AUTO/PERSONAL INJURY INSURANCE & YOUR CARE

We are happy to help you after your accident! Receiving treatment after an accident can be essential for your complete and quick recovery. We understand that arranging for your treatment and payment can be confusing, so we've put together this quick guide to automobile and personal liability insurance.

MEDICAL INSURANCE COVERAGE THAT MAY APPLY TO YOUR SITUATION

Personal Injury Protection (PIP)

This is YOUR AUTO INSURANCE COVERAGE. In the state of Texas, every driver has PIP as part of his or her basic automobile insurance policy, unless it is specifically declined in writing. PIP coverage is meant to cover medical coverage expenses related to an accident, whether or not it is your fault. PIP allows medical providers to obtain payment for your medical needs on a regular and ongoing basis, and will allow you to obtain medical treatment without paying your physician in advance out of your own pocket. A claim filed against your PIP coverage will not increase your insurance premiums, and money paid in PIP claims may be recovered at settlement from the liable party's insurance company. Speak with your attorney or insurance carrier for details.

Liability Insurance

This is THE RESPONSIBLE PARTY'S INSURANCE COVERAGE that will include the final settlement. This insurance may cover almost anything related to your accident, including damage to your car (in the case of auto accident), lost work hours, medical bills, etc. However, this insurance does not pay until you (and your attorney, if applicable) agree to settle with the responsible party's insurance company. This will leave you liable for medical bills and other expenses incurred in the meantime. Additionally, if your settlement is less than your medical bills, you will be liable for those bills. Many health care providers will require you to either post a deposit or pay all or part of your bill in advance.

Health Insurance

Your health insurance plan (depending on your specific rules of coverage) may be used to cover you in the event of an auto accident. Your health insurer will usually try to recover funds from the responsible party's insurance spent on your healthcare. Depending on your situation, this might be a reasonable alternative. On the other hand, you may wish to see a provider that's out of network, and may incur expenses due to deductibles or limitations of coverage that you would not otherwise encounter using some form of insurance.

ONGOING THERAPY AND ATTENDANCE

All of your therapy appointments are thoroughly documented to include treatment provided, your response to treatment, tardiness, no-shows, cancellations or other delays. To speed your recovery, please comply with your therapist's recommendations and adhere to your therapy schedule. If you have any problems regarding transportation, schedule conflicts with your employer, please notify us immediately so that we can attempt to resolve these with your employer or adjuster.

We must have a prescription or a signed plan of care for any injuries or body parts treated, so ensure that your physician is aware of all problems you are experiencing related to your accident. Your therapy will continue as long as you are making significant progress, and you can be reasonably expected to continue to make significant progress with additional therapy. In the event that your therapy does not result in significant progress, your therapist will make recommendations regarding other treatment options.

If you miss two or more appointments without 24-hour advance notice, a therapy discharge will be sent to your referring physician and adjuster, and you will be placed on "space available" basis. You will need to call on the day that you can attend therapy, and you will be given a choice of unbooked appointment times that day. A $35 no-show fee will apply to any therapy appointments missed without 24-hour advance notice on a Saturday or weekday immediately preceding a holiday.

I have read and understand the above information as it applies to my care.

Printed Name of Patient or Representative

Signature and Date

MVA/PI COLLECTION POLICIES & PAYMENT AGREEMENT

You must supply us with all insurance coverage that may be applicable to your situation.

PLEASE INITIAL YOUR SELECTION:

_____ **I instruct Terry Rehabilitation & Testing, Inc. to file claims with my Personal Injury Protection (PIP)** insurance carrier for my therapy expenses. If my PIP coverage is exhausted, please file claims with the responsible party's insurance, or with my health insurer with the terms set forth below.

_____ **I instruct Terry Rehabilitation & Testing, Inc. to file claims with the responsible party's insurance** carrier. I agree to a $60 copayment for my physical therapy care at the time of service, or $275 for FCE, EMG/NCS.

The remainder will be due immediately upon settlement with the responsible party's insurance company.

If represented by an attorney, a Letter of Protection may substitute for copayment, but will be considered on a case-by-case basis.

_____ **I instruct Terry Rehabilitation & Testing, Inc. to file claims with my personal health insurance carrier.**

This will be contingent on verification of eligibility and subrogation of benefits. I agree to pay all co-payments, estimated coinsurance, and deductibles at the time of service.

LIEN, SECURITY INTEREST, AND PAYMENT TERMS

Terry Rehabilitation & Testing, Inc. will have a security interest in, and lien on, all insurance proceeds payable by my insurance carrier or its intermediaries regarding the services rendered, as well as any claims and causes of actions relating to injuries for which physical therapy services are being provided, including, without limitation, the proceeds of any recovery whether by settlement, arbitration award or court judgment. Such security interest and lien will secure payments of all amounts now or hereafter owing by me to Terry Rehabilitation & Testing, Inc. for services rendered to me.

I agree that my therapy bills will be paid directly by the insurance company, and will instruct them to do so both verbally and in writing. I will be liable for any collection fees, legal fees, or court costs should I: instruct them otherwise; fail to provide full insurance coverage or attorney information; fail to provide required information to my insurance carrier(s); fail to notify Terry Rehabilitation & Testing, Inc. upon receipt of any insurance funds intended to pay for therapy.

If I am represented by an attorney, I will provide that information at my first appointment or as soon as I retain one, and extend a Letter of Protection regarding my therapy bills.

I understand that I am ultimately liable for all therapy-related costs.

Printed Name of Patient or Representative

Signature and Date

Please provide your health insurance card as well as any other proof of insurance, as applicable.

Personal Injury Protection Coverage		Company:	
Subscriber Name:		Phone:	
Phone:		Policy #:	
Relationship:		Claim #:	
Responsible Party Coverage		Company:	
Subscriber Name:		Address:	
Address:		City:	
City:		State:	Zip:
State:	Zip:	Phone:	
Phone:		Policy #:	
Relationship:		Claim #:	

Terry Rehabilitation & Testing

Physical Rehabilitation and Functional Testing Services

Section One – Patient Information			
Legal Name:		Date of Birth:	
Nickname (name you go by):		Social Sec #:	
Address:		Primary Phone:	
City:		Secondary Phone:	
State:	Zip:	Email Address:	

Terry Rehabilitation may send the following via email:
☐ Appointment Reminders ☐ Statements ☐ Receipts ☐ Care Program Items (exercises, instructions, etc)

How did you hear about Terry Rehabilitation? (mark all that apply)

☐ Your Physician:	☐ Family	☐ Friend:
☐ Current/Former Patient:	☐ Newspaper	☐ Insurance Company:
☐ Internet	☐ Drove By	☐ Other:

Section Two – Emergency Contact Information	
Name:	Primary Phone:
Relationship:	Secondary Phone:

Section Three – Physician Information			
Referring Physician:		Primary Care Physician (if not the referring physician):	
City/State:	Phone:	City/State:	Phone:

Date of your next physician follow-up appointment for this problem:

Automobile/Personal Injury Claim and Attorney Details (REQUIRED)			
Date of Injury:		Cause of Injury:	
Attorney:		Firm:	
Phone:		Fax:	
Address:		City:	Zip:

Section Six – Applicable Insurance Information	
This is my: ☐ Primary ☐ Secondary Insurance Coverage	This is my: ☐ Primary ☐ Secondary Insurance Coverage
Insurance Name	Insurance Name
Insured Name/Relationship (if not patient)	Insured Name/Relationship (if not patient)
This is my: ☐ PIP ☐ 3rd Party ☐ Health Insurance	This is my: ☐ PIP ☐ 3rd Party ☐ Health Insurance

The information that I have given above is complete, true, and accurate to the best of my knowledge. I agree to give immediate notice of any changes to the above information to Terry Rehabilitation & Testing, Inc.

Printed Name of Patient or Representative

Signature/Date

MEDICAL HISTORY AND SCREENING FORM

Today's Date:	Age:	Name:
Height:	Weight:	Occupation:

Please describe the problem(s) that bring you here today:

Please list all previous treatments for this problem:

Please list activities and hours involved in your occupation (sitting, standing, walking, lifting):

Please list sports, hobbies, or other activities, and frequency/hours normally involved:

Do you or a family member have a history of:		**Have you recently had or do you experience:**	
Cancer	☐Self ☐Family	A recent change in your health	☐Yes ☐No
Diabetes	☐Self ☐Family	Nausea or vomiting	☐Yes ☐No
High Blood Pressure	☐Self ☐Family	Fevers, chills, or sweats	☐Yes ☐No
Heart Disease	☐Self ☐Family	Unexplained weight loss	☐Yes ☐No
Angina/Chest Pain	☐Self ☐Family	Numbness or tingling	☐Yes ☐No
Stroke	☐Self ☐Family	Changes in appetite	☐Yes ☐No
Osteoporosis	☐Self ☐Family	Difficulty swallowing	☐Yes ☐No
Rheumatoid Arthritis	☐Self ☐Family	Changes in bowel or bladder function	☐Yes ☐No
Do you have a history of:		Shortness of breath	☐Yes ☐No
Allergies/asthma	☐Yes ☐No	Dizziness	☐Yes ☐No
Headaches	☐Yes ☐No	**Are your symptoms:**	
Bronchitis	☐Yes ☐No	☐ Unchanging ☐ Getting Worse ☐ Getting Better	
Kidney Disease	☐Yes ☐No	**How are you able to sleep at night?**	
Rheumatic Fever	☐Yes ☐No	☐ Fine ☐ Moderate Difficulty ☐ Only with Medication	
Ulcers	☐Yes ☐No	**Do you have a problem with:**	
Are you currently:		☐ Hearing ☐ Vision ☐ Speech/English	
Depressed or under stress	☐Yes ☐No	**Date of last physical examination:**	
Pregnant	☐Yes ☐No	**Any recent infections?** ☐Yes ☐No	

Please list your current medications:

Please list previous orthopedic (back, neck, hip, knee, etc) injuries or surgeries:

Please list any other information you would like your therapist to know:

Signature of ☐Patient or ☐Guardian: _____

Consent to the Use and Disclosure of Health Information (PHI) for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment I understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I request the following additional restrictions to the use or disclosure of my health information:

I have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent, and that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

Printed Name and Signature of Patient or Legal Guardian:	Date:

Assignment of Benefits

I authorize Terry Rehabilitation & Testing, Inc to furnish complete information to my insurance carrier or its intermediaries regarding the services rendered. I hereby authorize Terry Rehabilitation & Testing, Inc to submit a claim to my insurance carrier or its intermediaries for all services rendered and authorized, and direct my insurance carrier or its intermediaries to issue payment(s) directly to Terry Rehabilitation & Testing, Inc.

I understand that I am financially responsible for, and will be billed for by Terry Rehabilitation & Testing, Inc, any eligible balances remaining on my account, which are unpaid by my insurance carrier such as: co-payments, co-insurance, deductibles, etc; collection, legal fees, and court costs if my account is referred to a collection agency or attorney due to non-payment.

Signature of Patient or Legal Guardian:	Date:

Any clarification regarding the above statements should be addressed before signing this form.