CENTER FOR BALANCE & REHABILITATION
PATIENT INFORMATION SHEET

Patient name: _____
LAST FIRST MIDDLE

Date of Birth: _____ Age: _____ (please circle) Female Male

Address: _____ **Responsible Party SS#:** _____
Required if patient a minor and/or full-time student

City: _____ State: _____ Zip: _____

Home/Cell Phone # _____ Work Phone # _____

Patient SS# _____ Driver's License # _____

Email Address: _____

Employer: _____ Occupation: _____

Employer's City: _____ State: _____ Zip: _____

Marital Status (please circle): Married Single Divorced Widowed

Name of Spouse: _____ Spouse's Work Phone # _____

Primary Insurance Company: _____ Name of Insured: _____

Relationship to Insured: _____ Insured's DOB: _____

Insured SS # _____ Group Name/Number: _____ Policy # _____

Secondary Ins: _____ **Name of Insured:** _____

SS# / Policy # of insured: _____ Insured's DOB: _____

Referring Physician: _____ Phone #: _____ Fax #: _____

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

INSURANCE REQUIRES THE DATE, MONTH AND YEAR (WILL NOT PAY WITHOUT THIS INFORMATION)

Type of Accident/Illness: _____ No Yes _____
(Home? Work? Sports? Auto?) Do you have an Atty? **If so, Name & Tel number**

I do hereby assign all insurance benefits to be paid directly to Center for Balance & Rehabilitation for all medical services provided to me. 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. **I have been informed of & agree to abide by the cancellation policy. ANY PERSONAL BALANCE 30 DAYS OR MORE PAST DUE MAY BE SUBJECT TO A 1.5% FINANCE CHARGE.**

_____ _____
Signature of patient / Parent (if patient is a minor) Date

_____ _____
Signature of responsible party / Parent (if patient is a minor/student) Date

Center for Balance & Rehabilitation - Patient Medical History Form

Patient Name:_____Date:_____

Date of Birth:_____/_____/_____ Age:_____ Date of Injury/Onset:_____

Referring Physician:_____Family Physician:_____

Height: _____ Weight: _____ Patient Appointment Reminder Phone #:_____

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? YES NO

MEDICATION

Please List All Present Medications. Please Also Note Dosage/Frequency of Use.

Name of Medication	Dosage/Frequency of Use
1	
2	
3	
4	
5	
6	

PAST MEDICAL HISTORY

Please Check YES or NO Whether You Have Had the Following Conditions

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	Bleeding Disorder	Yes	No
Stroke	Yes	No	Shortness of Breath	Yes	No
Epilepsy or Convulsions	Yes	No	Hernia	Yes	No
Kidney or Bladder Problems	Yes	No	Thyroid Disorders	Yes	No
Diabetes	Yes	No	Neuropathy	Yes	No
Tumor or Cancer	Yes	No	Vertigo / Dizziness	Yes	No
COPD or Emphysema	Yes	No	Osteoarthritis	Yes	No
Respiratory Disease	Yes	No	Lightheadedness	Yes	No
Tuberculosis	Yes	No	Do You Have a Pacemaker?	Yes	No
Asthma	Yes	No	Do You Have Surgical Implants?	Yes	No

Any Other Conditions Not Listed Above? _____

_____

SURGERY

Please List All Previous Surgeries & Indicate the Approximate Date of the Procedure

Surgery/Procedure	Approximate Date

FRACTURES AND OTHER SERIOUS INJURIES Please List the Type and Date

Fracture/Injury	Date

FAMILY HISTORY

Please Check Yes or No to the Following

Heart Disease	Yes	No	Bleeding Tendency	Yes	No
Cancer	Yes	No	Diabetes	Yes	No
Arthritis	Yes	No	Stroke	Yes	No
High Blood Pressure	Yes	No			
Gout	Yes	No			

Patient Signature _____ Date _____

Center for Balance & Rehabilitation

Cancellation Policy

Cancellation Policy: Effective January 1, 2019

RE: Missed (No Show) and Late Notice of Cancellation

REASONABLE NOTICE (SEE BELOW) IS REQUIRED OR A **$50.00 FEE** WILL BE ADDED TO YOUR ACCOUNT FOR EACH MISSED APPOINTMENT. YOUR THERAPIST HAS THIS TIME RESERVED TO TREAT YOU AND, IF YOU DO NOT SHOW, THIS TIME IS WASTED.

MOST MEDICAL OFFICES REQUIRE A 24-HOUR CANCELLATION NOTICE TO AVOID A CANCELLATION CHARGE. CENTER FOR BALANCE & REHABILITATION HAS SIGNIFICANTLY REDUCED THIS PERIOD IN ORDER TO ACCOMMODATE UNFORSEEN EVENTS AND TO MAKE IT LESS LIKELY YOU WILL BE ASSESSED A CANCELLATION FEE, BUT STILL PROVIDE CENTER FOR BALANCE & REHABILITATION TIME TO FILL A CANCELLED TIME WITH ANOTHER PATIENT WHO MAY BE WAITING FOR AN APPOINTMENT.

REASONABLE NOTICE FOR A MORNING APPOINTMENT IS ANYTIME PRIOR TO 6:00 PM THE EVENING BEFORE. REASONABLE NOTICE FOR AN AFTERNOON APPOINTMENT IS NOT LESS THAN 6 HOURS PRIOR TO YOUR APPOINTMENT TIME.

WE APPRECIATE YOUR COOPERATION & UNDERSTANDING.

THANK YOU.

_____

Patient initials for acknowledgement

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 we see at our facility, and the time it takes to directly contact an insurance company rep, we cannot give an immediate response regarding insurance benefits, which is why we highly encourage each patient to call their insurance. It is ultimately the patient's responsibility to understand your 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. If you desire, please request our "Patient Verification Form" that contains pertinent information you should obtain when contacting your insurance company. 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.

Following your conversation with your insurance company, should you have any additional questions about your insurance benefits, please contact our business office and we will try to explain what we can. However, remember we cannot and do not have any way to guarantee what your insurance plan may or may not pay.

For our **MEDICARE PATIENTS**, if your Medicare Part B insurance coverage is current and not assigned to a HMO, it is not necessary for you to call Medicare for insurance information. All Medicare benefits are standardized, and **Center for Balance & Rehabilitation** is a Medicare certified facility. We do highly suggest Medicare patients call to verify benefits with their secondary insurance since there are many different plans and some may not be 'supplemental' to Medicare.

Center for Balance & Rehabilitation appreciates your business and part of our practice courtesy is to let all patients know upfront that it is necessary to contact your insurance company to avoid any unexpected results.

Thank You.

I understand that it is my responsibility to call and determine what my insurance plan benefits are for physical therapy at **Center for Balance & Rehabilitation**.

_____ _____

Signature of Patient or Financially Responsible Person Date

Center for Balance & Rehabilitation
Notice of Patient Information Practices

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 AND REHABILITATION'S LEGAL DUTY

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

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

CENTER FOR BALANCE & REHABILITATION

INFORMED CONSENT FOR PHYSICAL THERAPY TREATMENT

Welcome to **Center for Balance & Rehabilitation**. This form is an effort by **Center for Balance & Rehabilitation** to provide you with information about your physical therapy treatment here at **Center for Balance & Rehabilitation** that is administered by the physical therapist, physical therapy assistant or other ancillary personnel. The purpose of "informed consent" is to provide you with sufficient information so that you can make an "informed" decision regarding your consent to physical therapy treatment. It is our desire and goal to provide you with appropriate and safe treatment that will result in an improvement in your particular condition. However, because there are many factors and issues involved in a specific individual's medical condition and treatment, we are unable to guarantee that every individual medical condition will respond positively to treatment.

Physical therapy involves many types of treatments, procedures and modalities. The type of treatment the therapist incorporates into your treatment care plan is generally based on the information gleaned from the prescription of your referring physician, your initial evaluation, and your response to various types of procedures employed during your treatment. Your treatment may be altered or changed by the therapist based on your response to current treatment and as your condition changes. As you may be aware there are benefits and risks associated with all types of medical treatment and this includes physical therapy treatment. While it may be possible to make an extended and long list of potential risks from all types of physical therapy treatment it is not practical nor is it likely to result in providing you with information that allows you a better understanding of "risks vs. benefits". We encourage you to ask your therapist about any concerns or questions you may have regarding your treatment. He or she will be glad to discuss and review any particular treatment that you are receiving.

Manual therapy (includes joint mobilization, soft tissue mobilization, and manual traction) and therapeutic exercise are frequent procedures utilized at **Center for Balance & Rehabilitation** that we believe provide our patients with significant benefits. Manual therapy involves applying varying degrees of pressure with the therapist's hands on the treatment area or surrounding area of your body. Manual therapy and exercise have inherent physical risks associated with them. These risks may include, but are not limited to, muscle and soft tissue strains or soreness, joint strains and sprains, intravertebral disc injury, heart attacks or cardio-vascular complications, bone injuries, strokes, and other complications known and unknown at this time.

By signing this form, you are consenting to treatment by **Center for Balance & Rehabilitation.** You are acknowledging that you understand and are accepting the benefits and risks of physical therapy treatment. You understand that you may question your physical therapist at any time regarding your treatment and that you may decline any proposed treatment or stop any treatment at any time that is currently being utilized.

Patient Signature_____ Date _____

CENTER FOR BALANCE & REHABILITATION

TO OUR PATIENTS

As you are likely aware, there are literally hundreds upon hundreds of different insurance plans from many different insurance companies. As a result, it would be impossible for our office to know the covered benefits of each and every patient and their insurance plan.

While we will attempt to assist you, often we are given incorrect information. It is the responsibility of the patient to know and understand the policies and benefits of their insurance plan and comply prior to starting treatment. This includes:

• Co-payment and Deductible amounts and paying at the time of visit.

• It is your responsibility to find out if the proposed facility for your procedure is contracted with your health plan.

• Prior authorized procedures with current phone numbers.

• The current claims address so your claim may be processed without delay.

Again, you are responsible to obtain the above information and any change of address and/ or insurance information.

I understand that I am responsible to pay any Deductibles and Co-pays at the time of service. I also agree to notify Center for Balance & Rehabilitation of any changes made to my insurance plan or benefits.

Signed: _____

Printed Name:_____Date: _____