Therapeutics Unlimited
OUTPATIENT PHYSICAL THERAPY AND SPORTS REHAB

NEW PATIENT APPLICATION

Date:_____

Name: _____

How did you hear about Therapeutics Unlimited?

☐ Physician

☐ Newspaper

☐ Friend or Family

☐ Returning Patient

☐ Health Fair

☐ Internet

☐ Other:_____

Physicians Name:_____

Would you like to be part of our E Newsletter? ____Yes ____No

If yes what is your email address _____

THANK YOU FOR CHOOSING THERAPEUTICS UNLIMITED

HISTORY AND PHYSICAL

To ensure you received a complete thorough evaluation, please provide us with the important background information on the following form. If you do not understand a question, leave it blank and your therapist will assist you. Thank you!

NAME:_____ **DOB:**_____

OCCUPATION: _____ **EMPLOYER:** _____

1. Emergency Contact 1:_____ Phone #_____

2. Emergency Contact 2:_____ Phone #_____

ALLERGIES

List any medication(s) you are allergic to: _____

Are you latex sensitive? ☐ Yes ☐ No

List any other allergies we should know about _____

Have you declared the Advanced Clinical Directive of Do Not Resuscitate? ☐ Yes ☐ No

Please check any of the following whose care you are under:

☐ Medical Doctor (MD) ☐ Psychiatrist/Psychologist ☐ Other_____

☐ Osteopath ☐ Physical Therapist

☐ Dentist ☐ Chiropractor

If you have seen any of the above during the past three months, please describe for what reason (illness, medical condition, physical, etc.): _____

_____

_____

Have you EVER been diagnosed as having any of the following conditions?

__Y __N **Cancer** If YES, describe what kind: _____

__Y __N **Heart Problems**	__Y __N **Thyroid Problems**	__Y __N **Hepatitis**
__Y __N **High Blood Pressure**	__Y __N **Diabetes**	__Y __N **Tuberculosis**
__Y __N **Circulation Problems**	__Y __N **Multiple Sclerosis**	__Y __N **Stroke**
__Y __N **Asthma**	__Y __N **Rheumatoid Arthritis**	__Y __N **Kidney disease**
__Y __N **Emphysema/Bronchitis**	__Y __N **Other Arthritic Conditions**	__Y __N **Anemia**
__Y __N **Chemical Dependency (i.e., alcoholism)**	__Y __N **Depression**	__Y __N **Epilepsy**

During the past Month, have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No

FOR WOMEN: Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including the approximate date and reason for the surgery or hospitalization:

DATE	**REASON FOR SURGERY/HOSPITALIZATION**
1. _____	_____
2. _____	_____

Please describe any significant injuries for which you have been treated (including fractures, dislocations, sprains) and the approximate date of injury:

DATE	**INJURY**
1. _____	_____
2. _____	_____

Has anyone in your immediate family (parents, brothers, sisters) ever been treated for any of the following?

__Y __N **Diabetes**	__Y __N **Cancer**	__Y __N **Tuberculosis**
__Y __N **Arthritis**	__Y __N **Heart Disease**	__Y __N **Anemia**
__Y __N **High Blood Pressure**	__Y __N **Headaches**	__Y __N **Stroke**
__Y __N **Epilepsy**	__Y __N **Kidney Disease**	__Y __N **Mental Illness**
__Y __N **Chemical Dependency (i.e., alcoholism)**		

Please list any OVER THE COUNTER MEDICATION you are currently taking (INCLUDING pills, injections, and/or patches):

1. _____ 2. _____

3. _____ 4. _____

Please list any PRESCRIPTION medication you are currently taking (INCLUDING pills, injections, and/or patches):

1. _____ 2. _____

3. _____ 4. _____

How much caffinated coffee or caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke a day? ___

How many days per week do you drink alcohol? ____

If one drink equals one beer or glass of wine, how much do you drink at an average sitting? _____

Have you ever recently noted:

__Y __N **Weight Loss/Gain**
__Y __N **Nausea/Vomiting**
__Y __N **Fatigue**
__Y __N **Weakness**
__Y __N **Fever/Chills/Sweats**
__Y __N **Numbness or Tingling**

Patient's Signature:_____

Therapist's Signature: _____

Date: _____

Therapeutics Unlimited
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FINANCIAL AGREEMENT & AUTHORIZATION FOR PHYSICAL THERAPY TREATMENT

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees financial policy or your financial responsibility.

Private Insurance Authorization for Assignment of Benefits/Information Release: I, the undersigned, authorize payment of medical benefits to Therapeutics Unlimited/TU Rehab LLC for any services furnished. I understand that I am financially responsible for any amount not covered by my contract. I authorize the release of my medical information to insurance companies, medical and legal authorized personnel. This information will be used for the purpose of evaluating and administering claims of benefits. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself.

- **SELF-PAY PATIENTS** - Payment is expected at the time of service unless other financial arrangements have been made prior to your visit.

- **MEDICARE**- We will submit claims to Medicare. The patient will be responsible for the deductible and the 20% coinsurance, which can be billed to a secondary insurance if you have one.

  Medicare Lifetime Signature on File: I request the payment of authorized Medicare benefits be made on my behalf to Therapeutics Unlimited/TU Rehab LLC for any services furnished to me. I authorize any holder of medical information about me to release any information to determine these benefits payable for related services. This information will be used for the purpose of evaluating and administering claims of benefits. Any balance due after insurances have been submitted will be the patient's responsibility.

  I hereby authorize Therapeutics Unlimited Incorporated to administer physical therapy treatments and assign payments to TU Rehab LLC. I also request that all payments be made directly to Therapeutics Unlimited Incorporated and that co-insurance and co-payments are the responsibility of the patient/responsible party.

- **CO-PAYMENTS** - Payment is expected at the time of service. Please be prepared to pay the co-pay at each visit. You will be responsible for any balance your plan indicates as due on their explanation of benefits form. All patients will be responsible for their co-insurance and deductible. Should you receive payment from your insurance carrier, please forward it to the physician's office.

Patients are responsible to bring any insurance payments that may be mailed to the subscriber's/patients home for payment of services provided by TU Rehab LLC.

All future prescriptions and referrals required for continued treatment are to be obtained by the patient. Patients who cancel visits at the last minute or fail to show up will personally be charged a $25 fee for the visit. This will not be billed to their insurance company.

WE ACCEPT CREDIT CARD/CASH OR CHECKS

Thank you for taking the time to review our policies. Please feel free to ask any questions or share with us special concerns.

Patient signature_____ Date_____

Parent/Guardian_____Date_____

Therapeutics Unlimited
OUTPATIENT PHYSICAL THERAPY AND SPORTS REHAB

THERAPEUTICS UNLIMITED/ TU REHAB LLC
NOTICE OF PRIVACY PRACTICES

We recognize the sensitive nature of personal health information. We are committed to protecting your privacy as well as your health. Therefore, the following Notice of Privacy Practices describes how medical information about you may be used and is disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURE OF HEALTH INFORMATION

Pursuant to law, we may use health information about you for treatment (such as sending you medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health insurance plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

Although the law does not require that we obtain a signed consent from you for treatment, payment, or healthcare operation purposes, we encourage you to sign a consent so that you are aware of our concern and practices regarding protection of your personal health information.

Our policies and procedures are designed to protect your privacy. We may need to use or disclose identifiable health information about you without your authorization for several other reasons, such as required law. Subject to certain requirements, we may disclose health information for public health purposes, abuse or neglect reporting, auditing purposes, research studies, funeral arrangements, organ donation, workers' compensation purposes, and/or emergencies. We provide information when otherwise required by law, such as for law enforcement in specific circumstances. We may also contact you about appointment reminders or treatment alternatives to raise funds. In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

We may change our policies in the future. Before we make a significant change in our policies, we will change our notice and post a new notice in the waiting area. You can also request a copy of our notice at any time

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or get a copy of health information about you that we use to make decisions about you. You also have the right to receive a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or related administrative purposes. If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information.
You have the right to request that your health information be communicated to you in a confidential manner such as sending mail to an address other than your home. If this notice was sent to you electronically, you may obtain a paper copy of the notice.
You may request in writing that we not use or disclose your information for treatment, payments, or administrative purposes or to persons involved in your care except when specially authorized by you, when required by law, or in emergency circumstances. We will consider your request but are not legally required to accept it.

COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, you may contact the person listed below. You may also send a written complaint to the U.S. Department of Health and Human Services. The person listed below can provide you with the appropriate address upon request. Under no circumstances will you be retaliated against for filing a complaint.

OUR LEGAL DUTY

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

Therapeutics Unlimited
OUTPATIENT PHYSICAL THERAPY AND SPORTS REHAB

CONSENT TO USE/DISCLOSE HEALTH INFORMATION FORM

Although Therapeutics Unlimited/TU Rehab LLC is not required by law to obtain a signed consent from you for treatment, payment, or healthcare operation purposes, we encourage you to sign this consent so that you aware of our concern and practices regarding protection of your personal health information.

Please refer to the Notice of Privacy Practices (the "Notice") for details if you wish prior to signing this consent. Please note that Therapeutics Unlimited/TU Rehab LLC reserves the right to change the privacy practices described in the Notice. By signing this consent, you agree that Therapeutics Unlimited/TU Rehab LLC may use or disclose your protected health information to carry out treatment, payment, or health care operations. You have the right to revoke this consent in writing, except to the extent that Therapeutics Unlimited/TU Rehab LLC has taken action in reliance on your consent.

ACKNOWLEDGEMENT AND AGREEMENT:

I consent to Therapeutics Unlimited/TU Rehab LLC sending protected health information to the insured in the event that I am receiving treatment but am not though insured under my insurance policy. Such information may include, but not be limited to, explanation of benefits ("EOB") or invoices regarding my treatment. I understand that if I do not want such protected information mailed to the insured, then I will notify Therapeutics Unlimited/TU Rehab LLC of my objection and will complete a Request for Restriction of Use and Disclosure form.

In addition, I understand and accept the risk of unintentional disclosure of my protected health information because the treatment area is an open area where I and other patients are treated simultaneously. I understand that some of my protected health may be inadvertently overheard by other patients and/or therapists. I also agree not to disclose any protected health information that I inadvertently overhear about other patients while I am receiving treatment in the open treatment area.

I have received a copy of Therapeutics Unlimited/TU Rehab LLC's Notice of Privacy Practices.

I hereby certify that I have read the provisions set forth in this consent. I understand and agree to the terms of this consent.

_____

Print Patient's Name

_____

Signature of Patient or Representative Date

_____

Name of Personal Representative (if applicable) Relationship to Patient

I consent to Therapeutics Unlimited/TU Rehab LLC releasing my protected health information to the following individuals:

_____ _____

Name Relationship to Patient

_____ _____

Name Relationship to Patient