Therapy for Health. Therapy for Life.

Joint Effort REHAB LLC

Joint Effort Rehab, LLC
New Patient Packet

DEMOGRAPHICS

Patient Information

First Name: MI: Last Name: Sex: M F

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

***Email** SSN#: Date of Birth:

***By providing my email address I understand and agree to allow Joint Effort Rehab, LLC and it's employees to contact me via unencrypted email.**

Referring Physician: Primary Care Physician:

Employer Name: Occupation:

Primary Insurance Subscriber Information * COMPLETE POLICYHOLDER INFO *

Insurance Carrier: Member ID: Group No:

First Name: MI: Last Name: Sex: M F **DOB:**

Address: City: State: Zip:

Relationship to Patient: **Employer:** **SSN:**

Secondary Insurance Subscriber Information (if applicable) * COMPLETE POLICYHOLDER INFO

Insurance Carrier: Member ID: Group No:

First Name: MI: Last Name: Sex: M F DOB:

Address: City: State: Zip:

Relationship to Patient: Employer: SSN:

Guarantor/Guardian (if patient is a minor)

First Name: MI: Last Name: Sex:

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

SSN: **Date of Birth:** Email:

Employer Name: **Patient's Relationship to Responsible Party:**

Emergency Contact

First Name: Last Name: Relationship to Patient:

Home Phone: Cell Phone: Work Phone:

Communication Consent

☐ **Option A**: I give Joint Effort Rehab LLC permission to leave detailed phone messages regarding my medical and/or billing information on:

Home# _____ ☐ Medical ☐ Billing

Cell# _____ ☐ Medical ☐ Billing

Work# _____ ☐ Medical ☐ Billing

I also authorize Joint Effort Rehab LLC to release ☐medical and/or ☐billing information to: _____

☐ **Option B**: I wish to be contacted personally and do not authorize Joint Effort Rehab, LLC to leave detailed messages or discuss my care or billing account with anyone other than myself.

Patient or Responsible Party: **Date:**

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MEDICAL HISTORY

A complete medical history is necessary for a thorough evaluation. Please answer the following questions:

Your Name:				Date:
Date of Birth:	Age:	Height:	Weight:	Do you Smoke?: No Yes

Have you ever been diagnosed with any of the following?

Tuberculosis	No	Yes	Fainting/Falls/Dizziness	No	Yes
Hepatitis	No	Yes	HIV/AIDS	No	Yes
Diabetes/Neuropathy	No	Yes	Bowel/Bladder Problems	No	Yes
Stroke	No	Yes	Blood Clots	No	Yes
Chronic Respiratory Problems	No	Yes	Headaches/Migraines	No	Yes
Epilepsy/Seizures	No	Yes	High/Low Blood Pressure	No	Yes
Arthritis	No	Yes	Pacemaker	No	Yes
Cancer	No	Yes	Arrhythmia	No	Yes
Osteoporosis / Osteopenia	No	Yes	Congestive Heart Failure(CHF)	No	Yes
Closed Head Injury/TBI	No	Yes	Angina	No	Yes
Are you currently pregnant?	No	Yes	Other Heart Problems	No	Yes

Are you exercising? No Yes Describe: _____

Problems with exercise? No Yes Describe: _____

What do you hope to accomplish with therapy? _____

List all medications you currently take or **ask us to copy your list**

Medications	Diagnosis	Prescribing Physician

Is there any other pertinent information you would like us to know about your condition?

_____

_____

WHO CAN WE THANK FOR REFERRING YOU TO JOINT EFFORT: _____

Patient or Responsible Party: _____ Date: _____

OFFICE USE- RTNP VERIFICATION:	
Initials	Date

Revised 1/1/2024

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SYMPTOM DETAILS

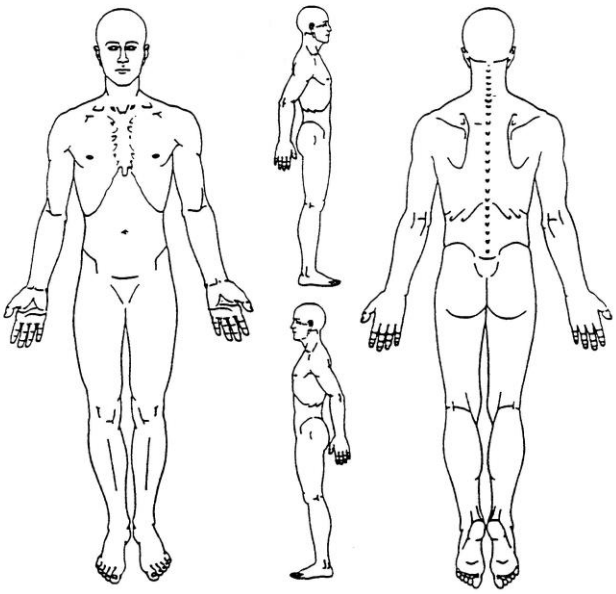
Patient Name:_____

Diagnosis (if you know or have been told):_____

_____

_____

Body part effected? (please indicate below)



Shoulder Elbow Wrist Neck Mid-back Low-back

Hip Knee Ankle Other:_____

Which side(s)? ☐ Right ☐ Left ☐ Both

Dominant arm? ☐ Right ☐ Left

Problem(s) (please check all that apply)

☐ Pain

☐ Weakness

☐ Instability/Giving way/Dislocation

☐ Stiffness

☐ Swelling

☐*Other*_____

How severe is your pain? (0=none & 10=severe)

At rest?	0	1	2	3	4	5	6	7	8	9	10
When active?	0	1	2	3	4	5	6	7	8	9	10
At it's worst?	0	1	2	3	4	5	6	7	8	9	10
At it's best?	0	1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ☐YES ☐NO

Does the pain awaken you from sleep? ☐YES ☐NO

Have you <u>ever</u> been seen <u>for this issue</u> by any other provider (ie. chiropractor, physician)? ☐YES ☐NO

In 2024 have you received any of the following treatments (related or unrelated to todays visit):

☐ None
☐ Physical Therapy _____# visits
Services rendered at:_____
☐ Occupational Therapy _____# visits
Services rendered at:_____
☐ Chiropractic _____# visits
☐ Speech Therapy _____#visits
☐ Home Health _____# visits
Were you discharged from home health? ☐YES ☐NO

Have you received any injections? ☐YES ☐NO

Are you post surgical? ☐YES ☐NO

Date of Surgery:_____

Type of Surgery:_____

List any additional surgeries you've received for this problem:_____

_____

Other unrelated surgeries:_____

_____

_____

This is a result of... (mark all that apply)

☐ No injury – just started hurting

Date of Onset_____

☐ Sports Injury (which sport?) _____

☐ Motor Vehicle Related

Do you have an open/payable claim Y N

☐ Work/Job Related

Do you have an open/payable claim Y N

☐ 3rd Party Accident (involving insurance other than your own)

Injury : ☐Current ☐Old (greater than 1 year)

Date of Injury:_____

Please briefly describe how your injury happened:

_____

_____

_____

_____

(Patient Signature) **(Date)**

1. **Authorization for Release of Information** – The HIPAA Privacy Rules allows those doctors, nurses, hospitals, laboratory technicians, and other healthcare providers that are covered entities to use or disclose protected health information, such as x-rays, laboratory and pathology reports, diagnoses, and other medical information for treatment purposes with the patient's authorization. This includes sharing the information to consult with other providers, including providers who are not covered entities, to treat a different patient, or to refer the patient.

2. **Authorization for Treatment** – I understand that therapy evaluations and treatment may potentially cause or aggravate symptoms, and give my consent for the therapist to perform treatment as he/she deem necessary.

3. ****Verification of Benefits**** – I understand that Joint Effort Rehab, LLC will attempt to obtain benefits from my insurance company, however, they will not be responsible for unauthorized services as well as any discrepancies between quoted benefits and actual benefits paid**. I understand I am responsible for payment of services not covered by my insurance. I also understand and agree that I am responsible for verifying my own insurance benefits as well as knowing and understanding my plan limitation, maximum benefits available, deductible, coinsurance and copayments**. Because my insurance is a contract between myself and my insurance company, I understand that I must direct questions or concerns regarding payment of benefits to them.

4. **Financial Agreement** – I understand there is no guarantee of reimbursement or payment from any insurance company or other payor. I acknowledge full financial responsibility for, and agree to pay all charges of the clinic and of therapist rendering services as allowable per the contractual terms between my insurance and Joint Effort Rehab, LLC. All charges are due and payable upon receipt of the bill. If payment is not made within 30 days of the receipt of the bill a delinquent charge or interest at the maximum legal rate may be added. I agree to pay all reasonable legal expenses necessary for the collection of any debt.

5. **Assignment for Direct Payment** – I authorize and instruct my insurance carrier to make payment of medical benefits to Joint Effort Physical Therapy, LLC for therapy services rendered and that no payment be made payable to myself/insured party. If payment is made directly to myself/insured, I understand that I will be responsible for balance due.

6. I have read the Notice of Privacy Practices and have been offered a copy for my records. I am aware the Notice may be changed at any time. I was given the opportunity to review the Notice and ask questions regarding my privacy rights.

I ACKNOWLEDGE I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS. I FURTHER ACKNOWLEDGE THAT I AM THE PATIENT, OR PERSON DULY AUTHORIZED EITHER BY THE PATIENT OR OTHERWISE, TO SIGN THIS AGREEMENT, CONSENT TO, AND ACCEPT ITS TERMS

_____ _____

Patient/Responsible Party **Date**

OFFICE USE- RTNP VERIFICATION:	
Initials	Date

Cancellation/No-Show Policy update 2024

We continue to strive to provide the best care possible for all of our patients here at Joint Effort PT. The best way to achieve that goal is for our patients to attend all their scheduled sessions.

We respectfully ask that you provide us with at least 24 hour notice to allow us to try and fill your appointment slot. You will be charged a **$40 fee**…

- If you cancel with less than 24 hours notice.
- If you No Show for an appointment.

If you cancel with less than a 24 hour notice 3 times or no show 2 times, you will be asked to move to a '**Same Day Only**' schedule. This means we will not schedule you ahead of time. You will need to call our office on a day you know you can come in and if we have an opening, you will be scheduled that day.

I understand the above cancellation/no-show policy for Joint Effort Physical Therapy.

_____	_____	_____
Printed Name	Signature	Date

Revised 1/1/24