THRIVE
WELLNESS & REHAB

Patient Demographics

Name: ____ Today's Date: ____________
Last First MI

Address: ________________________ City __________ State ________ Zip ____________

Home Phone: ________________ Work Phone: ________________ Cell: ________________
□ Male □ Female □ Married □ Child

SSN#: ________________ Date of Birth: ____________ Email: ______________________

Emergency Contact: ____
Name Relationship Phone Number

EMPLOYEE INFORMATION
Employer: ______________________ Occupation: ______________________
Employer Address: ________________ City: ____________ State: ________ Zip: ________
Employer Contact: ________________ Number: ______________________

Who recommended us to you?: ________________ May we thank them for this referral?: □ Y □ N
Referring Physician: ________________ Date of RX: ____/____/____ Frequency/Duration: ________
NEXT DR.'S APPOINTMENT: ____________ Prior Physical Therapy for this injury? □ Y □ N
Is injury related to: **WORK** **AUTO ACCIDENT** **FALL** **SPORTS** **N/A** If yes: Date: ____/____/____

Diagnosis/Chief Complaint: ____

Accident Details: ____

Insurance Information (Please fill out completely and provide insurance card)

Primary Ins.:	Phone #	Group #
ID #	Name of Insured:	Relationship to Patient:
Insured DOB:	Insured SSS#	Employer:
Secondary Ins.:	Phone #	Group #
ID #	Name of Insured:	Relationship to Patient:
Insured DOB:	Insured SSS#	Employer:

Worker's Comp Information/Personal Injury Protection

Employer:	Phone #
WC Insurance CO	
Adjustor:	Phone #:
Claim #	Fax #:

Medicare Patients Only
Are you currently receiving Home Health Care Services for any reason? □ Y □ N
If yes, provide the name of the agency: ______________________________
Start Date of Service: ________________ Discharge Date: ________________

TO THE BEST OF MY KNOWLEDGE THE INFORMATION PROVIDED HEREIN IS CORRECT.

Signature: ______________________________ Date: ________________

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Treatment Information

Name: ____ Today's Date: ____________

Referring Physician: ____ Phone #: ______________

Date of first doctor visit for this injury: __________________ DOI: __________________

Have you had surgery for this injury? □ Y □ N Date of Surgery: ________________

Current Medications: ____

____

How would you describe your present health? (CIRCLE ONE) EXCELLENT GOOD FAIR POOR

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL OR REHABILITATIVE SERVICES **FOR THIS INJURY?**					
	Chiropractor		MRI		Orthopedist
	CT Scan		Neurologist		Physical Therapy
	Emergency Room Care		Occupation Therapy		X-Ray

What specific goals would you like to accomplish with therapy: ___________________________

____

Patient Health Information

Medical History Questions:

Have you had any recent trauma? □ YES □ NO If yes, please explain:

____

Do you have any symptoms of numbness, tingling, burning, and weakness? □ YES □ NO If so, please explain where: ____

Have you had a recent illness, fever, chills or night sweats? □ YES □ NO If so, please explain where: _______

____

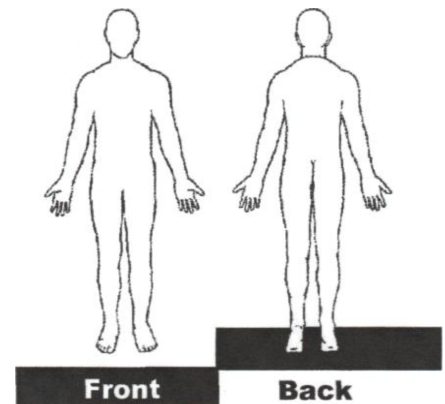
Have you ever had any of the following? Please check all that apply:

- □ Allergies
- □ Anemia
- □ Arthritis
- □ Asthma
- □ Bowel/Bladder Issues
- □ Blood Clot/Emboli
- □ Bronchitis
- □ Cancer
- □ Chemotherapy
- □ Diabetes
- □ Dizziness
- □ Emphysema
- □ Emotional Disorders
- □ Epilepsy
- □ Fainting
- □ Head Injuries
- □ Hearing Problems
- □ Heart Disease/Angina
- □ Hernia
- □ Heart Attack Surgery
- □ High Blood Pressure
- □ Infectious disease
- □ Mental Disorders
- □ Osteoporosis
- □ Pins/Metal Implants
- □ Severe Headaches
- □ Shortness of Breath/Chest Pain
- □ Sleeping Problems
- □ Stroke/TIA
- □ Swollen Joints
- □ Varicose Veins
- □ Vision Problems
- □ Weakness
- □ Weight/energy Loss

Height: ________________

Weight: ________________

Vitals: B/P______________



YES	NO	
□	□	Are you pregnant?
□	□	Do you smoke?
□	□	Do you have a pacemaker?

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Conditions of Treatment and/or Admission

CONSENT FOR TREATMENT/ADMISSION

I hereby authorize the Physical Therapist(s) in charge of the care of ______________________________ and Thrive Wellness Rehab to administer and perform such diagnostic studies and/or procedures that are considered medically necessary or deemed necessary for diagnosis and treatment.

PAYMENT GUARANTEE

I hereby guarantee payment of my insurance portion due to Thrive Wellness and Rehab at the time that services are rendered, unless other arrangements have been made in advance. *The patient's total account is due in full at discharge, with allowance made for insurance coverage approved, and assigned to Thrive Wellness and Rehab prior to dismissal. Patient co pays are due at the time of services rendered.*

MEDICAL RECORDS

If you need your medical records, please ask for our Medical Records Request Form, and understand we have a $25.00 Medical Records Fee. If a third party requires medical records from Thrive, we will need a fully signed Medical Release form from that agency faxed over to the Medical Records Department at 915.493.8264; a charge greater than $25.00 may occur for third party requests. Please note that Thrive has a 72 business hour policy to return the requested documents to the appropriate party.

Signature:______________________ Relationship:______________________ Date: ______________

HIPAA

Health Information Portability & Accountability Act

I am aware that a copy of the HIPAA (Health Information Portability & Accountability Act) is available for my review in the lobby of Thrive Wellness & Rehab; as pertains to my treatment.

1) I authorize my doctor and his clinic staff to release my private medical information to all medical sources involved in my care, including insurance health plans, physicians health plans, physicians, health care professionals, hospitals, clinics, laboratories, pharmacies, medical facilities, or other healthcare providers that have provided payment, treatment or services to me or on my behalf.

2) If we identify that you have missed an appointment time or you are not scheduled for future appointments per your treatment plan, we will call the phone number(s) you have provided. Please list any phone numbers YOU DO NOT WANT US TO LEAVE A MESSAGE ON.

   Phone number(s) to exclude: ______________________________

3) On occasion we have phone calls from patients' friends and family members regarding their appointment times. Please list the names of any people you **DO NOT WANT** our facility to give this information to.

NAME	RELATIONSHIP

I understand these authorizations and/or exclusions will remain in effect until such time I request in writing, that these be withdrawn. I further agree that a photocopy of this agreement shall be as valid as the original.

Signature:________________________________ Date: ________________________

Printed Name:____

Confirmation Number: ______________________________

Authorization Number (If Applicable):______________________

Insurance Verification

Full Name: ______________________ Member ID:___________________________ DOB: _____________

Date: ____________________ Group Number:__________________

Verification of coverage is not a guarantee of benefit. Actual plan coverage and benefit payments are determined when a claim is received by your insurance company. Therefore, the information below is an estimate of your coverage.

Verification/Authorization Given By: ____________________________

Billing Address: ____________________________________ Phone Number:________________

____

Effective Date: _____________ When does insurance calendar year begin/end: ______

Annual Deductible: $_________ How much of the deductible has been met: $_______________

OOP: $_____________ How much of the OOP has been met: $_____________

Ins./Pt. Portion: ______%__________% Co-Pay per visit $___________

Max/Cal Yr. $______________ # Visits/Cal Yr.: ____________

Is preauthorization required: Y N Is a PCP Referral Required Y N

If Yes, who is PCP?_________________________

Medicare Cap Met: _______________ Managed Care Replacement Plan: Y N

Medicare is: Primary Secondary Tertiary Home Health Episodes:______________

If authorization is required, fill out this section:

Auth Number: _____________________ # Visits: ____________Dates: _____________

Procedure Codes:

97001	PT Evaluation		97110	Therapeutic Exercise	
97014	E Stim Unattended		97113	Aquatic Therapy	
97035	Ultrasound		97140	Manual Therapy	

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _________________________ and assign directly Thrive Wellness and Rehab all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Thrive Wellness & Rehab to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

______________________________ ________________________ __________________

Responsible Party Signature Relationship Date

WORKER'S COMPENSATION ONLY:

I authorize Thrive Wellness and Rehab to contact my employer to obtain authorization that this is a worker's compensation claim. Should my employer not approve this as a worker's compensation benefit, I will supply my personal medical insurance information to Thrive and authorize Thrive to file my claims with my insurance company. I further understand if for some reason my insurance carrier does not pay for services rendered, I will be responsible for paying Thrive. In addition, I authorize and direct my insurance benefits to be paid directly to Thrive Wellness and Rehab.

Signature____________________________________ Date_____________________

Cancellation & No-Show Policy Agreement

Thrive Wellness & Rehab is here to serve and offer quality Physical Therapy not only to you, but the patients in the Texas/ New Mexico border. In order to continue to deliver quality service, we are enforcing an updated Cancellation/No-Show policy to all new patients as of March 01, 2015.

Appointments are not only important to us as a business, but primarily to you as a patient. The time set for you, is to help you reach your goals and regain full functionality. By missing your appointments, you hurt your long term recovery time and delay the advancement of your progress. If the need should arise and you **MUST** cancel your appointment, we are asking that you call the front office and give at least a 24 hour notice of your cancellations. That will give us the opportunity to give another patient your appointed time and a chance to reschedule you for later that same week.

If you cancel or miss your scheduled appointment and DO NOT give the front office a 24 hour notice, you will be charged the Cancellation Fee. Our fee schedule is set at: $15.00 for a regular Physical Therapy Appointment and $25.00 for an Aquatic Therapy Appointment.

We at Thrive understand that unforeseen emergencies happen and a cancelled appointment is inevitable sometimes. So we are offering a “One-Time Missed Appointment Waiver” and will not charge you for your first missed visit. Any missed appointment(s) after that, will result in us charging you, **NOT THE INSURANCE**, the correct Cancellation Fee amount.

ATTN MEDICAID PATIENTS: If you are fortunate enough to receive a state funded insurance (any Medicaid Plan: Texas or New Mexico) and miss a total of 3 appointments without rescheduling them during the same week or giving 24 hour notice, **you will not be charged the cancellation fee, but rather reported to your insurance plan for noncompliance.** Your referring physician will also be notified and a decision on your Plan of Care will then made. If you have any questions or need further explanation of this policy please do not hesitate to contact the front office.

Thank you for choosing Thrive Wellness & Rehab for your Physical, Aquatic and Sports Rehabilitation.

Acknowledgment: “I have read and understood the Cancellation/No Show policy. By signing below I am acknowledging that I have read and am in compliance with the Cancellation/No Show Policy. If I have any questions I will ask the front desk prior to signing the agreement. Also, I am aware that I will receive a copy of this policy and the original will be kept in my chart at Thrive Wellness & Rehab”.

Patient’s Name: ____
Please Print

Patient’s Signature: ____ **Date:**______________
Please Sign

Thrive Representative: ____ **Date:**______________
Please Sign