



ACCT# _____ (office use)

NEW _____ UPDATE _____

TODAY'S DATE _____

NAME _____ SOCIAL SECURITY # _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOME PH # _____ BIRTHDATE _____ AGE _____ MARRIED _____ YES _____ NO _____

EMPLOYER NAME, ADDRESS AND PHONE # _____

INSURED NAME _____ SS # _____ DOB _____

NAME OF INSURANCE COMPANY, ADDRESS AND PHONE # _____

SPOUSE NAME _____ SPOUSE EMPLOYMENT _____

REFERRED BY _____ MAJOR COMPLAINTS _____

ADDITIONAL INSURANCE COVERAGE _____

HOW DID YOU HEAR OF OUR SERVICES? ___ M.D. ___ FRIEND ___ OTHER NAME _____

IS YOUR VISIT DUE TO AN INJURY? ___ YES ___ NO DATE OF INJURY _____

IF YES, WILL YOU BE COVERED UNDER AUTO MEDICAL PAYMENT? ___ YES ___ NO

IS THIS INJURY DUE TO AN "ON THE JOB" ACCIDENT? ___ YES ___ NO ___ N/A

WHO MAY WE CALL TO VERIFY?

IF AN ATTORNEY IS INVOLVED, PLEASE LIST ACCIDENT DATE AND ATTORNEY'S NAME,
ADDRESS AND PHONE _____

*EMERGENCY CONTACT NAME AND NUMBER _____

I GIVE MY PERMISSION TO BE TREATED BY RICHLAND THERAPY SERVICES AS ORDERED BY MY PHYSICIAN.

(Patient's Signature)

RICHLAND THERAPY SERVICES, LLC

Patient Information Consent Form

I have read and fully understand **RICHLAND THERAPY SERVICES, LLC's** Notice of Information Practices. I understand that **RICHLAND THERAPY SERVICES, LLC** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I agree that upon initiation of treatment, my photograph will be taken and attached to my medical file and initial evaluation reports. This photograph will be used for identification only. Any other purpose would require specific approval.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **RICHLAND THERAPY SERVICES, LLC's** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date



DESIGNATED INDIVIDUALS AUTHORIZATION FORM

Authorization for Release of Medical Records

I hereby authorize Richland Therapy Services, LLC, to furnish a copy of all physical therapy billing records and/or medical records for the undersigned to any attorney/insurance company providing benefits.

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

AUTHORIZED DESIGNEES:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name (Print)

Patient Signature

Date

_____ Check if not applicable.



RICHLAND THERAPY SERVICES

P. O. Box 834, 160 Christian Drive

Rayville, LA 71269

(318) 728-4088

(318) 728-4124

THIS PAGE MUST BE CHECKED AND SIGNED

ARE YOU CURRENTLY RECEIVING HOME HEALTH?

YES _____

NO _____

ARE THERE ANY MEDICAL PERSONNEL COMING INTO
YOUR HOME FOR ANY OTHER PURPOSE?

YES _____

NO _____

IF SO, PLEASE INDICATE WHO AND FOR WHAT PURPOSE:

Signature

Date

RICHLAND THERAPY SERVICES

FINANCIAL RESPONSIBILITY FORM

Assignment of Insurance Benefits

In consideration of services rendered or to be rendered by Richland Therapy Services for any illness or diagnostic services, I hereby assign to RICHLAND THERAPY SERVICES all benefits due me covering medical expenses and/or benefits under any insurance policies or settlements (workers compensation, liability, etc.) or any award I might receive or have already received from any court proceeding to which I may be entitled. I authorize those benefits due me for services be paid and mailed directly to Richland Therapy Services, LLC.

I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical information about me to release to the Social Security Administration or its intermediaries or carriers any information needed to adjudicate a claim. I hereby request payment of authorized medicare benefits on my behalf for any services furnished by or in Richland Therapy Services, LLC.

Patient's Responsibility

Co-pays and/or co-insurance are due at the time of service (not less than weekly).

I fully understand that I am directly and fully responsible for all therapy bills submitted for service rendered me, and that this agreement is made solely for additional protection and in consideration of awaiting payment. And I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee. I further understand that Richland Therapy Services will make **two** attempts on my behalf to collect from my insurance company and after which, I will be billed the remaining balance. **After the first statement, if no attempt to make payment occurs, a 5% charge will be assessed on the outstanding balance of each statement thereafter.** It would then be my responsibility to work directly with my insurance company. **If after three attempts to collect from me, Richland Therapy Services will have no alternative but to turn my account over to their attorneys for collection and I will be responsible for any and all additional attorney fees and/or court costs.**

DATE: _____ PATIENT: _____

WITNESS: _____



PHYSICAL THERAPY PATIENT/CLIENT MANAGEMENT

NAME AND ADDRESS:

DATE: _____

Last First MI

Street/Mailing Address City St Zip

Date of Birth: ___/___/___ Sex: Male Female Are You: Righthanded Lefthanded

Type of Insurance: Commercial Medicare Worker's Comp Self Pay Other _____

EMPLOYMENT:

Full-time outside of home Part-time outside of home Homemaker Retired
Full-time from home Part-time from home Student Unemployed

WHERE DO YOU LIVE?

Private Home Apartment/Rented Home Assisted Living/Group Home Nursing Home
Family/Friends Other: _____

DOES YOUR HOME HAVE?

Stairs, no railing Stairs, railing Ramps Elevator Uneven terrain/Obstacles

DO YOU USE?

Cane Walker/Rollator Manual Wheelchair Motorized Wheelchair Other _____

HOW WOULD YOU RATE YOUR GENERAL HEALTH?

Excellent Good Fair Poor

ARE YOU CURRENTLY TAKING MEDICATIONS: IF SO, PLEASE LIST: _____

DO YOU EXERCISE BEYOND NORMAL DAILY ACTIVITIES AND CHORES? IF SO, PLEASE DESCRIBE THE EXERCISE. HOW MANY DAYS A WEEK AND HOW MANY MINUTES, ON AN AVERAGE, PER DAY: _____

HAVE YOU EVER HAD SURGERY? IF YES, PLEASE LIST WITH DATES: _____

WITHIN THE PAST YEAR, HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL TESTS?

- CT Scan MRI X-Rays Stress Test (treadmill, bicycle, etc.)

PLEASE CHECK IF YOU HAVE HAD ANY OF THE FOLLOWING:

- | | |
|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Infectious disease (such as TB, hepatitis) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Low blood sugar/hypoglycemia |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Lung problems |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Developmental or growth problems | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Seizures/epilepsy |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Other _____ |

CURRENT LIMITATIONS (Check all that apply)

- Difficulty with locomotion/movement
- bed mobility
 - transfers (such as moving from bed to chair, from bed to commode)
 - gait (walking):
 - on level terrain
 - on stairs
 - on ramps
 - on uneven terrain
- Difficulty with self-care (such as bathing, dressing, eating, toileting).
- Difficulty with home management (such as household chores, shopping, driving/transportation).

HISTORY OF CURRENT PROBLEM:

When did the current problem(s) begin? _____ Date: _____
Explain what happened: _____

Have you ever had this problem before? If so, please explain what you did for the problem(s): _____

Did the problem(s) get better? Yes No

Are you seeing anyone else for this problem? (Such as Acupuncturist, Chiropractor, Orthopedist, Massage therapist, Family practitioner, etc.)? _____

Please rate your major area of pain on the 0 to 10+ Pain Rating Scale by writing the number of your pain, considering the work descriptors, at the present time and your best and worst over the past 30 days.

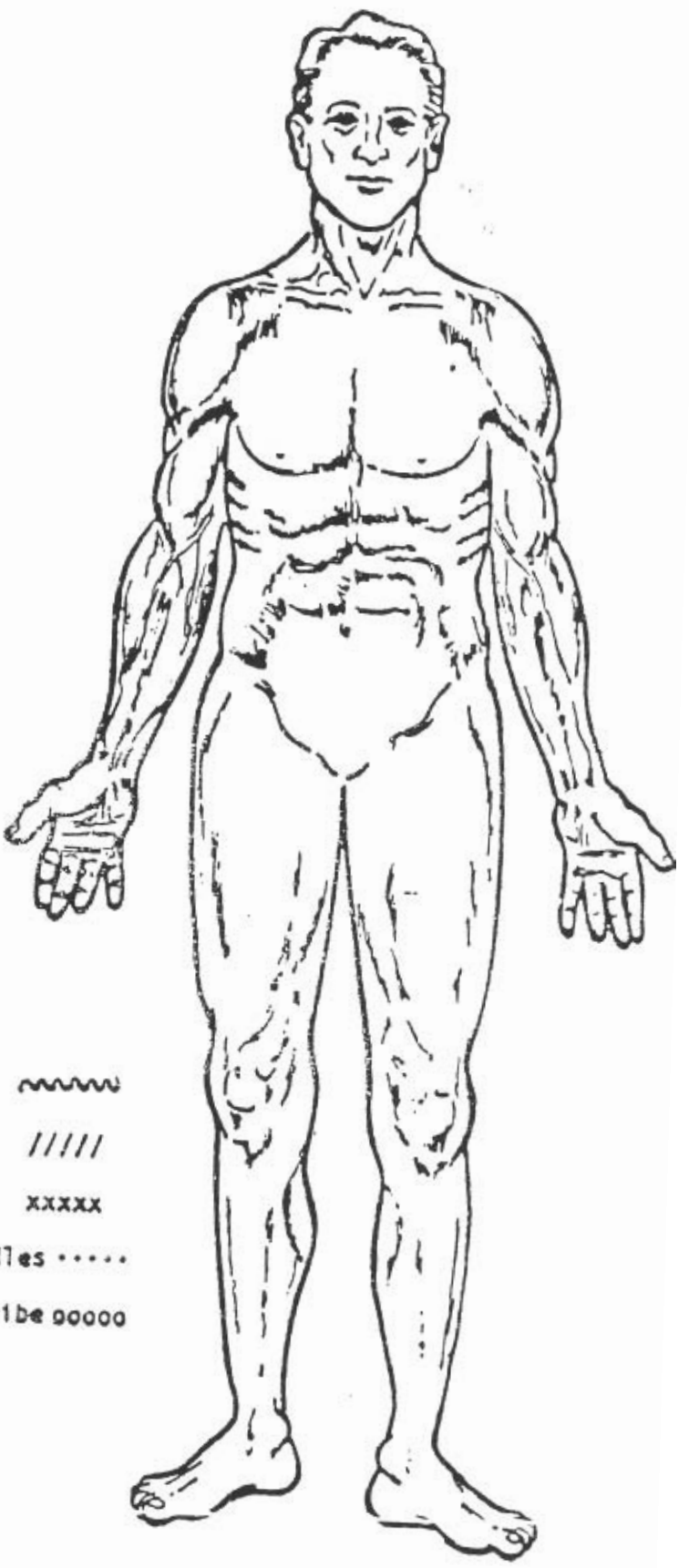
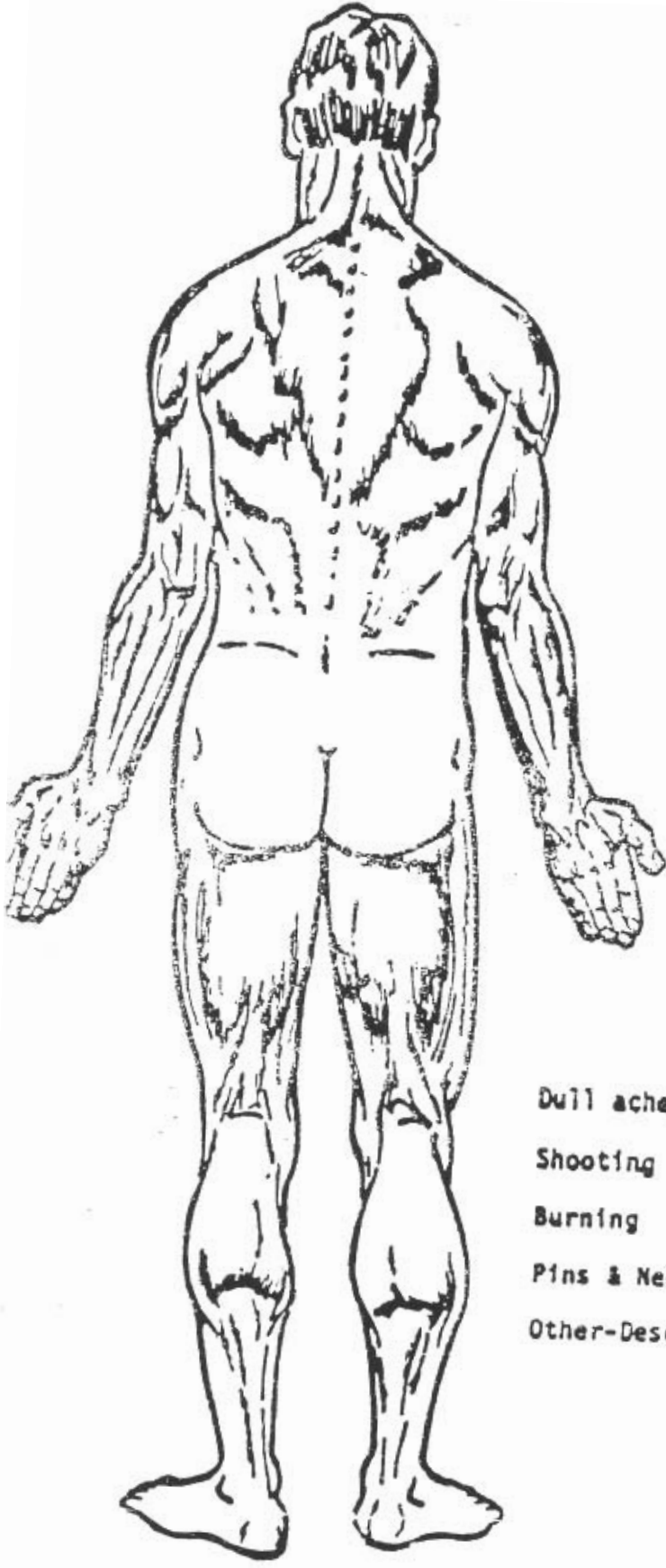
10+	Maximal
10	Very, very strong
09	
08	
07	Very strong
06	
05	Strong
04	Somewhat strong
03	Moderate
02	Weak
01	Very weak
.5	Very, very weak
0	Nothing at all

PAIN RATING **NOW:** _____

PAIN RATING OVER THE PAST 30 DAYS:

BEST: _____

WORST: _____



Dull ache ~~~~~
Shooting /////
Burning xxxxx
Pins & Needles
Other-Describe ooooo

DATE: _____

NAME: _____



RICHLAND THERAPY SERVICES

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

RICHLAND THERAPY SERVICES, L.L.C. LEGAL DUTY

Richland Therapy Services, LLC is required by law to protect the privacy of your personal health information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Richland Therapy Services, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Richland Therapy Services, LLC** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Richland Therapy Services, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Richland Therapy Services, LLC's** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Richland Therapy Services, LLC** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Richland Therapy Services, LLC** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Richland Therapy Services, LLC's** health information practices or if you have a complaint, please contact the following person:

Rita Wiedeman, Office Manager
Richland Therapy Services, LLC
P.O. Box 834, Rayville, LA 71269
(318) 728-4088 – Fax (318) 728-4124