balance
REHABILITATION AND
HEALTH SCIENCE, LLC

Patient Information Record

Extremity

Name: _____

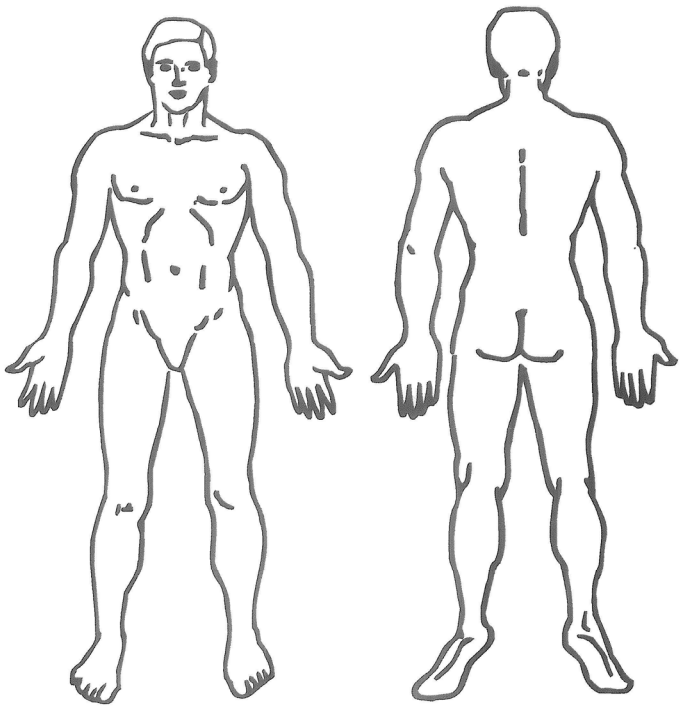
MD:_____

Date: _____

Age: _____Height:_____Weight:_____

HISTORY OF INJURY:

1. What is your primary complaint?_____Left or Right?_____
2. How and when (date) did the present symptom(s) occur?_____
3. A. Precisely where did the pain start? (please indicate on diagram) **X = numbness** **P = where pain started**
   B. Where did the pain spread? (please indicate on diagram) **T = tingling** **R = where pain spread**
4. On a scale of 0-10 (10 being excruciating) how painful was it:
   A. When it started? (please circle) 0 1 2 3 4 5 6 7 8 9 10
   B. At it's best? (please circle) 0 1 2 3 4 5 6 7 8 9 10
   C. At it's worst? (please circle) 0 1 2 3 4 5 6 7 8 9 10
   D. How is it today? (please circle) 0 1 2 3 4 5 6 7 8 9 10
5. Did you undergo surgery? Yes___ No___ If yes, what was the date of surgery? ___/___/_____
6. How long were you hospitalized?_____
7. Describe your symptoms, does it throb, _____twinge, _____burn, _____give you numbness/tingling _____?
8. What activities make your pain worse? _____
9. Can you get comfortable at night? Yes No
10. Do you have any back pain now or any history of back pain? _____
11. Do you have any problems with your bowels or bladder? _____
12. What is the effect of coughing? Worse,___ Better,_____ Same,_____
13. How does your problem feel on rising in the morning?
    Stiff _____ Sore_____ Fine _____
14. Once you start moving about, does it: Worsen ___ Ease ___ Same ___
15. What is it like at the end of the day compared to the beginning?
    Worse _____ Better _____ Same _____
16. Have you ever had this problem before?
    A. Is it increasing frequency? _____
    B. Increasing severity? _____
    C. Are your symptoms changing in character? _____
    D. If yes, please describe_____
    E. Can you identify what causes it? If so what? _____
    _____
    F. What did you do to resolve it?_____
17. Have you undergone a diagnostic medical test for this? _____
    If so where?_____



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1. MEDICAL HISTORY (circle one) DO YOU HAVE OR HAVE HAD:

Yes	No	High blood pressure?	Yes	No	Impaired vision?
Yes	No	Heart disease or other cardiac condition?	Yes	No	impaired hearing?
Yes	No	Angina (chest pain)?	Yes	No	Hepatitis?
Yes	No	Shortness of breath?	Yes	No	Asthma / or Allergies?
Yes	No	Lung disease?	Yes	No	Osteoporosis?
Yes	No	Stroke?	Yes	No	Bleeding Disorders?
Yes	No	Recent weight loss/gain?	Yes	No	Sleep Disturbances?
Yes	No	Unusual joint pain and/or swelling?	Yes	No	Diabetes?
Yes	No	Dizziness and/or a History of falls?	Yes	No	Depression?
Yes	No	A history of fractures?	Yes	No	HIV/AIDS?
Yes	No	A history of cancer?	Yes	No	Arthritis?
Yes	No	Increase in frequency or intensity of headaches?	Yes	No	Seizures?
Yes	No	Are you now, or do you have any reason to believe you may be pregnant?			

2. Please rate on a scale of 0-10 how painful the following activities are; use space provided for additional comments.

Rolling over in bed _____ Ascending/descending stairs _____

Transfer to/from bed _____ Transfer to/from car _____

Bathing _____ Driving _____

Dressing _____ Walking _____

Grooming _____ Sitting _____

Carrying _____ Standing _____

Household Cleaning _____ Bending _____

Reaching level/overhead _____ Lifting _____

Meal preparation _____ Child Care _____

Using the phone _____ Other _____

3. Please list ALL medications, dosage and purpose.

_____

_____

4. Please list all surgeries and approximate dates. _____

_____

5. Please indicate diagnostic tests for this problem. _____

_____

6. Have you seen anyone else for your current problems? If so, please list. _____

_____

Consent to Medical Treatment

I, _____, voluntarily consent to diagnostic procedures and related medical treatment as recommended by my physical therapist and their designees, and acknowledge that no guarantees have been or can be made as to the result of such treatments. This questionnaire is considered a part of your confidential medical record.

Signature_____ Date_____

Email_____

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The Missed Visit Policy

At Balance Rehab, our goal is to help all patients fully recover from injury and illness. At the end of your initial appointment, your physical therapist will provide you with a plan for your care based on their expertise and your goals.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To make sure you have the best chance at recovery, you'll need to schedule and arrive for your prescribed visits.
2. **We will begin your treatment sessions on time**, so we need you to arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at your scheduled appointment time.
3. **If you're running late**, we need you to call as soon as you know you're running late. We will check with your provider to make sure there's enough time to provide the care you need and deserve.
    - If you are more than 15 minutes late, your session may need to be rescheduled and our missed visit policy will apply at that time. Chronically late patients will be asked to change their appointment times.
4. **If you are sick at any time during care, we need you to call us as soon as you have symptoms**. Please don't wait for the day of your appointment. We need a 4 hour notice due to illness or the $50 missed visit fee will apply and your card on file will be charged that day.
    - Example: If you're sick on Monday but your appt is Wednesday, let us know Monday.
    - If you wake up sick the day of, we need a 4 hour notice so if your appointment is at 1:00 pm, call to let us know by 9:00 am or sooner if possible.
    - If you cancel your appointment due to illness the first time with a 4 hour or greater notice you need to give us 24 hours notice if you are still not well at your next scheduled appointment or your card on file will be charged $50.
5. **If you need to cancel or change a scheduled appointment, for any reason, we need 24 hour notice.**
    - This allows enough time to get you rescheduled AND help another patient get in for the care they need and deserve.
    - When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
6. **If you don't provide 24 hours notice for an appt change or cancellation, you will automatically be charged a $50 missed visit fee with your card on file.**
7. Patients who have multiple same-day cancellations or no-shows, will be removed from the active schedule, and placed on our day-to-day list to avoid future last-minute cancellations that keep other patients from care.

As I'm sure you understand, one patient's late (or lack of) notice for appointment changes or cancellations, keeps other patients from getting the care they need and deserve. You can avoid any problems with this policy by calling our office during business hours - at least 1 day in advance for any illness, appointment changes or cancellations.

This policy has been verbally reviewed with me and by signing below I am indicating that I understand this policy.

Patient Signature	Patient Name	Date

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REHABILITATION AND
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FINANCIAL POLICY

Medical Insurances:
We participate with and bill the following insurances, most plans: Aetna, Anthem, Cigna, Harvard Pilgrim, HealthPlans Inc, Humana, Medicare, NH Medicaid, Martin's Point, Private HealthCare System, Tricare, Tufts, Choice Care Network and United HealthCare . Please check with your insurance to make sure we are an In Network provider with your specific policy.

Please provide us with ALL of your information if you have multiple policies. (E.g. Medicare and Medigap) We will file supplemental or secondary insurances when appropriate.
We will make a reasonable effort to bill other insurance companies; however, there may not be any benefits or limited benefits for services provided by our therapists. You must obtain all necessary referrals and/or prescriptions before beginning Physical Therapy. ***Please be advised that it is your responsibility to contact your insurance company to determine your coverage prior to treatment.***

Managed Care Insurances & Referrals
Our therapists may not be authorized to provide service for patients with managed care insurance without a referral from a primary care physician. Please contact your primary care physician for a referral authorization. If you do not have an authorization prior to your appointment, you will be asked to sign a waiver accepting responsibility for payment should authorization be denied.

Understanding your insurance coverage:
We will do our best to help you understand your benefits. If you have any questions about your health insurance in regards to coverage for physical therapy services, please call us at (603) 890-8844.

Card on file:
In order to book an appointment with us we require to have a card on file at the time of booking. This card will be utilized to pay for a missed appointment fee of $50 if you do not show up or you cancel without giving us notice as outlined in our cancellation policy. (credit card surcharge of 2.5% applies when applicable).

Payment at Time of Service:
If you have no medical insurance, payment in full is expected at the time of service. **Co-payments co-insurances and deductible amounts are due at the time of service.** Patients with previous uncollectible balances are expected to pay before the provision of services. **We accept cash, checks, debit cards, and most credit cards.**

Minors:
It is our policy that the individual who brings a child/minor into our offices and consents to treatment for services is accepting full responsibility for any balance due for services rendered.

I authorize assignment of insurance benefits to Balance Physical Therapy, LLC for the purpose of payment towards services rendered by Balance Physical Therapy, LLC.

I understand and agree that regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered by Balance Physical Therapy, LLC.

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

We are required by law to:

- Ensure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you;
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU.

The following describes different ways that we are permitted to use and disclose medical information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment. We may use and disclose your medical information to make a decision about and plan for your care and treatment. This may include consulting with other health care providers during the course of your treatment.

For Payment. We may use and disclose your medical information so that the treatment and services you receive at the clinic may be billed and payment may be collected from you, an insurance company, or a third party.

Determine Eligibility for Insurance Coverage: We may tell your health plan about a treatment you are going to receive in order to obtain prior approval or to determine whether your plan will cover the treatment.

Other Purposes: We may use and disclose your medical information to perform various office, administrative and business functions that support the clinic's ability to provide you with appropriate care.

As Required By Law. We will disclose your medical information when required to do so by federal, state or local law.

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Workers' Compensation. We may release your medical information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU.

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Obtain a Copy. You have the right to inspect and obtain a copy of your medical information that may be used to make decisions about your care.

Right to Amend. If you think that the medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by or for the clinic. Please note that no part of the original documentation in the medical record can be destroyed.

Right to Request an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of your medical information for which an authorization was not obtained, or which were not made for purposes of treatment, payment, or healthcare operations.

Right to Request Restrictions. You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

We are not required to agree to your request for restrictions. If we do agree, we will comply with your request unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we contact you only at work or by mail.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us at any time to give you a copy of this notice.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with the Clinic or with the Secretary of the Department of Health and Human Services. You may file a complaint with the Clinic by speaking with any of the Staff and requesting a HIPAA complaint form.

You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Changes to this Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in the clinic. The notice will contain the effective date on the first page, in the top right-hand corner.

I have read and agree to the information given to me above.

Signed:_____ Date:_____

Parent/Guardian:_____ Date:_____

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