

EVAL DATE:

**PATIENT INFORMATION**

LAST NAME		FIRST	MI
ADDRESS (STREET, CITY, STATE ZIP)			
ADDRESS CON'T		SSN	DOB
HOME PHONE	WORK PHONE	CELL PHONE	
EXT.			
IS INJURY RELATED TO: <input type="checkbox"/> WORK <input type="checkbox"/> AUTO <input type="checkbox"/> OTHER IF WORK, COMPLETE WORK RELATED INJURY INFORMATION BELOW.			
IS A HOME HEALTH AGENCY CURRENTLY PROVIDING NURSING SERVICES IN YOUR HOME? <input type="checkbox"/> YES <input type="checkbox"/> NO			
HAVE YOU HAD ANY THERAPY SERVICES IN THE LAST 12 MONTHS? <input type="checkbox"/> YES <input type="checkbox"/> NO			

<b>EMERGENCY CONTACT NAME</b>	<b>RELATIONSHIP</b>	<b>PHONE NUMBER</b>
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**RESPONSIBLE PARTY (IF OTHER THAN PATIENT)**

NAME (PARENT/GUARDIAN/OTHER, WHO BROUGHT MINOR FOR THERAPY)		
RELATIONSHIP TO PATIENT	DATE OF BIRTH	SSN
ADDRESS (STREET, CITY, STATE ZIP)		
HOME PHONE	WORK PHONE	CELL PHONE
EXT.		

**WORK RELATED INJURY**

EMPLOYER NAME:	CASE MANAGER NAME:	CASE MANAGER PHONE:
EMPLOYER ADDRESS (STREET, CITY, STATE ZIP)		CASE MANAGER FAX:
EMPLOYER LIABILITY CARRIER	LIABILITY CARRIER ADDRESS	
DATE OF INJURY	CLAIM #:	NUMBER OF VISITS APPROVED:

**TO BE COMPLETED BY OFFICE**

IS THE PATIENT THE SUBSCRIBER? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF NO, THEN: SUBSCRIBER/ POLICYHOLDER NAME:	DOB
SUBSCRIBER/POLICYHOLDER ADDRESS (IF OTHER THAN PATIENT):		
<b>PRIMARY INSURANCE</b>	<b>ID #</b>	<b>GROUP #</b>
INSURANCE EFFECTIVE DATE:	PRE-CERT REQUIRED: <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON QUOTING BENEFITS:	PRE-CERT CONTACT:	
DEDUCTIBLE AMOUNT:	DEDUCTIBLE AMOUNT MET:	PRE-CERT INFORMATION:
COPAY \$:	COINSURANCE %:	
OUT OF POCKET AMOUNT:	OUT OF POCKET AMOUNT MET:	DOES PRE-EXISTING APPLY? <input type="checkbox"/> YES <input type="checkbox"/> NO
LIMITATIONS/EXCLUSIONS:		
CLAIMS MAILING ADDRESS:		
		PHONE:

INITIALS	I confirm that my quote of benefits has been provided to me and I have been given the opportunity to address any questions with the front office staff regarding this quote.
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MEDICAL HISTORY QUESTIONNAIRE (PLEASE PRINT)		
PATIENT LAST NAME	FIRST	MI
DATE OF ONSET OF INJURY/CONDITION:	FAMILY PHYSICIAN	REFERRING PHYSICIAN
HAVE YOU EVER HAD SURGERY FOR THIS INJURY? <input type="checkbox"/> YES <input type="checkbox"/> NO	IF YES, TYPE OF SURGERY:	DATE OF SURGERY:
HAVE YOU HAD PREVIOUS PHYSICAL THERAPY FOR THIS CONDITION? <input type="checkbox"/> YES <input type="checkbox"/> NO	HAVE YOU BEEN ADMITTED OR DISCHARGED FROM A PART A STAY AT ST. CATHERINE'S REGIONAL HOSPITAL WITHIN THE PAST 72 HOURS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DO YOU SMOKE? <input type="checkbox"/> YES <input type="checkbox"/> NO	ARE YOU PREGNANT OR THINK YOU MIGHT BE PREGNANT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
HOW HAS YOUR INJURY AFFECTED YOU EMOTIONALLY? <input type="checkbox"/> DEPRESSION <input type="checkbox"/> WITHDRAWAL <input type="checkbox"/> ANGER <input type="checkbox"/> ANXIETY <input type="checkbox"/> NONE <input type="checkbox"/> OTHER, PLEASE LIST:		
WHAT IS THE SEVERITY OF YOUR EMOTIONAL REACTION? SCALE OF 1(LOW) - 10(HIGH)	WHO IS YOUR FAMILY/COMMUNITY SUPPORT?	
LIST ALL MEDICATION (S) YOU ARE ALLERGIC TO:		
DO YOU HAVE ANY SENSITIVITY TO LATEX THAT YOU ARE AWARE OF? <input type="checkbox"/> YES <input type="checkbox"/> NO		
LIST MEDICATIONS THAT YOU ARE CURRENTLY TAKING, EITHER PRESCRIPTION OR NON-PRESCRIPTION:		
PLEASE LIST ANY OTHER HEALTH CARE PROFESSIONALS WHOSE CARE YOU ARE CURRENTLY UNDER FOR THIS CONDITION:		
IS THERE ANY OTHER INFORMATION THAT WOULD ASSIST US WITH YOUR CARE?		

<b>HAVE YOU EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS?</b>	
<p><b>YES NO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Chest Pain or Shortness of Breath</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> <input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> <input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> <input type="checkbox"/> Stroke or TIA</p> <p><input type="checkbox"/> <input type="checkbox"/> Congestive Heart Disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Blood Clots</p> <p><input type="checkbox"/> <input type="checkbox"/> Circulation Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Seizure Disorder or Epilepsy</p> <p><input type="checkbox"/> <input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> <input type="checkbox"/> Asthma, Emphysema or Bronchitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> <input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> <input type="checkbox"/> Rheumatoid Arthritis</p> <p><input type="checkbox"/> <input type="checkbox"/> Other Arthritis Conditions</p> <p><input type="checkbox"/> <input type="checkbox"/> Fibromyalgia</p>	<p><b>YES NO</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Infectious Diseases</p> <p><input type="checkbox"/> <input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> <input type="checkbox"/> Headaches Frequent/Severe</p> <p><input type="checkbox"/> <input type="checkbox"/> Hearing/Vision Difficulties</p> <p><input type="checkbox"/> <input type="checkbox"/> Numbness or Tingling</p> <p><input type="checkbox"/> <input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> <input type="checkbox"/> Weakness</p> <p><b>Surgery or Injury of any of the following:</b></p> <p><input type="checkbox"/> <input type="checkbox"/> Neck-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Back-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Shoulder-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Elbow-type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Hand-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Hip-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Knee-Type: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Ankle or Foot-Type: _____</p>

\_\_\_\_\_  
**THERAPIST SIGNATURE**

\_\_\_\_\_  
**DATE**

**ProgressiveHealth Rehabilitation, LLC  
Medicare Secondary Payer Questionnaire**

PATIENT NAME	MEDICARE NO:
ONSET DATE:	DATE OF SERVICE:
INFORMATION SUPPLIED BY:	RELATIONSHIP:
<b>1. Is this illness/injury covered under the Federal Black Lung Program?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, Federal BL Program is primary for claims related to BL)</i> <span style="float: right;">Date benefits began: _____</span>	
<b>2. Is treatment for this illness/injury authorized by the Veteran's Administration?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, DVA is primary)</i>	
<b>3. Is this illness or injury due to a work-related accident/condition?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Employer Name & Address: _____  <i>(If yes, worker's compensation insurer is primary. Collect appropriate insurance information)</i>	
<b>4. Is this illness/injury covered under no-fault or automobile insurance?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, no-fault/auto ins is primary. Collect appropriate insurance information)</i>	
<b>5. Is this an illness or injury for which another party could be held liable?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes, liability ins is primary. Collect appropriate insurance information)</i>	
<b>6. Is patient insured by an employer group health plan due to current employment of self?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Date coverage began: _____ If yes, how many employees work for the sponsoring employer? <input type="checkbox"/> Don't know <input type="checkbox"/> 1-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100 or more <i>(If yes, EGHP is primary. Collect appropriate insurance information)</i>	
<b>7. Is patient insured by an employer group health plan due to current employment of spouse or other family member?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> Date coverage began: _____ If yes, how many employees work for the sponsoring employer? <input type="checkbox"/> Don't know <input type="checkbox"/> 1-19 <input type="checkbox"/> 20-99 <input type="checkbox"/> 100 or more <i>(If yes, EGHP is primary. Collect appropriate insurance information)</i>	
<b>8. Is patient under 65 and entitled to Medicare due to disability?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>Is patient insured by an employer group health plan?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes to both questions, EGHP is primary. Collect appropriate insurance information)</i>	
<b>9. Is patient entitled to Medicare due to End Stage Renal Disease (ESRD)?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>Is patient insured by an employer group health plan?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <b>Is patient within the 30-month coordination period?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> <i>(If yes to all question, EGHP is primary. Collect appropriate insurance information)</i>	
<b>10. If applicable, attorney's name and address:</b>   <p style="text-align: center;">If all questions are answered <b>NO</b>, Medicare is the primary payer</p>	
<b>11. Are you a member of a Medicare health maintenance organization (HMO) program?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>	
<b>12. Have you been hospitalized in the past 60 days?</b> <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span> If yes, when and where? _____	

## ProHealth a SCRH Physical Therapy Facility

### Cancellation / No-show Policy

We strive to provide not simply good, but absolutely the best care to our clients. We schedule our clients according to care plans that optimize their wellness outcomes. Making your appointment as scheduled is very important, not just for us, but for you. We are convinced that if you make your wellness a life priority, you will achieve not only a higher level of function, but a greater degree of happiness.

We have the most highly trained and experienced clinicians in the region. You are working with the best. Their services and time are in high demand, with waiting lists for many of their services. As you know, we attempt to schedule all new clients within 24-48 hours of their initial request for service. Thus, appointment time is a valuable commodity for both you and us.

*If negative circumstances require you to cancel a scheduled appointment, we request that you do so at least 48 hours in advance. **If you must cancel within 24 hours of your appointment or fail to show up for your appointment, a \$20 fee will be applied to your account, which will be patient responsibility and is not billable to insurance. This facility also reserves the right to cease rescheduling new appointments due to habitual no shows or cancellations and reserves the right to discharge any patient who fails to give proper notice three consecutive times.***

While we are not fond of the negative connotation of any cancellation policy, we believe such a policy is in the best interest of accommodating all of our clients who are dedicated to improving their wellbeing. Thank you for your consideration.

By signing below, I understand and accept the above cancellation / no-show policy.

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NAME

DATE

# NOTICE OF PRIVACY PRACTICES

Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)



**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.**

On the last page of this document is the name and phone number of the Facility Privacy Officer should you have questions about your privacy rights. You will also find the effective date of this document.

**WHO WILL FOLLOW THIS NOTICE** – This notice describes our hospital’s practices and the physicians who provide services to patients at this hospital. It will also apply to any healthcare professional authorized to provide you with treatment and/or authorized to enter information into your hospital chart.

**MEDICAL INFORMATION** – Each time you visit a hospital, physician, or other provider of health care, a record is made of your visit. We need this information to provide you with quality care and to comply with the law. Your health record is the physical property of the healthcare provider that compiles it; however, the information belongs to you. We are required by law to maintain the privacy of your health information and we are committed to doing so. We will abide by the terms of this notice as required by federal law.

**HOW WE USE AND DISCLOSE MEDICAL INFORMATION –**

**Treatment** – Medical information is used to provide you with medical treatment. This information may be disclosed to physicians, nurses, technicians and other individuals who are involved in your care. Departments of the hospital may share information about you in order to coordinate the things you need, such as prescription drugs, lab tests and X-rays. For example, a physician treating you for a broken bone will need to know if you are diabetic as this may slow the healing process. The physician may need to tell the dietitian about the diabetes so appropriate meals can be provided for you.

**Payment** – We use and disclose medical information about you so that we can bill and collect payment. This could include an insurance company or a third party. If you are covered by health insurance your health plan may need information from us about a surgery or other procedure you had, or will have, before they will pay us. We may disclose information about you for the payment activities of another healthcare provider.

**Health Care Operations** – Your medical information may be used or disclosed for purposes of our day-to-day operations. These activities are necessary to operate the hospital and to monitor the quality of care our patients receive. Examples would include to assess your satisfaction with our services; remind you of appointments; to tell you of possible treatment alternatives; evaluation of the treatment you received by our staff; to work with health oversight organizations which would include audits, investigations, inspections and licensure; and to combine information about you with other patients to determine what additional services should be provided.

**Clergy** – In accordance with the law, we may disclose your name, location in the facility, religious affiliation and general condition to members of the clergy, but only if you have not objected to this information being released.

**Individuals Involved in Care or Payment for Your Care** – We may disclose your medical information to a family member or friend who will be involved in your care.

**Law Enforcement** – Subject to certain restriction, we may disclose information required by law enforcement.

## NOTICE OF PRIVACY PRACTICES

Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

**Legal Requirements** – We disclose patient information to comply with both state and federal laws. For example, we are required to report to the state anytime a patient has certain diseases, for example, tuberculosis. Other examples of required reporting would involve cases involving abuse, negligence or domestic violence; Workers Compensation Agents; Food and Drug Administration; Correctional institutions regarding inmates; to comply with court orders, subpoenas, or other administrative process; organ procurement organizations; and to reports to the state all births and deaths.

**Medical Examiners, Coroners, and Funeral Directors** – We may disclose information to these entities when necessary for them to carry out their job responsibilities.

**Military and Veterans** – If you are, or have been, a member of the armed forces we may disclose information about you as required by military authorities.

**National Security** – We may release patient information to authorized federal officials for matters related to national security.

**Patient Directory** – You have the opportunity to be included in the patient directory or you may “opt out.” If you are in the patient directory and someone asks about you by name then we may provide verification that you are a patient, your location in the facility, and your general condition (for example, fair, stable, etc.). Should you decide to opt out of the directory then anyone asking for you will be given no information.

**Serious Threats to Health or Safety** – We may disclose information about you when necessary to prevent a serious threat to your health and safety as well as the health and safety of the public.

**Public Health Risks** – we disclose information to report reactions to medications or medical products; to notify people of recalls; to notify people who may have been exposed to a disease or at risk of contracting or spreading a disease; and to report certain injuries as gunshots or knife wounds.

### **YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU –**

You have the following rights with regard to your health information. Please contact the privacy officer to obtain the appropriate forms for exercising these rights.

**To Inspect and Copy** – In most cases you have the right to inspect and to obtain a copy of the health information that may have been used to make decisions about your care. A fee may be charged if you obtain a copy of your records. The law provides in limited circumstances you may be denied access to this information.

**To Request an Amendment to Your Medical Record** – If you believe that the information we have about you is incorrect or is incomplete, you have the right to request an amendment to the information. You have this right for as long as we have the information.

**To Request Restrictions** – You have the right to request that we restrict or limit the medical information we use or disclose about you for treatment, payment, or healthcare operations. The law states we are not required to comply with your request; however, if we do then we will comply unless the information is needed to provide you with emergency care.

**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 particular location. We will accommodate all reasonable requests; however, you are not allowed to limit the way we can contact you in order to avoid your responsibility to pay us for the services rendered to you.

**To Request an Accounting of Disclosures** – You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations. We are not required to provide for an accounting which took place before April 14, 2003.

### **OTHER USES OF YOUR MEDICAL INFORMATION -**

## **NOTICE OF PRIVACY PRACTICES**

Required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If we wish to disclose medical information about you for a reason not covered by treatment, payment, healthcare operations, legal requirements or other disclosures as set forth in this notice, we will seek your written authorization. If you provide us written authorization to use or disclose medical information about you, you may revoke it at any time by doing so in writing. If you revoke your authorization, we will no longer use or disclose medical information about you for the reasons covered by your written authorization.

### **CHANGES TO THIS NOTICE -**

We reserve the right to change this notice and our policies at any time. If our policies change and we make changes to our Notice then we will post the new Notice in a public area. You can request a copy of our Notice at any time.

### **COMPLAINTS -**

If you believe your privacy rights have been violated, you may file a complaint with the Facility Privacy Officer or with the Secretary of the Department of Health and Human Services in Washington, D.C. To file a complaint you will need to contact the Facility Privacy Officer whose name and phone number is on the following page. All complaints must be submitted in writing.

**You will not be penalized for filing a complaint.**

### **PRIVACY OFFICER**

If you have questions, requests, or complaints, please contact:

Holly Hoffman, RHIA, HIM Director, 2200 Market St, Charlestown, IN 47111 (812-256-7685)  
Chief Executive Officer, 2200 Market St, Charlestown, IN 4711 (812-256-7491)

**The Effective Date of this Notice is April 14, 2003.**