

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ Work Phone: \_\_\_\_\_

ST: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Whom may we contact in case an emergency? \_\_\_\_\_  
 Name Phone number

Date of Birth: \_\_\_\_\_ Sex: M / F Marital Status: \_\_\_\_\_ Social Security: \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Primary Physician: \_\_\_\_\_

Email address: \_\_\_\_\_

**INJURY/ACCIDENT INFORMATION**

Date of Onset of Injury/Problem: \_\_\_\_\_ Date of Surgery: \_\_\_\_\_

Have you ever had any previous physical therapy services this year? Y / N

Employment Related: Y / N  Initials Accident Related: Y / N Auto: Y / N Other: Y / N (Explain)

Attorney Name (If Applicable): \_\_\_\_\_ Telephone: \_\_\_\_\_

**PATIENT EMPLOYMENT/STUDENT INFORMATION**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Student: Y / N School: \_\_\_\_\_

**INSURANCE INFORMATION**

Employer of Insured: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Insured Name: \_\_\_\_\_

Group #: \_\_\_\_\_ ID#: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

**WORKER'S COMPENSATION INFORMATION**

Worker's Compensation Company (If applicable): \_\_\_\_\_

Supervisor/Case Worker: \_\_\_\_\_ Telephone: \_\_\_\_\_

Case Number: \_\_\_\_\_ Claim Number: \_\_\_\_\_

**PLEASE READ AND SIGN**

I authorize Rehabilitation Centers of Charleston to release to my insurance company any information necessary to file claims for service rendered. I also authorize payment of medical benefits to Rehabilitation Centers of Charleston. I further understand that I remain responsible to Rehabilitation Centers of Charleston for any and all charges not paid by my insurance company.

Signature of patient or parent/guardian if minor \_\_\_\_\_

Date \_\_\_\_\_

SS# of parent/guardian \_\_\_\_\_

# Patient Medical History

Your medical history is very important information for us to ensure your safety during your rehabilitation process. Please be as complete as possible with your answers, and feel free to discuss your history with your therapists

## Do you have a history of the following?

	Yes	No
Diabetes	_____	_____
Heart Disease	_____	_____
Cardiac Pacemaker	_____	_____
Cancer	_____	_____
Stroke	_____	_____
High Blood Pressure	_____	_____
Gastrointestinal problems	_____	_____
Lung Disease	_____	_____

## Please list any significant surgeries you have had in the past five years:

\_\_\_\_\_

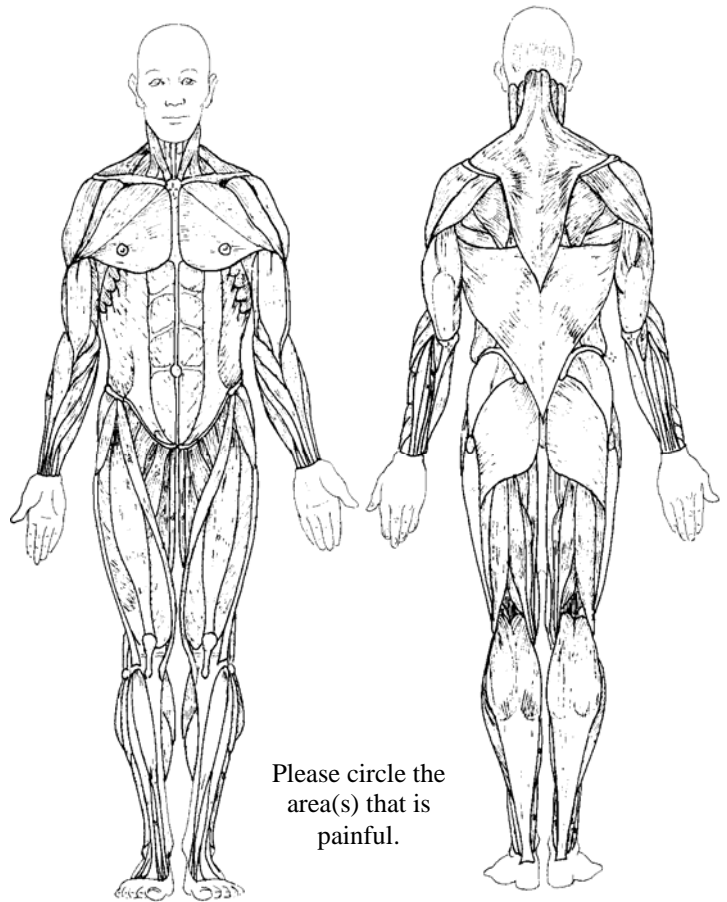
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Current Medication:** \_\_\_\_\_

\_\_\_\_\_



## What diagnostic test(s) have been performed for your current condition and where were they done?

X-ray    MRI    CT    EMG/NCV    Blood work   Other: \_\_\_\_\_

Have you received physical or hand therapy for your current condition?  Yes    No

If Yes, When and where, and how long?

\_\_\_\_\_

\_\_\_\_\_

## Have you experienced any of the following:

	Yes	No		Yes	No
Persistent pain at night	_____	_____	Frequent nausea or vomiting	_____	_____
Fever or night sweats	_____	_____	Recent unexplained weight loss	_____	_____
Are you pregnant	_____	_____	Frequent or severe abdominal pain	_____	_____
Loss of appetite	_____	_____	Unusual menstrual irregularities	_____	_____
Shortness of breath	_____	_____	Frequent heartburn or indigestion	_____	_____
Dizziness	_____	_____			

**Other medical history:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## ***Summary Notice of HIPAA Privacy Practices***

This summary notice of privacy practices serves to inform you how Rehabilitation Centers of Charleston may use and disclose your protected health information (PHI). Rehabilitation Centers of Charleston creates and maintains a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by law to protect the health information that identifies you and inform you of our legal duties and privacy practices.

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### **Uses and Disclosures of Protected Health Information (PHI) by Patient Consent**

- **Treatment:** We may use PHI to provide you with health care treatment or services. This includes but is not limited to discussions with referring physicians to plan care and treatment.
- **Payment:** We may use and disclose PHI to a third party or insurance company to obtain benefit information and prior approval for treatment or to justify medical care.
- **Health Care Operations:** We may use and disclose PHI to ensure that you are receiving the highest quality of care.

**Uses and Disclosures of Protected Health Information (PHI) as Required by Law** - We will disclose PHI about you when required to do so by federal, state or local law. Such examples are:

- To avert a serious threat to health or safety
- For military personnel or veterans, supply PHI to military command authorities or Dept of Veterans Affairs
- Supply information regarding Workers' Compensation claims to insurance companies, case managers or employers
- Public health risks
- In response to a subpoena, court order or other lawful request
- Supply information to a Health Oversight Agencies for activities authorized by law (audits, investigations, inspections, licenses)
- Law Enforcement requests
- Coroners, Health Examiners and Funeral Directors
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- Inmates

### **Your Rights as a Patient to your Protected Health Information (PHI)**

- You have the right to inspect and copy your medical records.
- You have the right to request an amendment to your medical records. RCC, however, is not required by law to change your records.
- You have the right to request an accounting of the disclosures RCC has made.
  
- You have the right to request restrictions or limitations on your PHI.
- You have the right to request confidential communications.
- You have the right to obtain a copy of this notice at any time

\*\* For all requests, please note that RCC has 30 days to respond to your request and has the right to charge you copying fees.

**Complaints** - If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary or the Department of Health and Human Services. To file a complaint with us, please contact the Privacy Officer at 843-884-7880. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

**Changes to this Notice** - RCC reserves the right to change this notice at any time. We reserve the right to make the revised notice effective for health information we already have about you as well as information we receive in the future.

**Consent to Use and Disclose Protected Health Information (PHI)** -By signing this document, I agree to truthfully, completely and correctly provide all requested information to Rehabilitation Centers of Charleston. Additionally, I am giving consent to Rehabilitation Centers of Charleston to use and disclose my protected health information for treatment, payment and health care operations.

Patient Name \_\_\_\_\_ Signature of Patient or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

**\*THIS WITNESS MAY ACCEPT CONSENT VERBALLY, BY TELEPHONE OR ELECTRONIC MEANS**



## Clinic and Financial Policies

### NEW PATIENT INFORMATION

Please read and initial the following statements:

\_\_\_\_\_ I have presented myself to this facility for physical therapy treatments and consent to diagnostic procedures and care provided by my attending clinician

\_\_\_\_\_ You have been sent to RCC by your physician to accelerate your recovery process. It is very important that you attend every scheduled session to obtain maximum benefit from your treatment. **A 24 hour advance notice by phone MUST be given for all cancellations.** If no notice is given there will be a \$15 charge.

\_\_\_\_\_ If you are 15 minutes or more late for your appointment without giving advance notice, we may reschedule that appointment for a later time or date.

\_\_\_\_\_ RCC is in network for most insurance companies, it is the patient responsibility to know their specific policy to know whether RCC is in network for your plan.

\_\_\_\_\_ The following steps are taken by our office with any missed appointment:

1. A record is kept in each patient’s file on attendance and reasons must be documented by our office as to why a session was missed.
2. If tardiness and/or missed appointments become excessive, they may lead to discharge from physical therapy and the following will be notified
  - a. The referring physician
  - b. The insurance company, Worker compensation case manager and/or attorney

\_\_\_\_\_ I authorize RCC to release and discuss any medical or general information necessary to process any claim for any treatment to my insurance company.

\_\_\_\_\_ All co-payments/co-insurance and deductibles are due at the time of treatment

\_\_\_\_\_ It is the patient’s responsibility to know the medical insurance coverage including; deductibles, co-payments, prescriptions, limit of visits allowed per your insurance, etc. Please verify with your insurance company.

\_\_\_\_\_ Pre-authorization may be required by many insurance companies. It is the patient’s responsibility to inform the office if pre-authorization is required by your insurance plan and secure all pertinent forms, if needed.

\_\_\_\_\_ Medicare will cover 80% of their approved fees for physical therapy. You are responsible for deductibles and co-pays. We will file any secondary insurance.

\_\_\_\_\_ Patients involved in auto accidents will be responsible for the balance on their account. Upon written request from the auto insurance, we will supply any needed information, however, the patient is responsible for filing those claims.

\_\_\_\_\_ As a courtesy, a billing representative will call your insurance company to inquire about your benefits for outpatient physical or occupational therapy. This is not a guarantee of payment. Non payment of premiums and other contractual limitation may result in denial of benefits or refunds.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_