Total Health & Rehabilitation **PATIENT REGISTRATION** Today's Date _____/_____/_____

First Name_____ **MI**_____ **Last**_____ **Age**_____

Street Address_____ **Apt#**_____

City _____ **State**_____ **Zip Code**_____ **Gender** M / F Other_____

Birth Date _____/_____/_____ **Social Security** _____-_____-_____

Please Check One for **Preferred Phone Number**

□ **Home Phone** _____-_____-_____

□ **Cell Phone** _____-_____-_____

□ **Work Phone** _____-_____-_____

Email_____

Emergency Contact_____

Phone _____-_____-_____ **Relationship**_____

Marital Status □ Single □ Married □ Domestic Partner □ Divorced □ Widowed

Occupation_____ **Employer**_____

My Injury is the Result Of □ Auto Accident □ Work Injury □ Slip/Fall □ Sports Injury □ Post-Surgery □ Recurring Illness □ Other _____

Describe *How* and *Where* the Injury Occurred _____

_____

DRIVER'S LICENSE AND INSURANCE CARDS ***Please Give All Cards To Front Desk To Copy***

1. ***Primary*** **Insurance Carrier**_____

Name of Insured_____ **DOB**_____/_____/_____ **Relationship**_____

2. ***Secondary*** **Insurance Carrier**_____

Name of Insured_____ **DOB**_____/_____/_____ **Relationship**_____

3. ***Tertiary*** **Insurance Carrier**_____

Name of Insured_____ **DOB**_____/_____/_____ **Relationship**_____

☐ **I Do Not Have Health Insurance**

MOTOR VEHICLE ACCIDENT / LIABILITY INSURANCE (if applicable)

Auto Insurance Carrier_____ **Auto Policy Holder's Name**_____

Claim#_____ **Date of Accident** _____/_____/_____ **Accident State**_____

Claim Adjuster_____ **Phone#** _____-_____-_____

This is *My* Auto Insurance Policy Y / N **This is the *Other Driver's* Insurance Policy** Y / N

WORKER'S COMPENSATION INSURANCE (if applicable)

Work Comp Insurance Carrier_____ **Claim#**_____

Claim Adjuster_____ **Phone#** _____-_____-_____

Date of Accident _____/_____/_____ **Accident State** _____

ATTORNEY INFORMATION FOR THIS INJURY (if applicable)

Attorney Name_____ **Phone#** _____-_____-_____

I hereby certify that all the above information is true to the best of my knowledge **X**_____

Signature of Patient, Parent, or Legal Guardian

TOTAL HEALTH & REHABILITATION, INC.

AUTHORIZATION AND CONSENT FORM

Patient Name_____

Please Print

INSURANCE ASSIGNMENT OF BENEFITS AND RIGHTS

This is a direct assignment of my rights and benefits under any applicable policy of insurance. I hereby authorize payment of medical benefits directly to Total Health & Rehabilitation, Inc. for any physical therapy services rendered to me and/or my dependent(s). This includes an assignment of any cause of action that might accrue against any such insurance carrier for its failure to pay insurance benefits. I understand that I am responsible for all costs of treatment, regardless of insurance coverage.

CONSENT FOR TREATMENT / CONFIDENTIALITY AGREEMENT

I hereby authorize and release Total Health & Rehabilitation, Inc. and all designated assistants to administer treatment, physical examination, and any other services deemed necessary for my care. I agree to maintain the confidentiality of the other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than me.

AUTHORIZATION AND RELEASE OF PROTECTED HEALTH INFORMATION

I hereby request and authorize Total Health & Rehabilitation, Inc. to disclose all or any part of my protected medical records and billing statements for the purpose of review and evaluation in connection with my healthcare, claims processing, securing payment of benefits, or settling legal claims regarding liability cases or worker's compensation cases if applicable. This authorization includes but is not limited to insurance companies, medical service companies, automobile carriers, worker's compensation carriers, healthcare providers, healthcare clearinghouses, welfare funds, disability offices, representing attorneys, and employers. I understand that I have the right to revoke this authorization in writing at any time and that my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.

FINANCIAL RESPONSIBILITY

I understand that I am responsible for notifying Total Health & Rehabilitation, Inc. of any insurance coverage and insurance changes. I understand that verification of benefits is not a guarantee of payment and that I am responsible for any balance not covered by insurance. I acknowledge that failure to pay my balance or make payment arrangements on balances greater than 120 days may result in my discharge from this facility and my account being referred to a collection agency and the credit bureau.

- **I hereby certify that I have read this document; I understand its content; and I agree to its terms. I also certify that I have provided Total Health & Rehabilitation, Inc., with all necessary information to process my insurance claims and that the information provided is true and complete to the best of my knowledge.**

X_____ Date _____/_____/_____

Signature of Patient / Parent or Legal Guardian

PERMISSION TO TREAT A MINOR (*if applicable*)

- **I hereby authorize and release Total Health & Rehabilitation, Inc. and all designated assistants to administer treatment, physical examination, and any other services deemed necessary to my _____.** Name of Parent or Legal Guardian_____.

Indicate relationship to child — Please Print

X_____ Date _____/_____/_____

Signature of Parent or Legal Guardian

1303 Veale Road
Wilmington, DE 19810
Ph 302-477-0800
Fx 302-477-0801

Total Health & Rehabilitation, Inc.

2707 Capitol Trail, Suite 2
Newark DE 19711
Ph 302-999-9202
Fx 302-999-9203

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand, under the Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

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

I have received, read and understand **Total Health & Rehabilitation, Inc. Notice of Privacy Practices** containing a more complete description of the users and disclosures of my health information. I understand that **Total Health & Rehabilitation, Inc.** has the right to change its Notice of Privacy Practices from time to time and that I may contact them to obtain a current copy.

I understand that I may request in writing that **Total Health & Rehabilitation, Inc.** restrict how my private health information is used or disclosed to carry treatment, payment and health care operations (TPO). I also understand that **Total Health & Rehabilitation Inc.** is not required to agree to my requested restrictions, but if they do agree then they are bound to abide such restrictions.

I understand that I may revoke my consent in writing at any time, except to the extent that **Total Health & Rehabilitation, Inc.** has taken action relying on this consent.

Patient Name: _____
Please Print

Relationship to Patient: _____
Please Print

Signature: **X**_____ Date: _____/_____/_____

OFFICE USE ONLY

I attempted to obtain the patient's signature on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____/_____/_____ Initials:_____ Reason:_____

Past Medical History

Patient Name:_____
Please Print

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING?

Broken Bones /Fractures	____*Yes*	____*No*	***Seizures /Epilepsy***	____*Yes*	____*No*
Osteoporosis	____*Yes*	____*No*	***Stroke / CVA***	____*Yes*	____*No*
Arthritis	____*Yes*	____*No*	***Headaches***	____*Yes*	____*No*
Joint Replacement	____*Yes*	____*No*	***Head Injury***	____*Yes*	____*No*
Difficulty Walking	____*Yes*	____*No*	***Multiple Sclerosis***	____*Yes*	____*No*
High/Low blood pressure	____*Yes*	____*No*	***Parkinson Disease***	____*Yes*	____*No*
Irregular Heart Rate	____*Yes*	____*No*	***Muscular dystrophy***	____*Yes*	____*No*
Pacemaker	____*Yes*	____*No*	***Vertigo***	____*Yes*	____*No*
Bypass	____*Yes*	____*No*	***Diabetes***	____*Yes*	____*No*
Heart Problems	____*Yes*	____*No*	***Cancer***	____*Yes*	____*No*
Lung Problems	____*Yes*	____*No*	***Allergies***	____*Yes*	____*No*
Emphysema	____*Yes*	____*No*	***Hepatitis***	____*Yes*	____*No*
COPD	____*Yes*	____*No*	***HIV / AIDS***	____*Yes*	____*No*
Tuberculosis	____*Yes*	____*No*	***Any other Disease***	____*Yes*	____*No*
Unexpected Weight Loss in the last 3 Months	____*Yes*	____*No*	***Falls in last 3 months***	____*Yes*	____*No*
			Night Pain	____*Yes*	____*No*

SURGERIES: if answered ***YES*** please date

Spine	____*Yes*	____*No*	*Date:*_____
Joint Replacement	____*Yes*	____*No*	*Date:*_____
Brain	____*Yes*	____*No*	*Date:*_____
Thyroid	____*Yes*	____*No*	*Date:*_____
Heart	____*Yes*	____*No*	*Date:*_____
Bowel	____*Yes*	____*No*	*Date:*_____
Kidney	____*Yes*	____*No*	*Date:*_____
Gall Bladder	____*Yes*	____*No*	*Date:*_____
Appendectomy	____*Yes*	____*No*	*Date:*_____
Prostate	____*Yes*	____*No*	*Date:*_____
Hernia	____*Yes*	____*No*	*Date:*_____
Hysterectomy	____*Yes*	____*No*	*Date:*_____
Stent	____*Yes*	____*No*	*Date:*_____

Other:_____

_____

I understand this is a questionnaire of my past medical history and health status. I certify that all above information is true and correct to the best of my knowledge.

Patient Signature:_____ ***Date***:_____/_____/_____