ER & P
Envision Rehab and Performance

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Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Who referred you? _____

History

Exercise Frequency: _____ Exercise Type(s): _____
Do you smoke? _____ Have you ever smoked? _____ How Often? _____
Are you pregnant? _____ Do you have a Pacemaker? _____
Allergies: _____
What medications are you currently using? _____
Previous complaints/surgeries: _____
Previous diagnoses/medications: _____

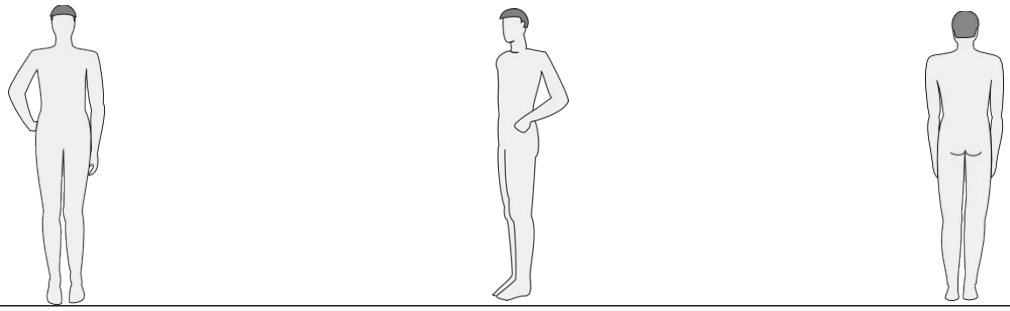
Situation/Complaints

What is your main complaint? _____
Start Date: _____ Possible Cause: _____
Symptoms: _____
Previous doctors seen for complaint: _____
Previous treatment for complaint: _____
Symptom-Aggravating Factors: _____
Symptom-Relieving Factors: _____
Time of Day Symptoms are Best: _____ Time They Are Worst: _____
Current Duration of Pain: ☐ Intermittent ☐ Constant ☐ With Certain Motions
Current Level of Pain: ☐ Mild ☐ Moderate ☐ Severe ☐ Excruciating
Is your pain getting better or worse? _____ Have you had this injury before? _____

Do You Have Any of the Following? (Check All That Apply)

☐ AIDS/HIV	☐ Anemia	☐ Angina	☐ Arteriosclerosis
☐ Arthritis	☐ Asthma	☐ Blood Clots	☐ Bone Infection
☐ Cancer	☐ Chemical Dependency	☐ Circulation Problems	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Eye Infection	☐ Heart Problems
☐ Hemophilia	☐ High/Low Blood Pressure	☐ Joint/Bone Infection	☐ Liver Problems
☐ Lung Issues	☐ Multiple Sclerosis	☐ Musculoskeletal Problems	☐ Pneumonia
☐ Stroke	☐ STD	☐ Tuberculosis	☐ Urinary Infection

Mark Areas of Discomfort



Financial Responsibility

I hereby consent to physical therapy treatment as prescribed by my physician, or as deemed necessary by the treating physical therapist. The patient is responsible for charges incurred, regardless of insurance coverage. If Envision Rehab has a contract with the patient's insurance carrier, Envision will file the claim for patient's services. **If the insurance company denies payment for no referral, non-covered services, deductible, etc, I understand that I am responsible for all balances due.** I understand, in some instances, all or some of the applicable physical therapy charges billed to my insurance company may not be covered under my insurance policy. I agree to be responsible for any portion of my bill not covered by insurance. I understand that it is my responsibility to understand my insurance benefits and comply with the requirements of the policy.

Appointment Times and Scheduling

All appointments are expected to last 30-60 minutes in length. Envision Rehab respects patient's time and makes every effort to arrive on schedule. However, because an employee cannot anticipate what every person will need, or if medical emergencies arise, he/she will take whatever time is necessary to give each and every patient the best care that is needed. As Envision Rehab employees make home visits, one cannot foresee challenges in parking, heavy traffic, or unforeseen road conditions. For this reason, therapists will give a window between 30 to 60 before or after the appointment time of arrival. If the therapist is running more than 30 minutes late then patient will be called and notified and given the opportunity to reschedule without a cancellation / no show fee.

Travel Fee

Envision Rehab travels to patients within Grafton County New Hampshire. Whenever the schedule permits, a therapist will travel outside this area to service patients for an additional travel fee. At times, patients on the outskirts of this service area may qualify for the travel fee due to the distance from the therapist's point of origin. Envision Rehab retains the right to decline admitting or treating patients who live outside the service area, or decline patients who live in conditions that are not suitable for therapy due to safety reason**. I agree to a travel fee of $25 per visit if I chose the mobile therapy option** and I am out of network with Envision Rehab's contracted insurances.

Cancellations and Missed Appointments

In the event that the patient is unable to keep an appointment please contact your therapist as quickly as possible. **A $25 fee will be charged for less than 24 hour cancellation as well as for no prior notice.** If you are able to re-schedule within the same week the cancellation fee well be waived. E-mail is also a suitable means to communicate visit cancelation if message is sent 24 hours prior to visit start time. In the case of a true medical emergency, the cancellation fee will be waived.

Informed Consent to Treatment

Physical Therapy involves the use of many different types of physical evaluation and treatment. The patient should understand that a Physical Therapy diagnosis are not a medical diagnosis by a physician or based on radiological imaging and that health plan or insurer might not cover such services. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict the patient's response to a certain modality or procedure. It is impossible to predict an individual patient's reaction to a particular treatment might be, nor can it be guaranteed that the treatment will help the condition the patient is seeking treatment for. There is also a small risk that the treatment may cause pain or injury, or may aggravate previous existing conditions. The patient has the right to ask the physical therapist what type of treatment she is planning based on medical history, diagnosis, symptoms and testing results. The patient may ask the therapist about the potential risks and benefits of a specific treatment. The patient has the right to decline any portion of the treatment at any time before or during the treatment session. Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If the patient has any questions regarding the type of exercise that he/she is performing and any specific risks associated with these exercises, the therapist will be glad to answer them.I acknowledge that a Envision Rehab therapist has explained my treatment program, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and wish to proceed.

Patient Privacy

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:
1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.2. Obtain payment from third-party payers.3. Conduct normal healthcare operations such as quality assessments and physician certifications.
I have been informed by Lance Berry PT, DPT of the Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Envision Rehab has the right to change her Notice of Privacy Practices from time to time and that I may contact Envision Rehab at any time to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that Envision Rehab restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Envision Rehab is not required to agree to my requested restrictions, but if the owner does agree than she is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Envision Rehab has taken action relying on this consent.

Patient Media Release

I hereby grant permission to the staff of Envision Rehab to use images, likenesses, audio or any other data (heretofore referred to as "Media") obtained through my treatment for instructional, educational or research purposes. This included all photos, videos, audio recordings, charts, graphs, analysis or any other data obtained by or submitted to the staff of Envision Rehab in the course of my treatment. The Media may be used in any professional manner that Envision Rehab deems necessary and I understand that the Media belongs to Envision Rehab and I will not receive any compensation or payment in connection to their use.
I assume the risks involved in releasing this information and release Envision Rehab and its employees and contractors from any and all liability that could arise from the use of this Media.

Consent to Email / Text for Appointment Reminders Or Healthcare Matters

Patients in this practice may be contacted via e-mail and / or text messaging to be reminded of an appointment, to obtain feedback on their experience with this healthcare team, and / or to provide general health reminders / information.

If at any time I provide an e-mail or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that e-mail or text address from Envision Rehab.

I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or e-mails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing.

Signature Date