #: ____________________ Relation: ______________

Primary Insurance Company: _____________________ Name of Insured: ______________________

Relation to Insured: ____________ Policy #: ______________________ Group Name/#: ____________
(SSN if VA is primary insurance)

Secondary Insurance Company: _______________________ Name of Insured: ___________________

Relation to Insured: _____________ Policy #: ___________________ Group Name/#: _______________

Referring Physician: _______________________**Type of Accident/Illness?** _____________________
(Home? Work? Sports? Auto?)

Date of Injury/Start of Symptoms: _________________ **Area of Body to be treated**:______________

Are you currently receiving home health PT? Yes / No If yes, with who? _____________________

Are you workman's comp or do you have an attorney covering your therapy services? Yes / No
Please explain: ____

I hereby certify that all the information provided by me in this application (or any other accompanying or required documents) is correct, accurate and complete to the best of my knowledge.

____ ____________________
Signature of Patient / Responsible Party Date

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CENTER FOR BALANCE AND REHABILITATION
PERSONAL & FAMILY MEDICAL HISTORY FORM

THE FOLLOWING FIVE QUESTIONS MUST BE ANSWERED:

1. For what condition or symptoms are you being seen for at this time?
2. When did this condition begin?
3. What treatment have you already received?
4. Has this problem occurred in the past?
5. Have you had two or more falls in the past year and/or any fall resulting in injury in the past 12 months? (please circle) YES NO

MEDICATIONS:
Please list all present medications & their dosages
(We will make a copy if you have a list in hand.)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

SURGERIES:
Please list all major surgeries & the approximate date/year they occurred.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________

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PAST MEDICAL HISTORY

Please circle YES or NO whether you have a history of any of the following conditions:

Condition			Condition		
Heart Disease/Heart Attack	Yes	No	Peptic Ulcer/Pancreatitis	Yes	No
Rheumatoid Arthritis	Yes	No	Anemia/Blood Disorders	Yes	No
High Blood Pressure	Yes	No	Shortness of Breath	Yes	No
Stroke/TIA (ministroke)	Yes	No	Hernia	Yes	No
Epilepsy or Convulsions	Yes	No	Thyroid Disorder	Yes	No
Kidney/Bladder Problems	Yes	No	Neuropathy	Yes	No
Diabetes	Yes	No	Vertigo/Dizziness	Yes	No
Tumor or Cancer	Yes	No	Osteoarthritis	Yes	No
COPD or Emphysema	Yes	No	Lightheadedness	Yes	No
Respiratory Disease	Yes	No	Do you have a pacemaker?	Yes	No
Tuberculosis	Yes	No	Do you have surgical implants?	Yes	No
Asthma	Yes	No			

Any Other Conditions Not Listed Above? ______________________________________

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CENTER FOR BALANCE
& REHABILITATION

CANCELLATION POLICY

Center for Balance and Rehabilitation strives to provide 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 with a specific therapist in order to minimize your waiting and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery. While we are sensitive to the fact that an emergency may occur in some instances, cancellations, especially last-minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients who are waiting for an appointment. Additionally, no-shows display a complete lack of respect for your therapist and fellow patients. Most medical offices require a 24-hour cancellation notice to avoid a fee, but CBR has significantly reduced this period in certain circumstances to accommodate these unforeseen events and make it less likely for our patients to have added fees to their accounts. That being said, a **$20 NO SHOW/LATE CANCELLATION FEE CHARGE** will be added to your account in the instance of a last-minute cancellation or no-show appointment to avoid any inconvenience to our staff or schedule. We appreciate your understanding and cooperation.

____
Initial for Acknowledgement

INFORMED CONSENT

The purpose of physical therapy is to treat disease, injury and disability by examination, evaluation, diagnosis, prognosis, and intervention by use of rehabilitative procedures, mobilization, massage, exercises, and physical agents to aid the patient in achieving their maximum potential within their capabilities and to accelerate convalescence and reduce the length of functional recovery. All procedures will be thoroughly explained to you before you are asked to perform them.

Response to physical therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. CBR does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical therapy treatment may result in aggravation of existing symptoms and may cause pain or injury. It is very important to communicate with you treating physical therapist throughout your treatment.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment. **I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.**

____
Initial to Grant Consent

CENTER FOR BALANCE
& REHABILITATION

EXPLANATION OF INSURANCE BENEFITS

Here at Center for Balance & Rehabilitation, we attempt to call each of our patient's insurance company to determine the physical therapy benefits and to advise each patient of their benefits at this facility as a courtesy. Due to the number of patients that we see at our facility, and the time it takes to directly contact an insurance company rep, we cannot guarantee an immediate response regarding insurance benefits, which is why we highly encourage each patient to be aware of their coverage with their insurance company prior to coming in. It is ultimately the patient's responsibility to understand their insurance company's eligibility and benefits. This includes in-network/out-of- network benefits for our facility, deductibles, co-pays, number of visits allowed, treatments allowed, authorization required, etc. Please understand that the information that is provided to us regarding your insurance is not a guarantee of payment, but simply what is told to us over the phone at the time of the call. Also note that Center for Balance & Rehabilitation will only bill a secondary insurance if we are a contracted provider.

If your insurance plan benefits are not what you think they are, it could result in significant out of pocket expenses that you did not expect. Do not hold Center for Balance & Rehabilitation responsible for what your insurance company may or may not pay. The type of insurance benefits you have are between you, the policy holder, and your insurance company. If you have a large deductible that has not been met, or if you have a co-pay for each visit, you will need to pay for services at the time of each visit. We strongly encourage each patient to call/review their insurance for an explanation of benefits, if you have not already done so.

Furthermore, IF YOU HAVE A CHANGE OF INSURANCE DURING YOUR TREATMENT WITH US, PLEASE LET OUR OFFICE MANAGER KNOW AS SOON AS THAT CHANGE IS MADE TO ENSURE ACCURATE BILLING AND PROCESSING OF CLAIMS.

Center for Balance & Rehabilitation values each and every one of our patients and we appreciate you trusting us with your care. That being said, thank you for being understanding and cooperative with our company policies.

I do hereby assign all insurance benefits to be paid directly to Center for Balance & Rehabilitation for all medical services provided to me. I understand that it is my responsibility to be aware of my benefits and eligibility with my insurance plan prior to my treatment at Center for Balance & Rehabilitation. I also acknowledge that I am personally liable for all charges incurred by me for treatment services provided me at Center for Balance & Rehabilitation. I further authorize Center for Balance & Rehabilitation to release information required regarding the course of my treatment for the purpose of evaluating and administering claims for benefits. I understand I am responsible for services not covered by my insurance, i.e. benefits exhausted or do not meet criteria of medical necessity per your plan's guidelines. Lastly, I agree to notify Center for Balance & Rehabilitation of any changes made to my insurance throughout the course of my treatment.

__________________________________ __________________

Signature of Patient or Responsible Party Date

CENTER FOR BALANCE AND REHABILITATION
NOTICE OF PATIENT INFORMATION PRACTICES

(Please detach this form from new patient packet, as it is for your own reference.)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Center for Balance & Rehabilitation is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Center for Balance & Rehabilitation can use your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Center for Balance & Rehabilitation** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Center for Balance & Rehabilitation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Center for Balance & Rehabilitation**'s policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Center for Balance & Rehabilitation may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

CENTER FOR BALANCE & REHABILITATION

You have the right to obtain a copy of your personal health information. **Center for Balance & Rehabilitation** shall have not less than 48 hours from the date of your written request to prepare and copy your medical records. The fee for copying is $30.00. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Center for Balance & Rehabilitation** will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Center for Balance & Rehabilitation** may have violated your privacy rights, or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Center for Balance & Rehabilitation's** health information practices, or if you have a complaint, please contact the following person:

Center for Balance & Rehabilitation
ATTN: OFFICE MANAGER
1220 Azalea Road
Mobile, AL 36693
251-607-6495 office