USA HEALTH

THERAPY SERVICES PATIENT INFORMATION

Today's Date: _____

Name: First_____ MI____ Last_____ Date of Birth: _____ Age: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone #: (_____) _____ Cell Phone #: (_____) _____

Referring Physician: _____ Next Scheduled Appointment: _____

Are you receiving any type of Home Health (HH) Services? Yes No

If so which HH Agency:_____ **Date of Discharge from HH:**_____

Have you given us ALL Health Insurance Coverage you have? Yes No

Have you received any PT, OT or Chiropractor services this year? Yes No

Are we treating you for a condition as a result of an accident: Yes No Date of Accident or Injury: _____/_____/_____

If yes, what kind of accident? Auto Accident Worker's Compensation Other _____

Briefly describe accident:_____

_____

Medical History Information: Do you suffer from any of the following?

Fracture	Joint Problems/Swelling	Arthritis	Seizures	Communicable Diseases
Tuberculosis (TB)	Weight Loss Surgery	Osteoporosis	Visually Impaired	Kidney Problems
Low Blood Pressure	Breathing Problems	Circulatory Problems	Hearing Problems	Stomach Problems
High Blood Pressure	Numbness	Diabetes	Lung Disease	Other_____
Tingling	Metal Implants	Stroke	Dizziness	_____
Heart Trouble	Cardiac Stent	Heart Valve Problems	Cancer, Type and Year: _____	

Past Surgeries: _____

Are you allergic to the following?

Tape Cortisone Gabapentin Dexamethasone Lidocaine Baclofen Latex

Other Allergies: _____

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Please circle any of these implanted devices that you have:

None Defibrillator Spinal Stimulator Vagus Nerve Stimulator

Pacemaker Gastric Pacemaker Metal Hardware

Have you been hospitalized in the last 12 months? _____

If yes, please list dates: _____

Have you had any falls in the past year? Yes No

If so, how many? _____ Any injuries as a result of the fall(s)?_____

Do you presently use an assistive device?

No device Cane 3 or 4 Point Cane Walker Wheelchair

Are you receiving rehabilitation dur to surgery? Yes No

Date of surgery: _____ Procedure: _____

Is your condition due to an injury? Yes No If yes, date of injury: _____

If your condition is not related to injury or surgery, when did the problem start? _____

Have you previously participated in any type of rehabilitation? Yes No

If so, list when and where _____

What is your current activity level? Very Active Active Not Active

What is your current occupation? _____

If you are a female, are you pregnant? Yes No

Emergency Contact: _____ Phone #: _____

Patient Signature: _____ Date: _____

USA HEALTH

Updated 5/14/2021

Patient's Name: _____

CONSENT FOR TREATMENT: I hereby authorize the performance of any medical procedure, which may be advised and/or recommended by my therapist and/or physician.

ASSIGMENT OF INSURANCE BENEFITS: I hereby assign payment directly to USA Health for medical benefits otherwise payable to me for their billed services, but not to exceed its charges. Any unpaid deductible and/or estimated co-pay is due and payable at the time of service. I understand that charges not payable by insurance are my responsibility and all charges are due in full within 90 days from the date of service; regardless of any insurance pending.

STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS: Payment for services rendered is to be made as follows: "I request that payment of authorized Medicare benefits be made payable to USA Health on my behalf for any services rendered to me by USA Health. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agency any information needed to determine these benefits payable for services rendered."

WORKER'S COMPENSATION PATIENTS: I authorize the release of all medical information to my Employer, Insurance Adjuster and/or Case Manager assigned to my Worker's Compensation Claim. I further understand that if I am non-compliant with my treatment program and/or appointments that USA Health may notify the above stated individuals.

RELEASE OF RECORDS: I authorize USA Health to disclose all or part of my medical and/or patient account records to my insurance company or association as may be necessary for the processing of any outstanding insurance claims, as well as to any treating physician or healthcare providers involved in my, or my child's, medical care to include copies of medical records.

ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES: Under federal HIPAA guidelines, all patients are to be provided with the opportunity to review and/or have a copy of our Notice of Privacy Practices which explains how medical information will be used and disclosed. By my signature below I acknowledge having been made aware there is a copy in the waiting room, and I may obtain a copy from USA Health, if desired.

PAYMENT POLICY: Standard charges have been established for all services provided by USA Health. The fee for your rehabilitation services will be billed to your insurance company as a courtesy to you. You are required to pay any co-pay and/or unmet deductible amounts at the time of service. You will be sent a statement for any remaining balance after your insurance has processed your claims. At that time, your entire balance for processed dates of service will be due. If payment arrangements need to be made, please contact our regional billing office. Our policy is to have the entire balance or your account with USA Health paid within 90 days from your date of service.

CREDIT POLICY: In the event that I do not meet the payment terms above and further action is taken on my account I agree to pay 28% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

COMMUNICATION CONSENT: I expressly consent and authorize USA Health to communicate with me for any reason, including reasons related to the services provided by USA Health or services to be provided in the future by USA Health, including collection of amounts owed for said services, via communications at the telephone number or numbers I provide, or that is provided on my behalf, or any phone number, or other forms of communication that USA Health obtains or finds on its own which is not provided by me. Until my accounts are settled, I give my consent to receive communications regarding my account from any servicers and collectors of my accounts through various means such as cell, landline, text, email, auto dialer systems, voicemail messages or other forms of communication.

I have read and understand the terms of this Statement of Consent and Financial Responsibility.

Responsible Party's Signature: _____ Date: _____

Responsible Party's Name (please print): _____

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Updated 5/14/2021

PATIENT RIGHTS/GRIEVANCE FORM

Patient utilizing rehabilitation services are entitled to:

1. Licensed/certified clinicians to evaluate all admissions and if deemed necessary and reasonable, initiate an appropriate plan of treatment under the order of the physician.
2. A clean, safe, healthy environment and proper infection control procedures as determined by clinical guidelines.
3. Assessment of functional levels using appropriate evaluative techniques.
4. Protection of privacy and confidentiality. Photography, video recording or audio recording of any kind, by a patient or USA Health employee, is strictly prohibited within the premises of any USA Health facility without permission of the Facility Director and documented consent of the patient. This policy is in place to protect patient privacy, enhance confidentiality, and maintain security.
5. Patient teaching and/or family education as each individualized treatment process from his/her admission through discharge.
6. Inclusion of the patient and patient's family in the rehabilitation treatment process from his/her admission through discharge.
7. Orientation to rehabilitation services including the physical setting, expectations, outcomes, treatment programs and scheduled therapy services.
8. Be treated with consideration, respect and full recognition of dignity and individuality.
9. Voice grievances regarding treatment or care that is (or fail to be) furnished or regarding the lack of respect by anyone furnishing services and must not be subjected to discrimination or reprisal for doing so. Grievances may be reported to the Clinical Director or the Patient Relation Department. The Patient Relation Department number is (251) 471-7127.

I have read and fully understand my above patient rights.

Patient's Name (Printed): _____

Patient's Signature: _____ Date: _____

USA HEALTH

Updated 5/14/2021

No-Show/Cancellation Policy

USA Health's mission is to provide you with the best health care in order to return you to your normal activities as soon as possible. Therefore it is our policy that three (3) consecutive "No Show" visits or a total of six (6) cancellations and/or "No Shows" may result in discontinuation of treatment and patient discharges as well as physician notification of non-compliance.

I also understand that my therapist schedules their appointments to minimize patient wait time. I understand that if I am late for my appointment this may result in my treatment being shortened or may necessitate rescheduling my appointment in order not to affect other patient's appointment time. If I am unable to keep an appointment I will notify the office in order to reschedule my appointment.

I understand if I cannot make my appointment that I need to call at least two hours in advance to cancel. USA Health reserves the right to charge for any non-cancelled appointment. I give you permission to remind me of appointments via call, text or voicemail message.

I agree to schedule my follow-up appointments at the front desk weekly. I also understand the importance of notifying my therapist of any referring physician appointments.

I understand the above policy and agree to comply.

Patient Signature: _____ Date: _____