InBalance
restore your body... back in balance

109 Cleveland Avenue
Cocoa Beach, FL 32931
Phone: (321) 799-0030

PATIENT INFORMATION

Name ______________________ Middle Initial ________
Street Address ______________________
City ______________________ State ________ ZIP ________
Home Phone ____________ Work Phone ____________ Email ____________
Date of Birth____________Age ________ Sex ________ Marital Status ________
SS#____________ Employer ____________ Phone____________
Employer's Address______________________ Years with Firm ________
Spouse's Name ____________ Date of Birth ________ Spouse's Employer ____________
Nearest Relative Not Living with You ____________ Phone ____________
Emergency Contact ______________________ Phone ____________
How did you hear about us? ____________ Family Doctor/Internist ____________
Driver's License # ____________ State Issued ____________

Insurance information must be filled out completely or a copy of card attached.

PRIMARY INSURANCE COMPANY	SECONDARY INSURANCE COMPANY
Name ____________	Name ____________
Address ____________	Address ____________
City & State ____________	City & State ____________
Policyholder ____________	Policyholder ____________
Group # ____________	Group # ____________
Policy # ____________	Policy # ____________
Verified by ____________	Verified by ____________

Injured on the Job? ________ Auto Injury? ________ Date of Injury ________
Claim Number ____________

Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operation of your practice.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use of disclosure that occurred prior to the date I revoke this consent is not affected.

I give permission to share appointment, billing or medical information with the person(s) named here:

____

Patient or Responsible Party Signature: ______________________ Date: ____________

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PATIENT MEDICAL HISTORY

Name (Printed): ____________________ Referring Physician: ____________________

Family Physician: ____________________

Date of Injury: ____________________ Date of first doctor visit for this injury: ____________________

Last date worked due to this injury: ____________ Date returned to work after this injury: ____________

Is an attorney involved in this case? YES NO

Have you had surgery for this injury? YES NO Number of surgeries: 1 2 3 4

Type of surgery: ____________________ Date: ____________

Please enter your: HEIGHT ________ WEIGHT ________ AGE ______

Are you currently taking any prescriptions or non-prescription medications? YES NO

	List Medications
[ ] Anti-inflammatories	____________________
[ ] Muscle Relaxes	____________________
[ ] Pain Medications	____________________

Have you had any of the following medical or rehabilitative services for this injury/episode?

	YES	NO		YES	NO
Chiropractor	___	___	EMG/NCV	___	___
Neurologist	___	___	Myelogram	___	___
Orthopedist	___	___	Emergency Room Care	___	___
General Practitioner	___	___	CT Scan	___	___
Occupational Therapy	___	___	MRI	___	___
Physical Therapy	___	___	X-Rays	___	___

OTHER: ____________________

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, bronchitis, or emphysema	___	___	Severe/frequent headaches	___	___
Shortness of breath/chest pain	___	___	Vision/hearing difficulties	___	___
Coronary heart disease or angina	___	___	Dizziness or Fainting	___	___
Heart attack or surgery	___	___	Weight loss/Energy Loss	___	___
Do you have a pacemaker?	___	___	Hernia	___	___
High blood pressure	___	___	Allergies	___	___
Stroke/ITA	___	___	Any joint/muscle pain	___	___
Blood clot/emboli	___	___	Joint Replacement	___	___
Epilepsy/seizures	___	___	Shoulder injury/surgery	___	___
Anemia	___	___	Elbow/hand injury/surgery	___	___
Infectious disease	___	___	Neck/back injury/surgery	___	___
Diabetes	___	___	Knee injury/surgery	___	___
Cancer or chemotherapy/radiation	___	___	Leg/ankle injury/surgery	___	___
Arthritis/swollen joints	___	___	Are you pregnant?	___	___
Osteoporosis	___	___	Do you smoke?	___	___
Sleeping problems/difficulties	___	___	Difficulty/Frequent urinating	___	___
Thyroid Condition	___	___	Night Pain	___	___

List any other information that would assist us in your care:

____

Are you aware of your diagnosis? ____________________ YES NO

Patient or Responsible Party Signature: ____________________ Date: ____________

I have reviewed this information with the patient.

THERAPIST (Printed) Kimberly A. Scales, PT THERAPIST (Signature) ____________________

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Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for In Balance Rehab to furnish the medical care and treatment considered necessary and proper in assessing or treating ___________________________'s physical and mental condition.

Patient/Guardian ____ Date: _______________

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitle, including that from Medicare, Medicaid, private insurance and third part payers to In Balance Rehab. A photocopy of this assignment is to be considered as valid as the original. I hereby authorized said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian ____ Date: _______________

Financial Policy Statement

In Balance Rehab will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If your insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit same to In Balance Rehab.

The above does not apply for those claims considered under Worker's Compensation. However, be advised that if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to In Balance Rehab, including court costs, collection agency fees and attorney fees.

Estimated Insurance Benefits: ____

Estimated Patient Payment: ____

Note: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____ ________________________
Patient/Guardian/Responsible Party signature Date

____ ________________________
In Balance Rehab Representative/Witness Date

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New Patient Orientation

1. Reserve your appointments well in advance to ensure availability.

2. Be on time for your appointment. If you are more than 15 minutes late from the scheduled time, you may be required to reschedule for another day.

3. Give us 24-hours notice when canceling your appointment. Since appointment slots fill up fast, we require a 24-hour notice when canceling your appointment. If you fail to show for your appointment without calling, you will personally be charged $25.00 a visit.

4. All insurance plans are different. We will call your insurance carrier to verify your benefits, but it is ultimately your responsibility to know your insurance plan benefits.

5. All co-pays, co-insurance and payments for our services will be billed to you and are due prior to continuing treatment. It is unlawful to routinely waive co-payments, deductibles, co-insurance or other patient responsibility payments.

6. Payment methods available for your convenience include: personal checks, credit cards or cash.

I have carefully read and fully understand the policies described above. I herby agree to follow these polices to the best of my ability.

New Patient Signature ____