Confidential Medical History/Evaluation

Name: (First, MI, Last)_____ ○ Mr ○ Mrs ○ Ms ○ Miss

Address: _____ City: _____ State: ____ Zip Code: _____

Email address: _____ Date of Birth: ___/___/___ SS#: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ Address: _____

Occupation: _____ Is this injury Work Related Auto Accident Other?

Insured's Name: _____ Insured's DOB: _____ Insured's SS# _____

Emergency Contact/Relationship: _____ Emergency Phone: _____

Referring MD: _____ Primary Care Physician: _____

Chief Complaint: _____ Injury or Onset Date: _____

List any/all medications you are currently taking: _____

List any surgeries: _____

Have you had any Diagnostic or Rehabilitative Services for this injury? MRI Xrays Other

Please describe:_____

Do you have any of the following:

Allergies	○ Yes ○ No	Dizzy Spells	○ Yes ○ No	MRSA	○ Yes ○ No
Anemia	○ Yes ○ No	Emphysema/Bronchitis	○ Yes ○ No	Multiple Sclerosis	○ Yes ○ No
Anxiety	○ Yes ○ No	Fibromyalgia	○ Yes ○ No	Muscular Disease	○ Yes ○ No
Arthritis	○ Yes ○ No	Fractures	○ Yes ○ No	Osteoporosis	○ Yes ○ No
Asthma	○ Yes ○ No	Gallbladder Problems	○ Yes ○ No	Parkinson's	○ Yes ○ No
Autoimmune Disorder	○ Yes ○ No	Headaches	○ Yes ○ No	Rheumatoid Arthritis	○ Yes ○ No
Cancer	○ Yes ○ No	Hearing Impairment	○ Yes ○ No	Seizures	○ Yes ○ No
Cardiac Conditions	○ Yes ○ No	Hepatitis	○ Yes ○ No	Smoking	○ Yes ○ No
Cardiac Pacemaker	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Speech Problems	○ Yes ○ No
Chemical Dependency	○ Yes ○ No	High/Low Blood Pressure	○ Yes ○ No	Strokes	○ Yes ○ No
Circulation Problems	○ Yes ○ No	HIV/AIDS	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Currently Pregnant	○ Yes ○ No	Incontinence	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Depression	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Vision Problems	○ Yes ○ No
Diabetes	○ Yes ○ No	Metal Implants	○ Yes ○ No	Other	○ Yes ○ No

I hereby agree and give my consent to medical treatment in treating my physical condition. I authorize release of any medical information needed to process my claim. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur. I authorize release of payment directly to Carolina Rehab, Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs that are incurred.
I acknowledge that I have seen the "Notice of Privacy Practices." I understand that I may ask questions about the "Notice of Privacy Practices" at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

Carolina REHAB

Physical Therapy ▪ Rehabilitation ▪ Wellness

Insurance Information:

Primary Insurance Name:

Primary Insurance Claims Address:

Primary Insurance phone number:

Insureds member id:

Insureds date of birth:

Insureds group number:

Assignment of Benefits

Date: _____

Patient: _____
Employer: _____
Claim Group: _____
SS# / ID#: _____

I hereby instruct and direct _____Insurance Company to pay by check made out and mailed to: Carolina Rehab, Inc.
889 Sherwood Lane
Statesville, NC 28677
Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:
Carolina Rehab, Inc.
889 Sherwood Lane
Statesville, NC 28677

For the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at _____this _____ day of _____, 20_____

_____ _____
Signature of Policy Holder Witness
or
Signature of Claimant, if other than Policyholder.

Please read and sign the attached acknowledgement

CAROLINA REHAB PHYSICAL THERAPY
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

CAROLINA REHAB PT's LEGAL DUTY

Carolina Rehab PT is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Carolina Rehab PT uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Carolina Rehab PT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Carolina Rehab PT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Carolina Rehab PT's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Carolina Rehab PT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Carolina Rehab PT will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Carolina Rehab PT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Carolina Rehab PT's health information practices or if you have a complaint, please contact the following person:

Jeffrey Faulk,President
Carolina Rehab PT
889 Sherwood Lane
Statesville, NC 28677
Telephone: 704-881-0088 ***Fax: 704-881-0087***