Pro Motion Rehab, Inc.

MEDICAL HISTORY

Please list medications/surgeries on back

Last Name: _____ First Name: _____

DOB _____ Height _____ Weight _____ Smoke Cigarettes? Y / N # per day _____

- Have you had a fall in the last year? Y / N How many _____ What was the cause _____

_____

- Conditions, disease or other problems we should know about (surgical procedures, implants, pacemaker, fainting, cancer, blood pressure, heart problems, communicable disease, diabetes, respiratory problems, etc.) _____

_____

- Previous Therapy? Y / N For the current or other injury/illness AND when: _____

_____

- Describe the current problem _____

_____

- Approximately when did it start: _____ • Is it getting better or worse or same? _____
- Have you had this pain/problem before? Y / N • Explain _____

_____

- Rate your pain from 1 to 10 (0=mild, 10=severe) _____ • Is it constant (never goes away) Y / N
- Are you taking any medication for this pain/problem? Y / N • Is it helping? Y / N
- What activities/positions or tasks make it worse? _____

_____

- What activities/positions or remedies make it better? _____

_____

- List 3 tasks or goals that you want to be able to do better or accomplish:

1. _____
2. _____
3. _____

- Are there any issues or problems not mentioned above that you think we should know about that may affect the outcome of your therapy? _____

_____

I certify that I have read and understand the above. I acknowledge that the questions have been answered to the best of my ability and I will not hold the facility or staff responsible for any errors or omissions that I may have made in completing this form.

Patient or Guardian Signature: _____ ***Date:*** _____

If you have a medication/surgery list - please ask the office to copy it

Pro Motion Rehab, Inc.

Name: _____

Date: _____

Medication	Dosage	How Often	How Taken

Surgery	Date

Pro Motion Rehab, Inc.
2810 W. US Hwy 64
Suite #1
Murphy, NC 28906
828-837-0400

Patient Express Registration

Today's Date :

PLEASE PRINT & COMPLETE ALL CLEARLY

1. Personal Info

Last Name _____ First Name _____ Age _____ ___ Male ___ Female

Street Address _____ City _____ State _____ ZIP _____

( ) Home Phone _____ ( ) Cell Phone _____ Email Address **(Important)** _____

Social Security # _____ Date of Birth ___/___/___ Single / Married / Divorced

- My condition is related to: ___ Work ___ Auto Accident (State _____) Other _____

Occupation _____ Employer Name _____ ( ) Phone # _____

Work Status: ___ Currently Employed ___ Retired ___ Disabled (___ Total or ____ Temporary) ___ Student (___ P/T ____ F/T)

Emergency Contact Person _____ ( ) Phone # _____ (If Minor) Parent/Guardian Name and Signature _____

2. Referral Info

How did you hear about us? _____

If you were referred by a friend or family member, please provide their phone number /address below so we may send a thank you note and gift.

_____

Referring Physician: _____ Do you have a follow-up appointment? Y / N Date: _____

Primary Physician Name: _____

3. Payment Info

PLEASE SELECT YOUR DESIRED PAYMENT METHOD **(Check appropriate box or boxes)**

Insurance: (Primary and Secondary)

- ❑ Medicare ❑ Medicare Replacement ❑ Medicaid ❑ PPO / Private / POS
- ❑ Worker's Compensation ❑ Auto Insurance ❑ VA Insurance ❑ Health Savings Account
- ❑ **Self Pay:** (**Note: Self pay rate is a community service **discounted at time of service rate** we offer as a courtesy to our patients. Paperwork and Administrative costs may incur additional fees. Please discuss any concerns with Billing Manager)
  - ❑ Cash ❑ Check (s) ❑ Credit Card ❑ Care Credit
  - ❑ Payment Plan (Additional Fees May Apply)

Litigation / Lien: (**Note: Additional Paperwork Required)

- ❑ Auto Lien/Litigation ❑ Work Injury Lien/Litigation ❑ Other: (Specify)_____

4. Additional Info:

I understand that I am directly and fully responsible to said provider for all therapy and/or medical benefits submitted by provider for services rendered to me or other person for which I accept financial responsibility and that this statement/document is made solely for said provider's additional protection. I understand that provider will not/does not receive immediate payment for my services, as such the balance of my account may accrue to a point at which the provider will need to ensure my credit worthiness to extend credit to me. I authorize Pro Motion Rehab to verify my credit worthiness at any such time as may be deemed necessary. I further understand that such payment is not contingent on any settlement, judgment, or verdict by which I may eventually recover said fee. If this account is assigned for collection and/or suit, collection costs and/or interest, and/or attorney's fees, and/or court cost will be added to the total amount due.

Authorized Signature _____ Date: _____

Important Company Policies

We strive to provide you with the best personalized care available. To make this possible we adhere to a set of very important policies. Please read them carefully and indicate your acknowledgement by signing at the bottom. *Note: While these policies are not negotiable, we are VERY understanding of life situations and will try to work with you when or if those situations arise.

Late Policy "10-minutes" - Being late by more than 10 minutes may require you to reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We discourage appointment overlap due to tardiness because this undeservedly compromises the care of another patient.

Cancellation/No Shows - If you wish to change or cancel your appointment we require a minimum **24-hour advance notice.** Anything less may result in a **$25 fee** charged to your account. If you fail to show for an appointment without notice all future appointments may be removed. You may reschedule appointments again on a "first come, first serve basis" when you have paid for the missed visit in full. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expense (for staff wages, rent, etc.). We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. We understand extenuating circumstances may sometime apply, if so, please let us know as soon as possible. YOUR COURTEOUS CONSIDERATION AND UNDERSTANDING ARE APPRECIATED.

Co-pays and Self-Payment are due at time of each visit - If you happen to forget your wallet or checkbook we may still be able to see you however payment will be expected at the time of or before your next appointment. Additionally, if you fail to return for further visits you will still be responsible for any balance owed on your account. This allows you to keep your appointments however multiple offenses or extended delay in payment may result in a small surcharge. **Any check returned for NSF will result in a $25 fee.**

Therapy/Service and Emotional Support (Comfort) Animals - At Pro Motion Rehab, we respect the need for Service/Support Animals for those with a specific disability that would require such assistance. However, we are unable to accommodate Emotional Support Animals in the facility due to the difference in training, function and the potential difference in temperament. As allergies often cause certain patients to be unable to tolerate the dander on such animals and the potential for fleas to be left behind, we ask that you consider leaving your comfort animal in the care of someone that you trust. Americans With Disabilities Act cites that emotional support animals do not have the training to do specific tasks in assisting a person with disability or impairment, unlike service animals. Hence, the pets may not be allowed to accompany their owner in public places ie. restaurants, stores, hotels. Under the ADA and North Carolina law, owners of public accommodations are not required to allow emotional support animals, only service animals in their establishments.

Cell phones must be shut OFF or silent - We realize emergencies may arise and therefore allow you to carry your phone during your session, however please be courteous and set to vibrate / silent mode or turn off. Thank you. We also request that electronic devices are not used during the one-on-one portion of your treatment.

Children/Minors or Adults requiring supervision are NOT allowed to be left unattended in the reception area - You may **not** bring children/adults who require supervision with you and leave them **unattended** in the reception area. If a child is a source of distraction from your care, we request that the child not attend your appointment. Likewise, if a patient with impairments such as dementia, Alzheimer's or behavior issues, we request that you stay in the reception area or with the patient during their treatment. If your child does not require supervision and is capable of waiting quietly without disruption in our reception area then you may bring them. If any disturbance is caused to other patients or staff you may be asked to terminate your session early and attend to your child.

Parental / Legal Guardian Supervision / Availability - Any minor under the age of 16 years will be required to have a parent or legal guardian present, onsite or readily available (on premises), while treatment is being rendered. Any minor under the age of 16 years left or dropped off by the parent or legal guardian will not receive treatment until the parent or legal guardian is readily available as described above. ***NOTE: A minor over the age of 16 years may be required to have a parent or legal guardian readily available if requested by the Therapist.**

Patient Drop-Off/Pick Up - If you are dropping off or picking up a patient, please do so in a timely manner. Please have patient on time to their appointment.. Do not leave until the patient is checked in and appointment has been confirmed. Likewise, please pick up patients promptly after appointment. Appointments are approximately 60 minutes in length. Please do not leave patients waiting in the reception area.

Financial Hardship - If you are experiencing financial difficulties and are unable to pay co-pays/co-insurance associated with your services, we have a "Financial Hardship Form" which may be filled out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portion of the bill. Ask the Billing Office for assistance.

Important Notice from the Federal Government:
"It is unlawful to routinely avoid paying your co-pay, deductible or co-insurance payments… even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's—Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws, Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply.

I have read, understand, and agree to follow all the policies on this form.

Patient Signature: _____ **Date:** _____

Assignment Of My Benefits

For Commercial Insurance, POS, Medicare, Medicaid, Med-Pay, PIP, Lien,
Workers Compensation, Other Liability and Private Third Party Payers

1. Benefits Info

Please provide **all** insurance cards and information, as well as your driver's license or photo ID card. Benefits will be verified between our office and your insurance however, as stated by most insurance policies, *"a verification of benefits is not a guarantee of payment"*. **You are responsible for any co-insurance, co-payment, or *unmet* deductible amount at time of service/each visit.**

2. Policy Info

I hereby instruct and direct my insurance company, attorney, and/or person(s) responsible for settlement/payment services related to my claim/case to timely discuss and provide necessary information as well as to pay via check made payable and mailed to:

Pro Motion Rehab, Inc. 2810 W. US Hwy 64 Murphy, N.C. 28906
Office: 828-837-0400 Fax: 828-837-0404 Email: pt@promotionrehab.com

If my/this current policy prohibits direct payment to above company, I hereby also instruct and direct you to **make the check jointly payable to myself AND Pro Motion Rehab and mail it to the above address for the allowable professional or medical expense benefits,** and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment **will not** exceed my indebtedness to the above-mentioned assignee. I agree to pay, in a prompt manner, any balance of said professional service charges not paid by my insurance or designated responsible party. (co-pays, deductible, or denial). (Sign and date this document at the bottom)

- A photocopy or fax copy of this Assignment shall be considered as effective and valid as the original.
- I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney directly involved in this case for the purpose of processing claims and securing payment of benefits.
- I authorize the use of this signature on all insurance submissions.
- I authorize Pro Motion Rehab, Inc. to deposit insurance checks made in my name for their services.
- I authorize Pro Motion Rehab, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- **I understand that I am ultimately financially responsible for the services I receive whether or not paid by my insurance, settlement, or any other entity that I initially provided for said payment to Pro Motion Rehab.**
- **I authorize the release of any information regarding my clase/claim to/from ProMotion Rehab from/to any insurance provider, attorney, adjuster or any other related party.**

***Note: Providers may not bill any patient more than has been allowed by the insurance company with which they contract.**

NOTE: We accept cases of personal injury where fault is or is NOT determined. We reserve the right to **request payment be made at the time of service** even in cases where an attorney is involved. In certain cases we may defer payment until the cases settles, however, a **lien agreement** will be required to secure payment. We **do not charge any fees** for this service even though we may not receive payment for services provided for 12-24 months. Please be informed that **we do not accept "discounted settlements". We will not change the payor to your private insurance after you have been discharged unless your case has settled and no money had been awarded**. Please understand **all** amounts are due and payable by patient or their guardian/parent (for minor patients). **The patient or guardian/parent is responsible for all charges** regardless of the outcome of the case.

If it becomes necessary for Pro Motion Rehab to retain a collection agency or legal counsel to assist with collection of any unpaid patient responsible balance, by your signature below you agree to assume responsibility for all related fees.

Please note that any documentation requests and/or deposition appearance requests by an attorney other than your own or yourself may incur additional fees. We do not accept all cases and reserve the right to refuse service to anyone.

Dated this _____ day of _____ 20____.

Signature of Policyholder	Witness	Signature of Claimant, if other than Policyholder

V1.2020

Pro Motion Rehab & Wellness Center
2810 US Hwy 64W, Murphy NC 28906
828-837-0400 • 828-837-0404 (fax)
www.promotionrehab.com

PATIENT ACKNOWLEDGMENT OF THE NOTICE OF PRIVACY PRACTICES

Patient Name: _____

I acknowledge that I was provided with a copy of the Pro Motion Rehab HIPPA Notice of Privacy Practices for Personal Health Information.

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to the following:

Please check and list names below.

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to _____

[ ] Information is not to be released to anyone. This Release of Information will remain in effect until terminated by me in writing.

_____ _____
Patient Signature Date

_____ _____
Patient's Representative Authority to Act

Witness:_____ Date: _____

For Pro Motion Rehab, Inc. use only: Complete this section if this form is not signed and dated by the patient or patient's representative and no signed acknowledgement of receipt of the current notice of privacy practices is on file in the patient's chart

Patient [□ has □ has not] signed an acknowledgement of the CURRENT Notice of Privacy Practices either attached here or as documented in the patients chart.

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Patient Name: _____ Date of Birth: _____ Phone number: _____
Address: _____
The date that you requested the signature: _____
The reason that the signature and date were not obtained: _____
_____
_____