

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  \_\_\_\_\_

*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:  \_\_\_\_\_ 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: \_\_\_\_\_

**TOTAL HEALTH & REHABILITATION, INC.**

# Past Medical History

Patient Name: \_\_\_\_\_

Please Print

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

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

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

<b>Spine</b>	___ Yes	___ No	Date: _____
<b>Joint Replacement</b>	___ Yes	___ No	Date: _____
<b>Brain</b>	___ Yes	___ No	Date: _____
<b>Thyroid</b>	___ Yes	___ No	Date: _____
<b>Heart</b>	___ Yes	___ No	Date: _____
<b>Bowel</b>	___ Yes	___ No	Date: _____
<b>Kidney</b>	___ Yes	___ No	Date: _____
<b>Gall Bladder</b>	___ Yes	___ No	Date: _____
<b>Appendectomy</b>	___ Yes	___ No	Date: _____
<b>Prostate</b>	___ Yes	___ No	Date: _____
<b>Hernia</b>	___ Yes	___ No	Date: _____
<b>Hysterectomy</b>	___ Yes	___ No	Date: _____
<b>Stent</b>	___ 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:** \_\_\_\_/\_\_\_\_/\_\_\_\_

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**LETTER OF PROTECTION AND AUTHORIZATION**

**Patient Name:** \_\_\_\_\_ **Regarding Date of Loss:** \_\_\_\_\_  
Please Print

1. I hereby authorize my attorney to discuss my case or provide *Total Health & Rehabilitation, Inc.*, with any information necessary to have payment paid directly to them for such sums as may be due and owing for medical services rendered me.
2. I, furthermore, authorize my attorney to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay *Total Health & Rehabilitation, Inc.*, as soon as possible for said debt.
3. I fully understand that I am directly responsible to *Total Health & Rehabilitation, Inc.*, for all medical bills for services rendered me and the agreement does not relieve me of any personal responsibility for said charges.
4. I further understand that this agreement is made for the protection of *Total Health & Rehabilitation, Inc.*, for their patience and consideration in awaiting settlement, award, judgment or verdict by which I may recover said fees and that said provider will be paid regardless of the outcome of my legal claim arising out of this accident.
  - Pursuant to **Pennsylvania's Act 6 and Act 44** and the subsequent insurance commission regulation, *Total Health & Rehabilitation, Inc.*, understands that they are not entitled to collect from me the difference between their full charge and the amount determined to be payable by the automobile or worker's compensation carrier and is not entitled to be paid by any other source until benefits are exhausted or coverage is denied.
  - Pursuant to **New Jersey's** Department of Insurance Fee Schedule, *Total Health & Rehabilitation, Inc.*, understands that they are not entitled to collect from me the difference between their full charge and the schedule amount, after the appropriate deductible and copayment are applied.
5. I understand that this Letter of Protection is irrevocable and shall apply to any cause of action whether or not I should engage legal counsel or substitute attorney at any future time. I further understand and agree to notify *Total Health & Rehabilitation, Inc.*, if I change or terminate attorney/client relationship and instruct any new attorney to honor this Letter of Protection and Authorization and agree to enforce its terms.

**PATIENT (or guarantor) SIGNATURE:**  \_\_\_\_\_  
Relationship of Guarantor to Patient: \_\_\_\_\_ **DATE:** \_\_\_\_\_

I, the undersigned, being the attorney of record for the above patient, do hereby agree to observe all the terms of the above agreement and agree to withhold such sums from any insurance payments or from whatever source, settlement, judgment or verdict and pay *Total Health & Rehabilitation, Inc.*, as soon as possible for said debt.

I, furthermore, understand and agree to immediately notify *Total & Rehabilitation, Inc.*, in writing should there occur a substitution of counsel, referral to another attorney or law firm, retention of co-counsel or should the attorney/client relationship be terminated or modified in any manner.

**ATTORNEY SIGNATURE:**  \_\_\_\_\_ **DATE:** \_\_\_\_\_