TEAM REHABILITATION
PHYSICAL THERAPY

Patient Name: _____
MRN: _____

Patient Questionnaire

Patient Age _____

Medical History (check all that apply)
Specific medical history will be asked on tablet questionnaire.

☐ Seizures ☐ Dizziness/Vertigo
☐ Latex Allergy ☐ Other: _____

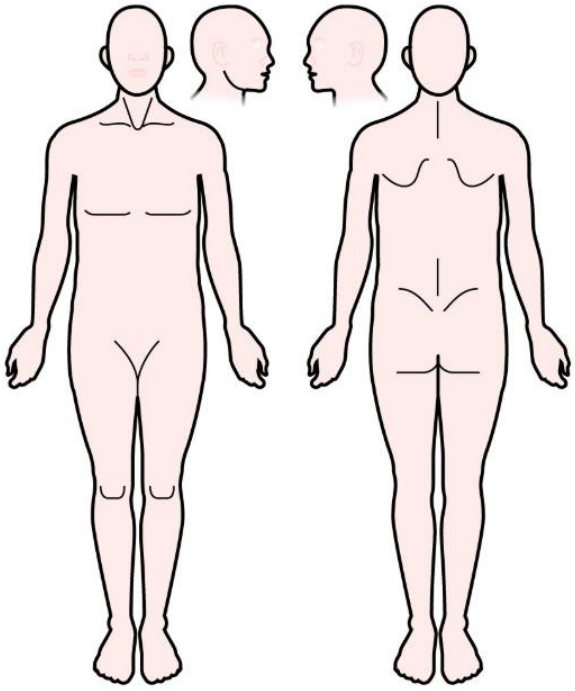
Please describe when & how your pain/illness/injury began, including any recent flare-ups:

_____
_____
_____

List of medications you are currently taking:

_____
_____
_____
_____
_____
_____
_____

Please mark the body part(s) you wish to have treated



Social Worker

Team Rehabilitation offers patients the services of a social worker free of charge. Some services referred by the social worker may have additional costs; the social worker will discuss these costs with you. The social worker can help with the following issues:

- Assistance with applying for benefits (for example Social Security or Medicaid)
- Assistance with Worker's Compensation
- Transportation
- Programs for Seniors
- Chore Services
- Meals on wheels
- Therapy Counseling
- Psychosocial Assessment
- Psychiatric Services
- Other community or medical services

Would you like to speak to the social worker? ☐ Yes ☐ No

If you would like to speak to the social worker, how urgently do you need an appointment

☐ Within 24 hours ☐ Within one week ☐ Not particularly urgent

Name: _____ Telephone number: _____

Best time to be contacted: _____ AM / PM May we leave a message? ☐ Yes ☐ No

Patient/Guardian Signature: _____ Date: _____

Forwarded to Social Worker by _____ Date _____

TEAM REHABILITATION
PHYSICAL THERAPY

Patient Name: _____
MRN: _____

General Consents and Releases

GENERAL CONSENT FOR TREATMENT

CONSENT: I consent to physical, occupational, and/or speech therapy treatments as deemed necessary by my doctor and therapist. I understand that while in Team Rehabilitation's clinics I am under the care of my doctor and my therapist, and that my therapist and any staff assisting him or her will follow a plan of care approved by my doctor.

ATTENDANCE AND RECOVERY: I understand that my doctor requested that I attend therapy at a specific frequency and duration because he/she feels this is appropriate for my recovery. I understand that my regular attendance is critical to my success. If a scheduling conflict arises, I will give Team Rehabilitation as much notice as possible to reschedule my appointment.

PAYMENT BY HEALTH INSURANCES: I authorize my health insurance (or Medicare) to make payment for my treatment directly to Team Rehabilitation. I authorize Team Rehabilitation to contact all the payors involved in my case, and to give them all the information they request about my case, in order to process payments.

Team Rehabilitation is a participating provider with Medicare, Blue Cross Blue Shield, and many health insurers. Thus, Team Rehabilitation accepts payment from all health insurers as payment in full for its services. The only exception is where the insurer requires Team Rehabilitation to collect copays, coinsurances, and/or deductibles from the patient. I understand that Team Rehabilitation will never bill me for contractual allowances (sometimes called network discounts) or payments for services that are denied or deemed to be not covered, unless I have agreed in writing, in advance, to pay for those services.

I understand that my contract with my health insurer may specify deductibles, copays and coinsurances. I understand that these payments are my responsibility and agree to pay them. I have been informed that Team Rehabilitation may waive all or part of my financial responsibility if I am experiencing financial hardship.

VERIFICATION OF BENEFITS: I certify that the information I have provided to enable Team Rehabilitation to verify my health insurance or Medicare benefits is accurate and complete to the best of my knowledge and belief. I authorize Team Rehabilitation to contact all the payors involved in my case, and to give them all the information they request about my case, in order to verify my benefits.

NO GUARANTEE: I understand that the practice of therapy is not an exact science, and that there is tremendous variation between the results achieved by apparently similar patients with apparently similar diagnoses. Therefore, neither Team Rehabilitation nor any of its therapists has made any promise to me concerning the results of my therapy. However, Team Rehabilitation and all its therapists do promise to use their best clinical judgment and their utmost efforts to help me to achieve the best result I possibly can.

PERSONAL PROPERTY: Team Rehabilitation is not responsible for loss or damage to any of my personal property while I am in any of Team Rehabilitation's clinics.

Patient/Guardian Name	Signature	Date
Team Rehabilitation Representative Name	Signature	Date

Patient Name: _____
MRN: _____

General Consents and Releases

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand Team Rehabilitation's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Team Rehabilitation has the right to change its *Notice of Privacy practices* from time to time and that I may contact Team Rehabilitation at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

Team Rehabilitation Records Department
33900 Harper Avenue
Clinton Township, MI 48035

I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient/Guardian Name	Relationship to Patient
Patient/Guardian Signature	Date

OFFICE USE ONLY
I attempted to obtain the patients signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below.

Date:	Initials:	Reason: