GENERATIONS R.C., INC.

Generations Physical Therapy

304-760-5660

Date________________________________ Patient Number______________________________

Patient Information

Name____ Date of Birth____________ Age________

Street Address (or PO Box)______________________________ City__________ State_____ Zip_______

Home &/or Cell Phone ______________________________ Work Phone______________ EXT______

Employer Name & Address____

Social Security # ____________________ Marital Status: (M) (S) (D) (W) Student Status: (P) (F) Sex: (M) or (F)

Primary Care Physician________________________ Location______________ Phone______________

How did you hear about our facility? ______________________ Email Address________________________

For Exercise Correspondence

Medical Information

Return to referring doctor date______________ Nature of Injury / Accident ________________________

Attorney Name____________________________________ Phone____________________________

Accident Date________________________________ Do you have a Letter of Protection? Y or N

Diagnosis/Symptoms________________________________ Precautions____________________________

Have you had any physical, speech, occupational, chiropractic treatments this year? Yes or No

Insurance Information

Primary Insurance________________________ Address____________________________________

Policy Number________________________________ Group Number____________________________

Name of Card Holder____________________________ SSN________________ Date of Birth__________

Card Holder Employer, Address, and Phone____

Secondary Policy____________________________ Address____________________________________

Policy Number________________________________ Group Number____________________________

Name of Card Holder____________________________ SSN________________ Date of Birth__________

Employer, Address, and Phone____

Emergency Information: In case of emergency notify the following people

1.____________________________________ Relationship________________ Phone____________________

I hereby consent to treatment by Generations Physical Therapy and authorize the release of any and all information acquired in the course of my treatment or dealing in any manner with my treatment, including, but not limited to medical records, electronic media, oral communicationsor other information of any type to my insurance company, employer or other third party payor. I agree to hold Generations Physical Therapy harmless from the release of any of the above information. I realize that I have the right to any refuse any procedure after having the risks and benefits explained to me.

I authorize payment to be made directly to Generations Physical Therapy for all services rendered.

Patient /or Authorized Representative____ **Date**______________

Authorization for Treatment

Physical therapy is a patient care service provided in response to a wide range of medical care needs of outpatients of all ages regardless of gender, color, race, creed, national origin, or disability, five days a week.

The purpose of physical therapy is to treat disease, injury, and disability by evaluation, examination, testing, and use of rehabilitative procedures, manipulations, massage, exercise, and physical agents including, but not limited to, mechanical devices, heat, cold, air, light, water, electricity, and sound in the aid of diagnosis or treatment; to prevent or minimize residual and mental disability; to aid the patient in achieving their maximum potential within their capabilities; and no accelerate convalescence and reduce the length of the functional recovery. Physical Therapy practice includes, but is not limited to, the use of: Electromyography (EMG) tests, Nerve Conduction Velocity (NCV) tests, Thermography, Transcunaneous Electrical Nerve Simulation (TENS), bed traction, application of topical medication to open wounds, sharp debridement, provision of soft goods, inhibitive casting and splinting, Phonophoresis, Iontophoresis, and Biofeedback services. All procedures will thoroughly be explained to you before you are asked to perform them.

You are not expected to experience any increase in your current level of pain or discomfort. You should attempt to stop each procedure before you experience any increase in your current level of pain or discomfort.

You are expected to cooperate fully with the evaluation and stop any test or treatment before any increase in your current level of pain or discomfort. Because of the nature of services provided, you may be asked to disrobe or partially disrobe. If this is necessary, your privacy, modesty, and dignity will be considered at all times by the staff. Should you feel uncomfortable or embarrassed, you may refuse the procedure, stop the procedure an/or request another therapist.

There are certain inherent risks with Physical Therapy treatment because you will be asked to exert effort and perform activities with increasing degree of difficulty, which could cause an increase in your current level of pain or discomfort, or an aggravation to your existing injury. There is also a possibility that you could experience a new injury, but this risk is small. You will be able to control any procedure by stopping if you feel any increase in pain or discomfort. You will also be able to stop treatment if you feel any discomfort in any other part of your body. The Physical Therapist or Physical Therapist Assistant will take every precaution to ensure that you are protected from any potentially hazardous situation. You will never be forced to perform any procedure, which you do not wish to perform.

Because of the nature of the procedures performed within the clinical setting, your communication with family and friends may be restricted. The department reserves the right to restrict visitors and outside communication at any time during your treatment sessions to ensure you receive the maximum therapeutic value from treatment. The law requires all staff members to report any evidence of abuse, neglect, and/or exploitation of patients. Should you wish to file a complaint or grievance for any reason, you will be provided, in written form, with the names and addresses of appropriate individuals and protective agencies and, if necessary, be given appropriate privacy to complete your communication with those individuals/agencies.

Based on the above information, I agree to cooperate fully and to participate in all physical therapy procedures and to comply with the plan of care as it is established. I acknowledge that I have read and received copies of the Authorization for Treatment and Patient's Rights and Responsibilities, and authorize release of medical information to appropriate third parties.

Also, to the best of my knowledge, I am NOT currently pregnant or receiving or have ever received treatment for any malignancies.

NOTICE TO PATIENTS:

For your personal safety, do not use any equipment without a staff member present. For your protection, random audio and video surveillance may be conducted in this facility in accordance with applicable State and Federal laws.

Date____________________ **Patient Signature**____

Date____________________ **Witness**____

Generations R.C., Inc.

dba/Generations Physical Therapy

This is the supplement to the form that allows us to bill your insurance company or personal injury case.

ASSIGNMENT, LIEN AND AUTHORIZATION re: INSURANCE BENEFITS AND ATTORNEY

To Whom It May Concern:

I hereby authorize and direct you, my insurance company and/or my attorney, to pay directly to

Generations R.C., Inc., such sums as may be due and owing this office for services rendered me, both by reason of accident or illness and by reason of any other bills that are due this office and to withhold such sums from any disability benefits, medical payment benefits, no-Fault benefits, health and accident benefits, Worker's Compensation benefits or any other insurance benefits obligated to reimburse me or from any settlement, judgment or verdict on my behalf as may be necessary to adequately protect said office such sums as may be due and owing this office for services rendered me. I hereby further give a lien to said office against any and all insurance benefits named herein of the injuries or illnesses for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event that the insurance company obligated to make payment to me upon the charges made by this office for their services refuses to make such payment, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor against such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further if authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due the office for their services. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office to await payment and they may demand payments from me immediately upon rendering services at their option.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under the Assignment, Lien and Authorization. I agree that the above-mentioned office be given power of Attorney to endorse/sign my name on all checks for payment of my therapist bill.

I further understand and agree, that if this office must take any action to collect an outstanding balance on my account, I will be responsible for payment of and will reimburse this office for all cost of such collection efforts, including but not limited to all court cost and all attorney fees.

Patient:______________________________ **Date:**________________

Witness:______________________________ **Date:**________________

Health History Questionnaire

Patient Name ______________________________ PT ID# ______________

When is your next appointment to your referring physician? ______________

Are you presently off from work secondary to your current condition? Yes or No

Please list al medications you are currently taking.

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Health History:

List any operations you have had including date or any complications.

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Explain any other health history you feel may be important in your care. (Allergies, Pacemaker, Pregnancy, etc.)

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Weight______________ Height______________

Do you use tobacco?______________

Do you drink alcohol?______________

Have you ever been treated for substance abuse?______________

____

Generations R.C., Inc.

dba/Generations Physical Therapy

We need authorization to bill your insurance company rather than billing you directly. This form provides that permission.

In case of personal injury litigation or motor vehicle accident litigation, we also need a Letter Of Protection by your attorney. If we have no Letter Of Protection from your attorney some state laws regarding subrogation require that we must bill you directly and therefore we must have full payment at the time of each office visit.

ASSIGNMENT OF INSURANCE BENEFITS AND STATEMENT OF SERVICE

I hereby authorize and assign payment made directly to Generations R.C., Inc., of the covered insurance benefits, including major medical benefits, whether payable to me by Blue Cross Blue Shield, Medicare, Worker's compensation, and/or commercial insurance companies. I understand that my health insurance provider may not cover part or all of the medical services rendered, and I fully understand that I am financially responsible for and agree to pay all charges not paid by my health care coverage, including deductibles, coinsurance, and payments from insurance companies sent directly to me.

This assignment shall apply to all medical services now rendered and to be rendered in the future until this authorization and assignment is revoked.

I have listed below the names of all my health insurance providers including tie-in coverage and I represent that such health care coverage is in full force and effect at this time.

If prior authorization or certification for medical services is required under my health care coverage, I agree to obtain and furnish such authorization or certification.

I authorization the release of medical information as may be required to process the claims for payment of the medical services rendered and it is expressly understood that the right of such information to be privileged is hereby waived.

I agree to promptly notify your office of any changes of address, phone number or insurance carrier.

A copy of this assignment shall be considered as valid as the original.

X______________________________	X______________________________
Signature of Patient or Guardian Date	Signature of Policy Subscriber Date
Social Security Number______________	Social Security Number______________
Employer-Firm______________	Employer-Firm______________
Insurance company______________	Insurance Company______________
Certificate or Policy#______________	Certificate or Policy#______________
Group/Individual______________	Medicare Number (If applicable)______________

GENERATIONS R.C., INC.

dba/Generations Physical Therapy of Barboursville, Milton, Teays Valley and Winfield

PF-2000 **Acknowledgement of Receipt of Notice of Privacy Practices**

Generations R.C., Inc. reserves the right to modify the privacy practices outlined in the notice.

Signature
I have received a copy of the Notice of Privacy Practices for Generations R.C., Inc..

____

Name of Patient (Print or Type)

____

Signature of Patient

____

Date

____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

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Relationship of Patient Representative to Patient

GENERATIONS R.C., INC.

dba/Generations Physical Therapy of Barboursville, Milton, Teays Valley, and Winfield

Individual Rights
You have certain rights under the federal privacy standards. These include:

~ The right to request restrictions on the use and disclosure of your protected health information

~ The right to receive confidential communications concerning your medical condition and treatment

~ The right to inspect and copy your protected health information

~ The right to amend or submit corrections to your protected health information

~ The right to receive an accounting of how and to whom your protected health information has been disclosed

~ The right to receive a printed copy of this notice

Generations R.C., Inc., Duties
We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice

Right to Revise Privacy Practices
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting an Office Assistant, Office Manager or Privacy Officer. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints
If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Generations R.C. Inc.
PO Box 219
Milton, WV 25541

If you believe that your privacy rights have been violated you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated for filing a complaint.

Contact Person
The name and address of the person you can contact for further information concerning our privacy practices is:

Generations Physical Therapy Privacy Officer
PO Box 219
Milton, WV 25541
304-733-9560

patient keeps!

This Notice of Privacy Practices is effective on or after April 14, 2003.

GENERATIONS PHYSICAL THERAPY

Barboursville ∘ Grayson ∘ Milton ∘ Teays Valley ∘ Winfield
Generationsphysicaltherapy.com
Phone: 304-760-5660
Fax: 877-487-5660

My name is Dr. Travis Tarr, as a physical therapist I serve as the director of rehabilitation services for Generations Physical Therapy. My family and I are pleased to know that you have recently chosen Generations to assist you with your rehab needs. I wanted to take this opportunity to introduce myself as well as extend a warm welcome to you on behalf of my family and our exceptional rehab team. The top priority of Generations is to provide you with a very comforting and respectful environment that meets your personal goals of rehab. Should you have any questions or concerns at anytime please feel free to speak to your physical therapist or contact me directly.

We take the utmost pride in meeting the physical therapy needs of our community and any feedback either positive or constructive is welcomed to assist us in continuing with the top level care you expect and deserve from our company. Once again, thank you for allowing us the opportunity to provide physical therapy services for you and have a wonderful day.

Sincerely,

Travis W. Tarr, PT, DPT
Doctor of Physical Therapy
Director of Rehabilitation Services
Senior Vice-President, Generations R.C., Inc.
P.O. Box 219, Milton, WV 25541
304-760-5660
t.tarr@generationspt.com

GENERATIONS PHYSICAL THERAPY