Unified Rehabilitation, PLLC

PATIENT INFORMATION

Patient's Name: _____ ____ _____ Date of Birth :_____/____/_____
First MI. Last

Address:_____ City:_____ State:_____ Zip code:_____

Birth Sex: ( ) Male ( ) Female Marital Status: ( ) Single ( ) Married ( ) Divorced ( ) Widowed

Cell Phone: (_____)_____ Email (please print):_____

How would you like to be contacted? ( ) Email ( ) Text message ( ) Voice Call

Referring Physician: _____ Phone: (_____)_____

Emergency Contact Name: _____ Phone: (_____)_____ Relationship:_____

HOME HEALTH INFORMATION

Have you received ANY Home Health Care during this calendar year? ___No ___Yes. If Yes, discharge date: _____

If yes, why were you were receiving Home Health Care? _____

What company provided your Home Health Care?_____

Home Health Care Agency phone: (_____)_____

Are you currently seeing a Nurse or any type of therapist in your Home? ____ No ____ Yes

PRIMARY INSURANCE INFORMATION

Primary Insurance Company: _____ Phone: (_____)_____

Subscribers Name: _____ Subscribers DOB___/____/_____ Relation: _____

ID#:_____ Group ID#_____ Employer/phone:_____

Insurance Address:_____

SECONDARY INSURANCE or SUPPLEMENTAL INSURANCE INFORMATION

Secondary Insurance Company: _____ Phone: (_____)_____

Subscribers Name: _____ Subscribers DOB____/____/_____ Relation: _____

ID#:_____ Group ID#_____ Employer/phone:_____

Insurance Address:_____

GUARANTOR INFORMATION

Guarantor Name:_____ Phone: (____)_____ DOB:_____

Address:_____ City:_____ State:_____ Zip code:_____

By my signature below, I acknowledge that all the information that I have supplied on these forms is true, accurate, current and complete.

_____ _____ _____
Signature Printed Name Date

Unified Rehabilitation, PLLC

Patient Medical History

Name: _____ **Date of Birth:**_____

Current work status: ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Disability ☐ Retired

Date Condition Began: ____/_____/_____ **Is your condition due to an on-the-job injury? Yes / No**

How would you rate your overall health? ☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Rate Your Pain (0 = No Pain, 10 = Worst Pain You Can Imagine)

Symptoms at Worst: _____ **Symptoms at Best:** _____ **Symptoms Today:** _____

How much does pain limit your activity? _____ **%**

Are you pregnant or is there a possibility you could be pregnant? ☐ Yes ☐ No

What tests have you had? ☐ X-Ray ☐ CT Scan ☐ MRI ☐ EMG ☐ PET Scan ☐ Ultrasound ☐ Venous Doppler

☐ Angiogram ☐ Urodynamics ☐ Cystoscopy ☐ Other_____

What surgeries have you had? _____ **List attached**

Type of Surgery: _____ Date: _____

Type of Surgery: _____ Date: _____

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

____ Chiropractor _____ Practitioner _____ Massage Therapy _____ Neurologist ____ Rheumatologist

____ Orthopedist ____ Podiatrist ____ Physical Therapy ____ Occupational Therapy ____ Speech Therapy

____ Oncologist

Past Medical History: Please check any condition you currently have OR have had in the past.

____ Asthma ____ Cancer (Please describe: _____) ____ Diabetes ____ Blood Clot/DVT

____ Anemia ____ Depression ____ Anxiety ____ Gout ____ Seizures ____ Stroke ____ Concussion

____ Hernia ____ Fibromyalgia ____ Pacemaker _____ Heart Problem (Please describe: _____)

____ Infectious Diseases ____ Sleep Problems ____ Varicose Veins ____ Osteoporosis ____ Osteoarthritis

____ Visual Dysfunction ____ Migraines/Headache ____ Pins or Metal Implants ____ Parkinson's Disease

____ Neurologic Disorder ____ Alzheimer's Disease ____ Dementia _____High Blood Pressure

____ Rheumatoid Arthritis ____ Thyroid Trouble/Goiter

____ Allergies. Please describe:_____

Unified Rehabilitation, PLLC

Patient Medical History – continued

Name: _____ Date of Birth:_____

Have you experienced any of these symptoms recently (please check all that apply):

___ Chest pain ___ Pain with Meals ____ Nausea/Vomiting ____ Dizziness ____ Changes in Vision

___ Memory Problems ____ Unusual Weakness ____ Poor Balance/Falls ____ Fever/Chills/Sweats

___ Difficulty Speaking ____ Numbness/Tingling ____ Change in Appetite ____ Difficulty Swallowing

___ Shortness of Breath ____ Confusion/Brain Fog ____ Unusual Pain w/Menstruation

___ Unexplained Weight Gain/Loss ___ Increased Pain at Night/Rest ___ Change in bowel Habits/Control

___ Change in Bladder Habits/Control ____ Other (Please describe:_____)

Current Medications, include ALL known prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements. ____ Check here if List Attached

Medication	Dose	Frequency	Method

____ Not currently taking any prescribed or over the counter medications, herbals or vitamin/mineral/dietary (nutritional) supplements.

<u>Additional Information</u>:

Do you smoke? (Please circle one) Yes No If Yes, how many packs per day?_____

Alcohol Use (Please circle one) Yes No If yes, frequency? ___Daily ___Weekly ____Occasionally

Recreational Drug Use (Please circle one) Yes No If yes, please describe: _____

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

_____	_____	_____
Signature	**Printed Name**	**Date**

Unified Rehabilitation, PLLC

Photograph, Video and Statement Copyright Release Form

I, _____ hereby grant and authorize **Unified Rehabilitation, PLLC**, it's successors and assigns, the right to take, edit, alter, copy, exhibit, publish, distribute and make use of any and all photographs and/or video taken of me as well as verbal statements and/or comments, to be used in and/or for any lawful promotional and/or educational materials including, but not limited to, newsletters, flyers, posters, brochures, advertisements, fundraising letters, annual reports, press kits and submissions to journalists, websites, social media networking sites and other print and digital communications, without payment or any other compensation. These photographic and/or video images listed below have been taken either by me _____ or a photographer on behalf of Unified Rehabilitation, PLLC. I do not grant permission to resale or use the photograph(s) and/or video or statements/comments in a manner that would exploit or cause malicious representation toward me.

- This authorization extends to all languages, media, formats and markets now known or later discovered.
- I understand that there shall be no payment for this release.
- I understand that no royalty, fee or other compensation shall become payable to me by reason of such use.
- I understand that with my authorization below for use of the photograph(s) and/or video, and statements/comments may never be revoked.
- I waive the right to inspect or approve any finished product in which my likeness appears, including written or electronic copy.
- I understand and agree that these materials shall become the property of Unified Rehabilitation, PLLC, it's successors and assigns, and will not be returned.

I hereby hold harmless and release Unified Rehabilitation, PLLC, it's successors and assigns, from all liability, petitions, and causes of action which I, my heirs, representative, executors, administrators, or any other persons may make while acting on my behalf or on behalf of my estate.

Printed Name: _____

Signature: _____

Date: _____

Unified Rehabilitation, PLLC

INFORMED CONSENT and WAIVER & RELEASE OF LIABILITY

Physical, Occupational and Speech Therapy

In agreeing to receive care provided by Unified Rehabilitation, PLLC, located at

14215 West Colonial Drive, Winter Garden, FL 34787, I agree as follows:

WAIVER & RELEASE OF LIABILITY: I fully understand and acknowledge that **(a)** the activities in which I will engage as part of the treatment provided by Unified Rehabilitation, PLLC and the equipment I may use as a part of that treatment have inherent risks, dangers, and hazards and such exists in my use of any equipment including the EVO Hydroworx Hydro-therapy tank, and my participation in these activities; **(b)** my participation in such activities and/or use of such equipment may result in injury or illness including, but not limited to, bodily injury, disease, soreness, strains, numbness, tingling, muscle tears, fractures, partial and/or total paralysis, death or other ailments that, could cause serious disability; **(c)** I hereby assume all risks and dangers and all responsibility for any losses and/or damages whether caused in whole or in part by the negligence or the conduct of the representatives or employees of Unified Rehabilitation, PLLC, or by any other person; **(d)** I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment; **(e)** I know that I have the right to choose what treatment I do or do not receive, in addition to withdrawing from treatment at any time; **(f)** I recognize that my participation in the activity covered hereby is conditioned upon my signing and returning this waiver and release. **Initial _____**

I, on behalf of myself, my personal representatives and my heirs, hereby voluntarily agree to release, waive, discharge, hold harmless, defend, and indemnify Unified Rehabilitation, PLLC and its representatives, employees, and assigns from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of services or otherwise which may arise out of my use of any equipment or participation in these activities. I specifically understand that I am releasing, discharging, and waiving any claims that I may have presently or in the future for the negligent acts or other conduct by the representatives or employees of Unified Rehabilitation, PLLC. **Initial _____**

INFORMED CONSENT: I consent to and authorize Unified Rehabilitation, PLLC (including Physical Therapists, Physical Therapy Assistants, Occupational Therapists, Occupational Therapy Assistants, Speech Therapists and students in training) to administer physical, occupational and/or speech therapy treatment under the direction and supervision of the Physical Therapist, Occupational Therapist or Speech Therapist. I understand, acknowledge and affirm that such services may involve bodily contact, touching, and/or direct contact of a sensitive nature. I know it is up to me to inform the physical therapist/staff about any health problems or allergies I have, as well as medications I am taking. **Initial _____**

I understand that I may show this **INFORMED CONSENT** and **WAIVER & RELEASE OF LIABILITY** to, and consult with, my own independent legal counsel before signing. **Initial _____**

I HAVE READ THE ABOVE WAIVER AND RELEASE AND BY SIGNING IT I AGREE IT IS MY INTENTION TO EXEMPT UNIFIED REHABILITATION, PLLC FROM LIABILITY FOR PERSONAL INJURY, PROPERTY DAMAGE OR WRONGFUL DEATH BY ANY CAUSE.

_____	_____	_____
Patient/Guardian Signature	**Printed Name**	**Date**

Unified Rehabilitation, PLLC

DISCLOSURE OF HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

Notice of Privacy Practices: I acknowledge that I have been made aware of the Unified Rehabilitation, PLLC notice of privacy practices and agree to their use and disclosure of my protected health information for treatment, payment and healthcare operations. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time. **Initial _____**

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree Unified Rehabilitation, PLLC and its duly authorized employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to any other individuals that I may indicate below who may contact ***Unified Rehabilitation, PLLC*** on my behalf.

List the name of individual(s), relationship and identify the type of information to be disclosed PLEASE PRINT

_____	_____	_____
Name	**Relation**	**Type of information**

I understand:

- At any time, I may add or remove individuals from this list by notifying Unified Rehabilitation, PLLC my desire to do so. I understand that until I notify Unified Rehabilitation, PLLC of requested changes to this list, Unified Rehabilitation, PLLC may rely on this list and disclose information to the individuals listed above.
- Information disclosed to the individuals identified above may be subject to disclosure by the recipient and is no longer protected by federal law.

* I understand that my medical information may indicate that I have a communicable or venereal disease which may include, but not limited to, diseases such as, hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses (AIDS). My medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____	_____	_____
Patient/Guardian Signature	**Printed Name**	**Date**

Unified Rehabilitation, PLLC

PATIENT AUTHORIZATION FOR PAYMENT AND FINANCIAL STATEMENT

Authorization for Payment: I hereby authorize Unified Rehabilitation, PLLC to file and appeal any insurance claim on my behalf with my signature on file. I hereby request that my insurance carrier make payment directly to Unified Rehabilitation, PLLC for all services rendered. If my insurance carrier makes payments to me, I agree to immediately pay these funds directly to Unified Rehabilitation, PLLC. I also authorize Unified Rehabilitation, PLLC to deposit any checks received on my account when made out to me. **Initial _____**

I authorize Unified Rehabilitation, PLLC to release any information including medical information that may be necessary to process medical claims on my behalf to related physicians, insurance carriers or attorneys. I understand that Unified Rehabilitation, PLLC will bill my insurance carrier for the services rendered based on coverage verified by my insurance carrier. I understand that verification of benefits is not a guarantee of payment, and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for the services rendered. **Initial _____**

I understand that payment is due immediately upon the provision of services unless a previous arrangement has been made. All patients are required to pay total charges at the time of service including self-pay, co-payments, co-insurance and deductibles. I also understand that I am responsible for the remaining balance due after my insurance company makes payment**. Initial _____**

I understand if my insurance company does not make payments on my account within 60 days, I agree to take an active role in petitioning my insurance carrier to make appropriate payments on my behalf for the services rendered. If my insurance company does not make payments on my account within 75 days, I understand that I will be responsible for the balance due in full. **Initial _____**

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, including court costs, collection agency fees, attorney fees and interest from the date of service in the amount of 18% per annum. **Initial _____**

Signature: By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, I agree to be bound by all of Unified Rehabilitation, PLLC payment policies and that I have been given adequate opportunity to ask questions about the same.

_____	_____	_____
Patient/Guardian Signature	**Printed Name**	**Date**

Unified Rehabilitation, PLLC

PATIENT CANCELLATION AND NO-SHOW POLICY

In order to provide you with the best care possible we ask that you agree to this policy and make every effort to keep your scheduled appointments and arrive in a timely manner.

We require **24-hour notice** for cancellations. Appointments that are cancelled with less than 24-hours' notice, or no-show/missed appointments, are subject to a charge of **$50.00** for an appointment fee. This fee is billed directly to the patient, is not reimbursable by insurance companies and must be made before or at the time of your next appointment before treatment can continue. After 2 no-show or cancellation appointments without a 24-hour notice, we reserve the right to discharge you from therapy. **Initial _____**

This policy has been established in order to provide the highest level of Therapy Services to all of our patients. It has been proven that consistent attendance provides the greatest opportunity for success. By providing us with notice of a cancellation, we may be able to accommodate other patients with your appointment slot. We understand that emergencies arise and that it may not be possible to give such a notice. Exceptions to the No-Show/Late Cancellation Policy will be determined by the Director of Rehabilitation.

If you need to reschedule or cancel an appointment, please call us as soon as you know you cannot make your scheduled appointment. We can be reached by phone at **407-614-8002**.

By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, I agree to be bound by all of Unified Rehabilitation, PLLC Patient Cancellation and No-Show policies.

_____ _____ _____

Patient/Guardian Signature **Printed Name** **Date**

At Unified Rehabilitation, PLLC we require keeping your credit or debit card on file, **OR** a $50.00 deposit that is refunded after the plan of care is complete, as a convenient method of payment for services rendered. Your account information is kept confidential and secure. I acknowledge that my card will be processed at the time of check-in or under circumstances that I have been notified (i.e. No Call/No show appointments). For such circumstances as a no-show appointment, I will be notified by a representative at Unified Rehabilitation, PLLC of the time and amount for which I am responsible.

I authorize Unified Rehabilitation, PLLC to charge the following credit or debit card for charges I am responsible for and have agreed to pay.

□ Amex □Visa □Mastercard □Discover

Credit Card Number _____ Expiration Date _____ CVV_____

Billing Address _____ City_____ State_____ Zip_____

Cardholder Name printed as it appears on card _____

Signature of card holder_____

I, the undersigned, authorize and request Unified Rehabilitation, PLLC to charge my card as indicated above for services from Unified Rehabilitation, PLLC. This authorization relates to all payments and charges I have been made aware of for services to be received at Unified Rehabilitation, PLLC. This authorization will remain in effect until I cancel this authorization. To cancel, I understand I must provide a written request to Unified Rehabilitation, PLLC and my account must be in good standing.

_____ _____ _____

Patient/Guardian Signature **Printed Name** **Date**