## PATIENT INFORMATION

| **NAME**: | | First time patient? ☐ Yes ☐ No | |
|---|---|---|---|
| Address: | | | |
| City: | | ST. | Zip |
| Home telephone: (     ) | Cell phone: (     ) | | |
| Social Security No.: | D.O.B. | | |
| **EMPLOYER**: | Occupation: | | |
| Address: | | | |
| City | | ST. | Zip |
| Work Telephone: (     ) | Contact Person: | | |
| **In case of an on-site emergency, I.W.R. should notify:** | | | |
| Relationship to patient: | | Telephone: | |

**CONSENT FOR TREATMENT**: I, the undersigned, understand that my treatment is under the direction of my referring physician and consent to prescribed treatment.

**ASSIGNMENT OF INSURANCE BENEFITS**: I assign payment directly to I.W.R. Therapy Systems in accepting this assignment of all therapy benefits and applicable and otherwise payable to me, but not to exceed the reasonable and customary charge for these services rendered by said group. I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverage is subject to a coordination of benefits clause. Where Medicare and/or Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII of XIX of the Social Security Act is correct, and request that said payment of authorized benefits be made on my behalf.

**FINANCIAL AGREEMENT**: I understand that I am responsible to I.W.R. Therapy Systems for all reasonable charges incurred to me. The undersigned agrees, whether he/she signs as agent or as patient, he/she hereby individually obligated himself/herself to pay the account in accordance with the regular rates and terms of I.W.R. Therapy Systems. Furthermore, he/she obligates himself/herself to make weekly payments if requested. Should the account be referred for collection, the undersigned shall pay reasonable attorneys fees and/or collection expenses. All delinquent accounts bear interest at the legal rate. The undersigned agrees that any monies collected on the above services may be applied directly to a delinquent account of the patient should one exist.
**LEGAL AUTHORIZATION**: I authorize I.W.R. Therapy Systems in 1) the collection of benefits from any responsible third party through whatever means may be deemed necessary, and 2) the endorsement of benefit checks made payable to myself or to I.W.R. Therapy Systems.

☐ **MOTOR VEHICLE ACCIDENT**: I understand in the event of a MVA, IWR Therapy Systems **does not** accept a letter of guarantee from attorney or responsible insurance party. We will file on the patients personal insurance or accept cash pay. This does NOT release patient from responsibility. Initial Here:_________________

☐ **BLUE CROSS / BLUE SHIELD**: By initializing this paragraph, I certify that I am responsible for any and all amounts not paid by BC/BS, including deductibles and percentages for each visit. Initial Here:___________________

**RELEASE OF INFORMATION**: I authorized I.W.R. to release and any all information required in the course of my examination and treatment in connection with therapy treatments for any and all purposes involved in medical treatment, professional services and/or billing. This consent and authorization specifically includes but is not limited to: psychological, psychiatric, alcohol, drug abuse, and HIV/AIDS information.

**SCHEDULING: We take scheduling very seriously because it can make the difference between whether you succeed in your treatment or not. Your treatment will have a set frequency (Example 2 or 3 times per week). Cancellations and no-shows are documented if you do not attend at this frequency. Documentation of any missed appointment will be forwarded to your adjuster, case manager and primary physician which can jeopardize your claim.**
**When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice. Initial Here:______________________**

I, the undersigned, certify that I have read and understand the above.

**Client Signature:** **Today's Date**:

# PAST MEDICAL HISTORY QUESTIONNAIRE

Name:________________________________________Height:___________Weight:___________

Reason for Physical Therapy evaluation:__________________________Referring Physician__________________________

Location of Injury / Pain:______________________________Date of Injury/Illness__________________________

List of current medications you are taking:________________________________________

____________________________________________________________________________

____________________________________________________________________________

List of any allergies to medication:______________________________________________

☐ No allergies to medication

**Check the boxes that apply to your medical history and explain if applicable.**

☐ Arm Pain: ________________________________________
☐ Ankle Swelling: ________________________________________
☐ Arthritis: ________________________________________
☐ Asthma: ________________________________________
☐ Back Injury: ________________________________________
☐ Black Outs: ________________________________________
☐ Cancer: ________________________________________
☐ Chest Pain/Pressure/Burning: ____________________________________
☐ Chronic Lung Disease: ________________________________________
☐ Diabetes: ________________________________________
☐ Dizziness/Vertigo: ________________________________________
☐ EKG Abnormality: ________________________________________
☐ Epilepsy: ________________________________________
☐ Heart Abnormality: ________________________________________
☐ Heart Attack: ________________________________________
☐ Hernia: ________________________________________
☐ High Blood Pressure: ________________________________________
☐ High Cholesterol: ________________________________________
☐ Kidney Disease: ________________________________________
☐ Liver Disease: ________________________________________
☐ Muscle cramping/spasms:________________________________________
☐ Neck Pain: ________________________________________
☐ Pace Maker Implant: ________________________________________
☐ Prosthesis/Brace: ________________________________________
☐ Headaches: ________________________________________
☐ Seizures: ________________________________________
☐ Shortness of Breath: ________________________________________
☐ Stroke / CVA: ________________________________________
☐ Surgery: ________________________________________

***WHEN IS YOUR NEXT VISIT WITH THE DOCTOR?***________________________

Patient Signature:____________________________________________Date:__________________

## CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATIONS

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 2048-A South Broad Street
Brookley Field Complex
Attn: Privacy Office
Mobile, AL 36615

Telephone: (251) 433-1414

Fax: (251) 433-9634

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

**The effective date of this Privacy Notice is March 24, 2003.**

**BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.**

_______________________________________________ _________________________
Printed Name of Patient Date

_______________________________________________
Signature of Patient or Patient's Representative

_______________________________________________
Printed Name of Patient's Representative (if applicable)

_______________________________________________
Representative's Relationship to Patient (if applicable)

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**To be completed by Industrial Wellness Rehab, Inc.**

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

______________________________________________________________________________________________
______________________________________________________________________________________________

_____________________________________________ ____________________________________
Signature of IWR Representative Date