YOUR MEDICAL CARE FOR WORK-RELATED INJURIES

PAYMENT OF MEDICAL EXPENSES FOR A WORK-RELATED INJURY

As a worker injured on the job, payment of medical expenses for your medical expenses will either come directly from your employer, through your employer's workers' compensation insurance company, or from a combination of both. In order for your therapy expenses to be covered, the injury must be judged to be work-related and therapy expenses must be approved in advance (pre-authorized) by the payer.

PHYSICAL THERAPY EVALUATION AND PRE-AUTHORIZATION

You first physical therapy appointment will include the initial evaluation, and possibly minimal treatment – such as a home exercise to begin the recovery process. This appointment allows the therapist to develop a plan of care, which is then submitted to the payer for pre-authorization. This process protects you, our financial interests, and allows all involved parties to participate in care planning.

In most cases, the payer has three business days to respond to our pre-authorization request, not including the day in which the therapy evaluation and plan of care are received. For example, if you come in on a Monday morning for evaluation, we may not receive an authorization decision until Friday morning. We will then notify you of that decision and schedule a therapy appointment as soon as possible.

Occasionally there are delays in the authorization process. When our suggested plan of care does not conform to Official Disability Guidelines (ODG) for your specific injury, your payer may want to speak with your treating physician or therapist before authorizing care. Other delays outside of our control may occur if you or your employer have provided inaccurate information, or your employer or payer do not respond in a timely fashion. Therefore, we suggest that you double-check all of your information (date of injury, claim number, employer contact number, adjuster name and contact number, etc) and make contact with all interested parties to ensure your care goes as smoothly as possible.

CONTINUING 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.

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. Your therapist may need to request additional therapy visits past your initial authorization (re-authorization) which may introduce a delay in care while the issue is consider by your payer. In the event that your therapy is stopped prior to full resolution of your problem, 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.

In the event that your injury is found not to be work-related, we will be happy to treat you utilizing any other insurance coverage or payment at the time of service. Please provide us with any health insurance coverage you would like to utilize in that situation.

I have read and understand the above information as it applies to care for my work-related injury.

Printed Name of Patient or Representative

Signature and Date

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/Clinic Information			
Referring Clinic/Physician:		Primary Clinic/Physician (if not the referring physician):	
City/State:	Phone:	City/State:	Phone:

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

Section Four – Employer's Contact Information		
Employer:	Contact Person:	
Address:	Phone Number(s):	
City:	State:	Zip:

Section Five – Accident Information
The date of my injury was:

Please describe how your injury occurred:

The information that I have given above is complete, true, and accurate to the best of my knowledge. I believe the injury described above is work-related. I understand that if the problem I am receiving treatment for is determined not to be work-related, I may pursue treatment using my health insurance or personal finances. I agree to give immediate notice of any changes to the above information, as well as immediate notice should I decide to obtain legal representation to Terry Rehabilitation & Testing, Inc.

Printed Name _____ 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.