Welcome

Non-Auto Accident Patient Information **Date** _____

Thank you for choosing complete Health and Rehabilitation for your health needs. If you have any challenges completing this form, please don't hesitate to ask for assistance. We're happy to help!

PATIENT INFORMATION

Name: _____ SS#: _____ Age: _____ DOB: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____ Mobile: _____ Email: _____
Sex: ☐ Female ☐ Male Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Separated
Emergency Contact: _____ Phone: _____

EMPLOYER INFORMATION

Employer: _____ Phone: _____
Employer's Address: _____
City: _____ State: _____ Zip: _____ Occupation: _____

INSURANCE INFORMATION

Health Insurance Provider: _____
Carrier Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
ID #: _____ Group #: _____

INJURY INFORMATION

Date Injured: _____ Time: _____ ☐ AM ☐ PM Place of Injury: _____
Have you missed work due to this injury? ☐ Yes ☐ No If yes, please give dates: _____
Have you returned to work? ☐ Yes ☐ No If no, why? _____ If yes, what date? _____

Give full description of how accident happened:
_____
_____
_____

Did you have: ☐ Fractures ☐ Cuts ☐ Abrasions ☐ Bruises

Were x-rays taken? ☐ Yes ☐ No Name of Hospital: _____
Have you seen other doctors for this injury? ☐Yes ☐No
Doctor's Name(s): _____
Have you had physical therapy? ☐ Yes ☐ No If yes, how often? _____

PAST MEDICAL HISTORY

Any previous Auto Accident Injuries? ☐ Yes ☐ No Date(s) of previous injuries: _____

Prior to this accident, have you ever had any physical complaints similar to what you are having now?

☐ Yes ☐ No If yes, please explain: _____

Have you had any other serious accidents, which required medical care? Yes No

If yes, please describe: _____

List any surgeries/dates performed:

_____

Have you ever had any nervous or mental illness? ☐ Yes ☐ No Psychiatric care? ☐ Yes ☐ No

HEALTH HISTORY

Circle only those conditions which are applicable:

AIDS/HIV	Diabetes	Measles	Prosthesis
Alcoholism	Emphysema	Migraine Headaches	Psychiatric Care
Anorexia	Epilepsy	Miscarriage	Rheumatic Fever
Appendicitis	Glaucoma	Mononucleosis	Scarlet Fever
Arthritis	Gout	Multiple Sclerosis	Stroke
Asthma	Heart Disease	Mumps	Suicide Attempt
Bleeding Disorders	Hepatitis	Osteoporosis	Thyroid Problems
Breast Lumps	Hernia	Pacemaker	Tuberculosis
Cancer	Herniated Disc	Parkinson's Disease	Tumors, Growths
Chemical Dependency	High Cholesterol	Pinched Nerve	Ulcers
Chicken Pox	Kidney Disease	Polio	Whooping Cough
Depression	Liver Disease	Prostate Problems	Other_____

Women: Are you, or could you possibly be, pregnant? ☐ Yes ☐ No

Please list any medications you are currently taking including over the counter medication:

_____

_____

PATIENT CURRENT CONDITION

I currently have pain in my: ☐ Low Back ☐ Mid Back ☐ Upper Back ☐ L/R Arm ☐ L/R Leg ☐ Neck

My pain began: ☐ Gradually ☐ Suddenly I have pain: ☐ Occasionally ☐ Constantly

Pain goes into my: ☐ Right Leg ☐ Left Leg ☐ Both ☐ Right Arm ☐ Left Arm ☐ Both Arms

Tingling and/or numbness in my: ☐ Right Leg ☐ Left Leg ☐ Both Legs ☐ Right Arm ☐ Left Arm ☐ Both

I have: ☐ Neck Stiffness ☐ Headaches My headaches occur: ☐ Occasionally ☐ Constantly

My pain is worse when I: _____

My back is worse with sexual activity: ☐ Yes ☐ No

I have trouble sleeping due to my pain: ☐ Yes ☐ No Weather changes affect my pain: ☐ Yes ☐ No

Rate the severity of you pain: (1-mild pain/discomfort to 10-sever pain): 1 2 3 4 5 6 7 8 9 10

AUTHORIZATION

I certify that I have read and understand the above information to the best of my knowledge. I have discussed with the staff of complete Health & Rehabilitation any questions I may not have understood regarding the new patient paperwork. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

I clearly understand and agree that all services rendered to me are charged directly to the insurance carrier unless a Letter of Protection is in place. In the event that my Auto Accident claim is denied due to liability issues, I am solely responsible for all charges incurred for services rendered to me. I also understand that if I suspend or terminate my care, any fees for professional services rendered to me will be immediately due and payable.

_____ _____

Print Name Date

_____

Signature

COMPLETE HEALTH & REHABILITATION

NOTICE OF PRIVACY PRACTICES

This notice is to describe how personal health information about you may be used and disclosed during the course of diagnosis/treatment at Complete Health & Rehabilitation, and how you can access this information. Please review freely:

By law, complete Health & Rehabilitation is required to protect the privacy of your personal health information. Complete Health & Rehabilitation is also required to provide notice of how it may use and share this information in accordance with your care.

Complete Health & Rehabilitation must use and share your personal health information to provide information:

- To you or your legal representative
- To the Secretary of the Department of Health and Human Services, if necessary, to verify your personal health information has been protected.
- Where required by law

Complete Health & Rehabilitation has the right to use and share your personal health information during the course of normal healthcare operations, which may include, but are not limited to:

- Verifying insurance benefits, billing charges, and collecting payments from all payers
- Coordinating diagnosis and treatment with other health providers involved with your care

Complete Health & Rehabilitation may use and share your personal health information, under limited circumstances:

- With State and Federal agencies that have the legal right to receive such information (for funded programs such as Medicare/Medicaid)
- For public health activities (such as the reporting of disease out breaks)
- For government health care activities (such as fraud and abuse investigations)
- For judicial proceedings (such as in response to a court order)
- For law enforcement purposes (such as providing information to locate a missing person)
- In order to avoid serious, or imminent, threat to health or safety
- To contact and verify your identity regarding changes in the course of your treatment

By law, you have the right to:

- Review and receive a copy of your personal health information kept on file at Complete Health & Rehabilitation
- Have your personal health information revised if you believe it is incorrect, or if information is missing. Should Complete Health & Rehabilitation disagree with any revisions, you have the right to have a statement of disagreement added to your personal health information.
- Be provided with a list of those receiving your personal health information from Complete Health & Rehabilitation. This list will include all parties involved with your diagnosis and treatment.
- Have Complete Health & Rehabilitation communicate with you in different ways (by home phone, work phone, cell phone, email, PO Box, or home address)
- Ask Complete Health & Rehabilitation how your personal information is used and shared. Complete Health & Rehabilitation has the right to disagree with your request (ex: should it interfere with billing and collections). A statement of disagreement will be added with your personal health information.
- Be provided with a separate copy of this notice

Additional information regarding the protection of your personal health information can be found by calling The Department of Human Health and Services at 1-877-696-6775, or on the web at www.hhs.gov

COMPLETE HEALTH & REHABILITATION

PATIENT RIGHTS

1. You have the right to exercise your rights as a patient
2. You have the right to have your property treated with respect
3. You have the right to voice grievances regarding treatment or care that is furnished (or fails to be), or regarding the lack of respect for property by anyone who is furnishing services on behalf of this clinic and must not be subjected to discrimination for doing so.
4. You have the right to be informed in advance about the care to be furnished and of any changes in the care to be furnished. Notification of reduction of services or termination of services (discharge) will be given to you in writing at least five business days prior to implementation.
5. You have the right to participate in the planning of care and the planning of changes in the care of treatment.
6. You have the right to confidentiality of your clinical record maintained by the clinic. Unless required by law, information from your clinical record will not be released without your consent.
7. Before care is initiated, this clinic will inform you orally and in writing of:
    a. The extent to which payment may be expected from Medicare, Medicaid, Texas Worker's Compensation Commission, private insurance, or other federally funded or aided programs known to this clinic.
    b. The charges for services that will not be covered by any of the above
    c. The charges that you may have to pay.
8. This clinic will inform you orally, and in writing, of any known changes in these charges no later than thirty working days from the date this clinic becomes aware of these changes
9. Any complaints or questions in regards to this clinic may be telephone, toll free, to the TDH Medicare Hotline at 800.228.1570, Monday through Friday, during regular business hours. A recorder will answer at all other times. If you case is related to the Texas Workers' Compensation Commission, you may phone them at 512.707.5892. You may contact your physician or insurance company, or you can send complaints to the Texas Department of Health, 1100 West 49th Street, Austin, TX 78756. Non-Medicare patients should phone 512.834.6656.

_____ _____

Patient's Signature Date

_____ _____

Staff Signature Date

COMPLETE HEALTH & REHABILITATION

CONSENT FOR TREATMENT

Prior to my admission to the treatment program, the doctor and/or appropriate staff member has informed me in simple, non-technical terms of the following information:

- The specific condition to be treated
- The program's services and treatment process
- The expected benefits of the treatment
- The probable health and/or mental health consequences of not consenting to treatment
- Side effects and risks associated with the treatment
- Any generally accepted alternatives, and whether an alternative might be appropriate
- The qualification of the staff who will provide the treatment
- Expectation for patient participation

The consent for treatment, unless provoked sooner, will expire one year from the signed date below.

_____ _____

Printed Name Date

_____

Signature

COMPLETE HEALTH & REHABILITATION
2310 FM 1960 West, Suite B
Houston, TX 77068

ASSIGNMENT OF BENEFITS: Assignment of Cause of Action: Contractual Lien

The undersigned patient and/or responsible party, in addition to continuing personal responsibility and in consideration of treatment rendered assigns to Complete Health and Rehabilitation, the following rights, power and authority.

Release of Information: Complete Health & Rehabilitation is authorized to release information concerning my condition and treatment to my insurance company, attorney, or insurance adjuster for the purpose of processing my claim for benefits and payment of services rendered to me.

Irrevocable Assignment of Rights: Complete Health & Rehabilitation is assigned exclusive, irrevocable right to any cause of action that exists in my favor against any insurance company for the terms of the policy, including the exclusive, irrevocable right to receive payment fore such services, make demand in my name for payment, and prosecute and receive penalties, interest, court loss, or other legally compensable amounts owned by an insurance company in accordance with Article 21.55 of the Texas Insurance Code to cooperate, provide information as needed, and appear as needed, wherever to assist in the prosecution of such claims for benefits upon request.

Demand for Payment: To any insurance company providing benefits of any kind to me / us for treatment rendered by the physician/facility named above, you are hereby tendered demand to pay in full the bill for services rendered by the physician / facility named above within 30 days following your receipt of such bill for services to the extent such bills are payable under the terms of the policy. This demand specifically conforms to Article 21.55 of the Texas Insurance Code, providing for attorney fees, 18% penalty, court cost, and interest from judgment, upon violation. I further instruct the provider to make all checks payable to Complete Health and Rehabilitation, and to send all checks to 2310 FM 1960 Rd West, Houston, TX 77068..

Third Party Liability: If my injuries are the result of negligence from a third party, then I instruct the Liability carrier to cut a separate draft to pay in full all services rendered, payable directly to Complete Health and Rehabilitation, and to send any and all checks to 2310 FM 1960 Rd West, Houston, TX 77068.

PIP Assignment: You are hereby notified that I have assigned my Personal Injury Protection (PIP Medical Pay) unto Complete Health & Rehabilitation and authorize payment directly to Complete Health & Rehabilitation for charges listed herein. Checks are to be made to the facility named above.

Statute of Limitations: I waive my rights to claim any statue of limitations regarding claims for services rendered or to be rendered by the physician / facility named above, in addition to reasonable cost of collection, including attorney fees and court cost incurred.

Limited Power of Attorney: I hereby grant to the physician / facility named above the power to endorse my name upon any checks, drafts, or other negotiable instrument representing payment from any insurance company representing payment for treatment and healthcare rendered by the physician / facility named above. I agree that any insurance payment representing an amount in excess of the charges for treatment rendered will be credited to my / our account or forwarded to my / our address upon request in writing to the physician / facility named above.

Rejection in Writing: I hereby authorize the physician / clinic named above to establish a PIP or UM claim on my behalf. I also instruct my insurance carrier to provide upon request to the provider / clinic named above, any rejections in writing as they apply to my lack of PIP or UM/UIM coverage. If my carrier is unable to proved said rejections in a timely manner, I acknowledge that I am entitle to minimum levels of coverage, as per section 1952.152 of the Texas Insurance Code, and further instruct my carrier to pay up to available limits directly to physician / clinic named above, and to send any and all checks or financial instruments to 2310 FM 1960 Rd West, Houston, TX 77068.

Termination of Care: I hereby acknowledge and understand that if I do not keep appointments as recommended to me by my caring doctor at this clinic, he has full and complete right to terminate responsibility for my care and relinquish any disability granted me within a reasonable period of time. If during the course of my care, my insurance company requires me to take an examination from any other doctor, I will notify this physician / facility immediately. I understand that failure to do so may jeopardize my case.

A photocopy of this instrument shall serve as the original

_____ _____

Patient/Guardian/Responsible Party's Signature Date

_____

Relation to Patient

COMPLETE HEALTH & REHABILITATION
2310 FM 1960 West, Suite B
Houston, TX 77068
Phone: 281.440.8899 Fax: 281.444.9214

Authorization for: Disclosure Inspection Amendment of Protected Health Information

Patient Name: _____ D.O.B.: _____

Address: _____ SSN: _____

Phone #: _____ Emergency Contact Name/Number: _____

I hereby authorize _____

(Name of Hospital)

to release information from the medical records of _____

(Patient Name)

for treatment dates: _____

For the following purpose: Medical Care Legal Insurance Other_____

To: COMPLETE HEALTH & REHABILITATION
2310 FM 1960 West, Suite B
Houston, TX 77068
Phone: 281.444.8899

Select Portions

Abstract/Pertinent Information	Entire record EXCLUDING – HIV testing & chemical dependency
Lab	
Emergency	Entire record INCLUDING – HIV testing & chemical dependency
Imaging/Radiology	
Nursing Notes	Entire record INCLUDING – HIV testing only
H & P	
Cardiac Studies	Entire record INCLUDING – Chemical dependency
MD Progress Notes	
MD Orders	Itemized Bill
Face Sheet	
Operative Report	Other: _____

This authorization is valid until 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is resolved, and covers only treatment(s) for the dates specified above.

I, the undersigned have read the above and authorized the staff of COMPLETE HEALTH & REHABILITATION to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected. I hereby release and hold harmless the above-mentioned facility from all liability and damages resulting from the lawful release of my Protected Health Information.

_____ _____ _____

Signature of Patient/Parent/Guardian Relationship to Patient Date