EDGE Rehabilitation and Wellness,LLC
2150 Hollow Brook Dr., Suite 100, Colorado Springs, CO 80918
Tel: 719-599-5330 / Fax: 719-599-5438

PATIENT INFORMATION

Patient Name: _____Date: _____

Date of Birth: _____Social Security #: _____

Home phone: _____Work phone: _____

Home address: _____Zip Code:_____

Emergency Contact Name: _____Phone: _____

Referring physician: _____ Primary care physician: _____

We offer the option to have reminder notifications regarding your appointment sent to your email address or cell phone through a text message. Please advise below if you would like to take advantage of either of these options.

Email Address:_____ Text Message:_____

CURRENT INJURY/COMPLAINT

Date of injury:_____ Diagnosis from doctor:_____

Surgery: ☐/☐ If yes, date: _____ Procedure:_____

Pain scale from 0-10 (no pain to severe): _____ Aggravating Activities:_____

Symptoms improved by:_____

Diagnostic tests: (x-rays, MRI,etc)_____

Previous treatment, if any:_____

Goals:_____

Is there any reason, physical or otherwise, why you should not participate in a therapy program? _____

_____

INFORMED CONSENT

I, the undersigned, do hereby agree and give my consent for **Edge Rehabilitation and Wellness, LLC** to furnish physical therapy care and treatment to:

_____

I acknowledge that this treatment is considered necessary and proper and that no guarantees or assurances can be given.

Patient signature:_____ Date: _____

Guardian signature (if needed): _____ Date:_____

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MEDICAL HISTORY

Date: _____

Patient Name: _____Sex: _____ Height: _____ Weight: _____

Activity level (please circle): Very Active Active Minimal Activity Sedentary

Currently Working: Y/N Employer:_____

Past Medical History: Do you have any history of the following? Please explain any **Yes** answers.

	Yes	No		Yes	No
Allergies	___	___	Hepatitis	___	___
Anemia	___	___	High blood pressure	___	___
Anxiety	___	___	Incontinence	___	___
Arthritis	___	___	Kidney Problems	___	___
Asthma	___	___	Metal Implants	___	___
Cancer	___	___	Multiple Sclerosis	___	___
Cardiac conditions	___	___	Osteoporosis	___	___
Cardiac pacemaker	___	___	Parkinson's	___	___
Chemical dependency	___	___	Rheumatoid arthritis	___	___
Circulation Problems	___	___	Currently Pregnant	___	___
Gall Bladder problems	___	___	Seizures	___	___
Depression	___	___	Speech problems	___	___
Diabetes	___	___	Strokes	___	___
Dizzy Spells	___	___	Thyroid Disease	___	___
Emphysema/Bronchitis	___	___	Tuberculosis	___	___
Fractures	___	___	Vision problems	___	___

Explanations of symptoms listed Yes above: _____
_____

	Yes	No	
Do you smoke?	___	___	Amount:_____
Do you consume alcohol?	___	___	Amount:_____

Please list or present copy of all medications currently taking:

Name	Dosage	Frequency	Route
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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Assignment of Benefits to Edge Rehabilitation and Wellness, LLC

Patient Name:_____

Insurance Policy #:_____

Insured Name:_____

Claim #_____

I hereby instruct and direct _____ insurance company to pay by check made out and mailed to:

Edge Rehabilitation and Wellness,LLC
2150 Hollow Brook Dr., Suite 100
Colorado Springs, CO 80918
719-599-5330

If my/this current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and **mail it to the above address** for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Initial each and sign at the bottom)

[ ] A photocopy of this Assignment shall be considered as effective and valid as the original.
[ ] I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
[ ] I authorize the use of this signature on all insurance submissions.
[ ] I authorize Edge Rehabilitation & Wellness, LLC to deposit checks made in my name.
[ ] I authorize Edge Rehabilitation & Wellness,LLC to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
[ ] I understand that I am financially responsible for all charges whether or not paid by insurance.

Your insurance is a contract between you and your insurance company. As a courtesy to you, we will bill most insurance companies for the services provided. We cannot guarantee the coverage of your particular plan and it is your responsibility to verify your insurance coverage. As well, it is your responsibility to pay the deductible, co-insurance, and other balances not paid by your insurance company. Unless prior arrangements have been made, **you agree to pay the charges within 30 days after receipt of statements**. In the event legal action is necessary to collect an unpaid balance, you will be responsible for costs for collecting monies owed, including court, collection agency, and attorney fees.

The information provided on this form is hereby certified by me to be true and correct. I agree to let **Edge Rehabilitation and Wellness, LLC** know of any changes to the information contained herein. I have read all information completely and understand it.

Patient/Responsible Party Signature: _____Date: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Edge Rehabilitation and Wellness, LLC **is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.**

Disclosure of Your Health Care Information

Treatment
We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations. (example)

> ***"On occasion, it may be necessary to seek consultation regarding your condition from other health care providers associated with Edge Rehabilitation and Wellness, LLC""***
>
> ***"It is our policy to provide a substitute health care provider, authorized by Edge Rehabilitation and Wellness, LLC to provide assessment and/or treatment to our patients, without advanced notice, in the event of your primary health care provider's absence due to vacation, sickness, or other emergency situation."***

Payment
We may disclose your health information to your insurance provider for the purpose of payment or health care operations. (example)

> **"*As a courtesy to our patients, we will submit an itemized billing statement to your insurance carrier for the purpose of payment to Edge Rehabilitation and Wellness, LLC for health care services rendered. If you pay for your health care services personally, we will, as a courtesy, provide an itemized billing to your insurance carrier for the purpose of reimbursement to you. The billing statement contains medical information, including diagnosis, date of injury or condition, and codes which describe the health care services received."***

Workers' Compensation
We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies
We may disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency or of your death.

Public Health
As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings.
We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement.
We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Deceased Persons.
We may disclose your health information to coroners or medical examiners.

Organ Donation.
We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.

Research.
We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board.

Public Safety.
It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies.
We may disclose your health information for military, national security, prisoner and government benefits purposes.

Marketing.
We may contact you for marketing purposes or fundraising purposes, as described below: (example)

> ***"As a courtesy to our patients, it is our policy to call your home on the evening prior to your scheduled appointment to remind you of your appointment time. If you are not at home, we leave a reminder message on your answering machine or with the person answering the phone. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."***
>
> *"It is our practice to participate in charitable events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity. We will provide you with information about the*

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type of activity, the dates and times, and request your participation in such an event. It is not our policy to disclose any personal health information about your condition for the purpose of Edge Rehabilitation and Wellness, LLC sponsored fund-raising events."

Change of Ownership.
In the event that *Edge Rehabilitation and Wellness, LLC* is sold or merged with another organization, your health information/record will become the property of the new owner.

Your Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information. Please be advised, however, that *Edge Rehabilitation and Wellness, LLC* is not required to agree to the restriction that you requested.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that *Edge Rehabilitation and Wellness, LLC* amend your protected health information. Please be advised, however, that *Edge Rehabilitation and Wellness, LLC* is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- **You have a right to receive an accounting of disclosures of your protected health information made by *Edge Rehabilitation and Wellness, LLC***
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

Changes to this Notice of Privacy Practices
Edge Rehabilitation and Wellness, LLC reserves the right to amend this Notice of Privacy Practices at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, *Edge Rehabilitation and Wellness, LLC* is required by law to comply with this Notice.

Edge Rehabilitation and Wellness, LLC is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions about any part of this notice or if you want more information about your privacy rights, please contact: Matthew Marchman by calling this office at 719-599-5330. If Matthew Marchman is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

Complaints
Complaints about your Privacy rights, or how *Edge Rehabilitation and Wellness, LLC* has handled your health information should be directed to Matthew Marchman by calling this office at 719-599-5330 If is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

This notice is effective as of _____/_____/_____

I have read the Privacy Notice and understand my rights contained in the notice.

By way of my signature, I provide *Edge Rehabilitation and Wellness, LLC* with my authorization and consent to use and disclosed my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice

_____ _____
Patient's Name (print) Date

_____
Patient's Signature