Tuttle Rehab

Patient Information: Date:_____

Name:_____ ☐ Male ☐ Female Age:_____

Address:_____ City:_____ St____ Zip_____

Ht:____ Wt:____ Birth date:_____ SS#:_____ Telephone:_____

(circle one) Married Single Widowed Divorced Have you been here before? ☐ Yes ☐ No

Family Physician:_____ Referred by:_____

Address:_____ Address:_____

_____ _____

Employment Information:

Company:_____ Telephone:_____

Address:_____ City:_____ St:____ Zip:_____

Type of work:_____ Contact person:_____

Spouse Information:

Name:_____ DOB:_____ Age:_____

Address:_____ City:_____ St:____ Zip:_____

SS#:_____ Telephone:_____ Employer:_____

Responsible Party Information:

Name:_____ DOB:_____ Age:_____

Address:_____ City:_____ St:____ Zip:_____

SS#:_____ Telephone:_____ Employer:_____

Relationship to patient:_____

Tuttle Rehab

Patient History

Name:_____ Age:_____ Sex (M or F) Hand Dominance (R or L)

Occupation:_____Referring M.D. or Hospital_____

HISTORY OF PRESENT ILLNESS OR INJURY

1. Chief complaint and location of pain?_____

2. When did this occur?_____Work related? (Y or N)

3. How did injury occur?_____

4. When is it painful?_____

5. What makes it worse?_____

6. What makes it better?_____

7. Have you seen another physician for this condition? If so, what was the treatment?

_____

8. Have you had any tests (x-rays, nerve studies, MRI, other) for this problem? If yes, list date and place.

_____

9. Have you missed work? Yes or No If yes, last date worked_____

Medical Problems (your health issues)

- ☐ None
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Diabetes
- ☐ Asthma
- ☐ Thyroid Disease
- ☐ Other_____
- ☐ Acid Reflux
- ☐ Cancer
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Peptic Ulcer Disease

Allergies to Medications

- ☐ None
- ☐ Penicillin
- ☐ Sulfa
- ☐ Aspirin
- ☐ Codeine
- ☐ Other_____

Surgical History

_____ date _____
_____ date _____
_____ date _____
_____ date _____
_____ date _____
_____ date _____

Medications

_____
_____
_____
_____
_____
_____

Family History

- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ Cancer
- ☐ Arthritis
- ☐ Stroke

Social History

Smoking: ☐ No ☐ Yes_____pks/day

Alcohol:

☐ none ☐ occasional ☐ frequent

Height:_____ Weight:_____

Are you on blood thinners? (Y or N)

To the best of my knowledge, the information provided above is accurate.

Patient/Responsible Party Signature:_____Date:_____

Tuttle Rehab

Patient Information (pg 2)

Insurance Coverage Information (primary)

Subscribers Name:_____ Date of Birth:_____

☐ BWC ☐ Medical Mutual ☐ Anthem ☐ UHC ☐ Medicare ☐ Other_____

ID number:_____ Group number:_____

Industrial case: Date of Injury:_____ Self Insured:_____ Claim #_____

MCO:_____ Group number:_____

Insurance Coverage Information (secondary)

Subscribers Name:_____ Date of Birth:_____

☐ BWC ☐ Medical Mutual ☐ Anthem ☐ UHC ☐ Medicare ☐ Other_____

ID number:_____ Group number:_____

PAYMENT AUTHORIZATION

☐ I AUTHORIZE TUTTLE REHAB TO RELEASE TO MY INSURANCE COMPANY ANY INFORMATION NECESSARY TO PROCESS INSURANCE CLAIMS ON MY BEHALF.

☐ I REQUEST THAT ALL PAYMENTS OR BENEFITS FOR SERVICES RENDERED BY TUTTLE REHAB BE PAYABLE TO, SENT TO TUTTLE REHAB.

☐ I REALIZE THAT I AM ULTIMATELY RESPONSIBLE FOR PAYMENT OF THESE CHARGES AND THE BALANCE NOT COVERED BY MY INSURANCE WILL BE MY RESPONSIBILITY.

Acknowledgement

Patient's Full Name:_____

Email Address:_____

Signature:_____ Date:_____

Tuttle Rehab

FINANCIAL POLICY

Thank you for choosing our practice! We are committed to the success of your medical treatment and care. Please understand that payment of your bill is part of this treatment and care. If your treatment is not being covered by your insurance (BWC, Private Insurance, or Personal Injury), please read and complete this form.

Tuttle Rehab is aware of the economic challenges that face our community. We are committed to providing quality healthcare. As part of providing quality services, making financial arrangement is also necessary.

Payment is expected at the time of treatment. However, if you are unable to pay your balance in full, we have set up guidelines to help you clear your balance.

- $50 balance or less: Entire balance due first month.
- $51-$500 balance: $50 minimum monthly payment.
- $501-$1000 balance: $100 minimum monthly payment.
- $1001-2500 balance: $200 minimum monthly payment.
- Over $2,500 balance: 10% of balance due each month

FINANCE CHARGES: A finance charge will be imposed on each item on your account which has not been paid within sixty (60) days of the time of service or charge to account. The finance charge will be computed at the rate of one percent (1%) per month or an annual percentage rate of twelve (12%) percent.

RETURNED CHECKS: There is a fee of $25 for any checks returned by the bank.

TRANSFERRING OF RECORDS: You will need to request in writing and pay a reasonable copying fee of $25 to have copies of your records sent to another doctor or organization.

PERSONAL INJURY: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your visit. Payment of the bill remains the patient's responsibility.

Acknowledgement

I understand that payment is due by my next scheduled appointment or the 1st of each month. I also understand that failure to follow the agreed upon payment arrangement will result in Tuttle Rehab refusing to continue treatment and further action for the full amount of the charge.

Patient's Full Name:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

Tuttle Rehab

RECIEPT OF NOTICE OF PRIVACY PRACTICES

Patient Information:

Patient Name:_____

Date of Birth:_____Social Security Number_____

Acknowledgement

I hereby acknowledge that on _____ (date) I was advised and offered a copy of the Privacy Practices from Tuttle Rehab, which sets forth the ways in which my personal health information may be used or disclosed by Tuttle Rehab, and outlines my rights with respect to such information.

Patient's Full Name:_____

E-mail Address:_____

Signature:_____Date:_____

Guardian Signature for minor:_____Date:_____

Authorization Representative of Patient:_____Date:_____