

**The Ellington Rehabilitation Center  
308 Amelia Street  
Rayne, La 70578  
337-393-6289**

Dear New Patient,

We would like to take this opportunity to welcome you to our rehabilitation center and thank you for choosing our therapist to participate in your care. We look forward to providing you with quality rehabilitation service. As continuity and coordination of patient care is essential in meeting your healthcare needs, our therapist and the business administration will work closely in a team approach to support your patient care.

Our office is open **Monday through Friday from 8:00am-5:00pm**. Booking an appointment is essential to ensuring all patients receive the time they require for quality therapy treatment.

Once again, we would like to thank you for choosing us as your therapy service. We look forward to working with you.

Sincerely,

The Staff of The Ellington Rehabilitation Center

Please tell us how you learned of our service or whom we can thank.

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> I was a Former Patient     | <input type="checkbox"/> Former Patient          | <input type="checkbox"/> Doctor recommendation     |
| <input type="checkbox"/> Family or Friend recommend | <input type="checkbox"/> Insurance Co recommend  | <input type="checkbox"/> Employer recommendation   |
| <input type="checkbox"/> Case Manager recommend     | <input type="checkbox"/> Newspaper advertisement | <input type="checkbox"/> Yellow Page advertisement |
| <input type="checkbox"/> Clinic Sign                | <input type="checkbox"/> Web Page                |  |

The Ellington Rehabilitation Center  
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**PERSONAL INFORMATION**

Date \_\_\_\_\_ Full Name: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Phone Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_  
Gender M F DOB \_\_\_\_\_ SSN \_\_\_\_\_ Marital Status S M D W  
Employer \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
MVA \_\_\_\_\_ WC \_\_\_\_\_ Other Accident \_\_\_\_\_ Date of Injury \_\_\_\_\_  
Primary Insured \_\_\_\_\_ SSN \_\_\_\_\_ DOB \_\_\_\_\_  
Relationship \_\_\_\_\_ Contact Number \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Employer \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

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**INSURANCE INFORMATION**

**PRIMARY INSURANCE**

Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_  
Patient Relationship to Insured \_\_\_\_\_ Policy Holder Name \_\_\_\_\_  
Policy Holder SSN \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

**SECONDARY INSURANCE**

Insurance Co \_\_\_\_\_ Policy# \_\_\_\_\_ Group# \_\_\_\_\_  
Patient Relationship to Insured \_\_\_\_\_ Policy Holder Name \_\_\_\_\_  
Policy Holder SSN \_\_\_\_\_ DOB \_\_\_\_\_ Phone # \_\_\_\_\_

**PLEASE GIVE ALL CURRENT INSURANCE CARDS TO THE BUSINESS OFFICE.**

## Medical History

Please complete all of the following as accurately as possible:

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Children (ages) \_\_\_\_\_

What is the Level of Your Health? Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_

How long have you had this problem? \_\_\_\_\_

Have you had surgery for this problem? Y N Date \_\_\_\_\_

Type of surgery \_\_\_\_\_ Area of surgery \_\_\_\_\_

Have you received Physical/Occupational Therapy for this problem before? Y N Year \_\_\_\_\_

Allergies \_\_\_\_\_ Pregnant Y N

Do you have, or have you ever had any of the following conditions? (please check all that apply)

<input type="checkbox"/> Lung Disease	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Dizziness/Fainting
<input type="checkbox"/> Joint Replacement	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Cancer
<input type="checkbox"/> Weakness	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Pins/metal Implants
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Stroke/TIA	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> TB	<input type="checkbox"/> Hepatis _____

### IF YOU HAD AN ACCIDENT PLEASE COMPLETE THIS SECTION

Date of Accident \_\_\_\_\_ How did it happen? Auto - Work - Other(Location) \_\_\_\_\_

Involvement in Accident if Auto: Driver – Passenger – Pedestrian – Cyclist

Attorney/Case Manager Name \_\_\_\_\_ Claim Number \_\_\_\_\_

Billing Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Ext. \_\_\_\_\_ Fax Number \_\_\_\_\_

### **Past Medical History:**

Please list any serious medical conditions for which you have been treated/hospitalized in the past:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

List any other doctors you currently see:

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When was your last:

Wellness Exam \_\_\_\_\_ Colonoscopy \_\_\_\_\_  
Eye Exam \_\_\_\_\_ Mammogram \_\_\_\_\_

**Past Surgical History**

Please list any Surgical Procedures you have had and the approximate date:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

**Family History:**

Please check any of the following disease that tend to run in your family (parent, grandparent, children) and list who had the problem.

Diabetes _____	High Blood Pressure _____	Cancer _____
Stroke _____	Heart Disease _____	Asthma _____
Seizures _____	Allergies _____	Eczema _____
Blood Disorder _____		

Mother: Living or Deceased: Cause of Death and Age \_\_\_\_\_  
Any medical or health problems: \_\_\_\_\_

Father: Living or Deceased: Cause of Death and Age \_\_\_\_\_

Any medical or health problems: \_\_\_\_\_

Are you adopted Y or N If yes, do you know your biological family history: Y or N

**Social History:**

Please check beside any of the following you have used in the past or currently. If you place a check, please state how often you use or when you stopped using:

Alcohol (beer, wine or spirits) _____	Tobacco (cigarettes, cigar, pipe) _____
Illegal drugs _____	Tobacco (chewing) _____
Birth Control Pills _____	Coffee _____
Vitamins/Supplements _____	Herbal Products _____

**Medications:**

List all of the Prescription Medications or Over the Counter Drugs you are now taking:

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**Allergies:**

Please list any medications or foods to which you are allergic or sensitive:

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Do/did you serve in the military? \_\_\_\_\_  
Were you deployed during wartime? \_\_\_\_\_

Is there anything else related to your health that we should be aware of?

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What are your goals for Physical, Occupational and or Speech Therapy?

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I hereby consent to such treatment procedures and patient care which, in the judgement of my therapist and/or physician, may be considered necessary or advisable while a patient at **The Ellington Rehabilitation Center**.

\_\_\_\_\_  
Signature of patient or guardian

\_\_\_\_\_  
Date

The Ellington Rehabilitation Center  
308 Amelia Street  
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**Insurance Patient Agreement**

Patient Name \_\_\_\_\_

Insurance: BCBS UHC Aetna Medicare Other \_\_\_\_\_

Deductible Amount (if any): \_\_\_\_\_

Deductible Remaining (if any): \_\_\_\_\_

Co-Pay/Co-Ins. (if any): \_\_\_\_\_

I understand as indicated by my insurance policy that I am responsible for payment on any and all charges for therapy services rendered. I agree to pay the amount of \$ \_\_\_\_\_ per session for outpatient therapy.

Patient Signature \_\_\_\_\_

Date Signed \_\_\_\_\_

**IMPORTANT NOTE:** If you have **NOT** met your deductible, each therapy session will have to be paid until deductible is satisfied (at least 20% of session fee). If you have a co-pay, it will need to be paid at the end of each session unless other arrangements have been made. Please note that you may still receive a bill if you have a remaining balance on your account.

**The Ellington Rehabilitation Center**  
**Medicare Financial Policy**

Welcome to The Ellington Rehabilitation Center. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to treatment. In order for our relationship to be mutually satisfying and beneficial, we encourage you to discuss with us promptly and openly any concerns about your treatment, services or fees.

Our patients can expect:

- High degree of professional skill and ability
- Fees that are customary for our area

In return we expect:

- Cooperation in making and keeping appointments
- Your payment of fees (for which you are personally responsible) at the time of service.
- Your assistance in keeping us informed of your health insurance Information

**Method of Payment**

1. We accept cash, checks, debit and credit cards
2. Insurance. We will bill your primary insurance as a courtesy to you.  
A fee of \$25.00 will be charged on all returned checks.

It is considered appropriate for a patient to pay the portion of their medical expenses for which they are responsible at the time of service. The balance of the service is then submitted to the insurance company. If you do not have a secondary insurance, you will be responsible for the portion of the allowed fees not paid by Medicare. This will be approximately \$20.00 per visit and is required at each visit. When we receive the EOB from Medicare, adjustments might need to be made. In the event there is an outstanding balance due, payment is required on receipt of the statement. Medicare recommends you start your therapies in a timely manner from your doctor's visit. If continuing treatment is deemed necessary after 30 days a re-certification is required.

It is your responsibility to inform us of any Physical, Occupational and Speech Therapy that you have received. Please check the box(es) for any of the clinical services that you may have received this year.

Physical Therapy  Occupational Therapy  Speech Therapy  Home Health

You can call Medicare at 1-866-794-0466 to verify your benefits

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**Account Balance**

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. If your insurance company has not paid your account in full within 60 days, from your last visit, the balance will be automatically transferred to your account for payment. Outstanding patient balance will be charged interest at a rate of \_\_\_% per month. Please be aware that some services may be non-covered services and not considered reasonable and necessary under the Medicare and/or medical insurance.

**Cancellations and Missed Appointments**

If needed, please cancel your appointment at least **24 hours** in advance. Appointments not canceled in 24 hours prior to scheduled time will be charged a fee of \$25.00. This fee is not covered by your insurance company.

**Collection**

In the event a patient's account is delinquent or a patient fails to abide by these financial terms, the account will be handed over for collection and the responsible party will be liable for any collection fees and court cost.

**Financial Agreement**

I hereby authorize direct payment of medical benefits to The Ellington Rehabilitation Center. I have read and understand the above financial policy, and agree to be responsible for any balances not covered by my insurance. My signature below authorizes the office to release medical information to my company only to assist with any outstanding balances on my account.

Patient's initials \_\_\_\_\_.

\_\_\_\_\_  
Signature of Patient or Guardian

\_\_\_\_\_  
Date

**THE ELLINGTON REHABILITATION CENTER  
308 AMELIA STREET  
RAYNE, LA 70578**

**CONSENT FOR TREATMENT**

For and in consideration of the medical treatment, which I may receive while a patient of **The Ellington Rehabilitation Center**, herein after referred to as **The Ellington Rehabilitation Center**, I either separately or collectively consent to treatment, voluntarily and knowingly, by me if of age and competent or for me, if a minor or incompetent, by my parents, guardian or nearest relative, as the case may be, to the said member of **The Ellington Rehabilitation Center** separately or collectively, to carry out, or cause to be carried out such medical treatment, as prescribed or ordered by my physician.

**AUTHORIZATION TO RELEASE INFORMATION & ASSIGNMENT BENEFITS**

I hereby authorize **The Ellington Rehabilitation Center**, or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits payable for related services. I request that authorized Medicare or Insurance payments of medical benefits be made to **The Ellington Rehabilitation Center**, or to any consulting physician or entity used in connection with this service (to be used only if necessary to file claims).

**GUARANTOR RESPONSIBILITY**

In consideration of the services, I agree that I am solitarily liable to **The Ellington Rehabilitation Center**, for and hereby guarantee the payment of all facility charges incurred for my treatment in accordance with the orders of my prescribing or consulting physician(s), **including any facility charge not paid, for any reason, by any payer or insurance company.**

I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by **The Ellington Rehabilitation Center**, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges assessed by the collection service, legal counsel or court.

The authorization and assignment may be revoked by me at any time by a written notice; I agree that a photocopy of this form may be used in lieu of the original.

**Intramuscular Manual Therapy aka Trigger Point Dry Needling (TDN) Consent Form**

IMT/TDN involves placing a small needle into the muscle at the trigger point which is typically in an area which the muscle is tight and may be tender with the intent of causing the muscle to contract and then release, improving the flexibility of the muscle and therefore decreasing the symptoms.

IMT/TDN is a valuable treatment for musculoskeletal related pain such as soft tissue and joint pain, as well as to increase muscle performance. Like any treatment there are possible complications. While these complications are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

**Risks of the procedure:**

Though unlikely there are risks associated with this treatment. The most serious risk associated with TDN is accidental puncture of a lung (pneumothorax). If this were to occur, it may likely only require a chest x-ray and no further treatment as it can resolve on its own. The symptoms of pain and shortness of breath may last for several days to weeks. A more severe lung puncture can require hospitalization and re-inflation of the lung. This is a rare complication and in skilled hands should not be a concern. If you feel any related symptoms, immediately contact your IMT/TDN provider. If a pneumo is suspected you should seek medical attention from your physician or if necessary go to the emergency room.

Other risks may include bruising, infection and nerve injury. Please notify your provider if you have any conditions that can be transferred by blood, require blood anticoagulants or any other conditions that may have an adverse effect to needle punctures. Bruising is a common occurrence and should not be a concern unless you are taking a blood thinner. As the needles are very small and do not have a cutting edge, the likelihood of any significant tissue trauma from IMT/TDN is unlikely.

Please consult with your practitioner if you have any questions regarding the treatment above.

Do you have any known disease or infection that can be transmitted through bodily fluids?

**YES            NO**

**If you marked yes, please discuss with your practitioner.**

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Please print your name

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Signature

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Date

The Ellington Rehabilitation Center  
308 Amelia Street  
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**CONSENT FOR MEDICAL CARE AND  
CONSENT FOR THE USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

The purpose of this form is to fulfill the obligations of this medical facility under the Health Insurance Portability and Accountability Act of 1996 (HIPPA) with regard to Protected Health Information (PHI), by implementing the regulations ensuring the integrity and confidentiality of PHI. PHI is individually identifiable health information created for a patient which is then transmitted and/or maintained electronically or in any other form.

Patient Name \_\_\_\_\_ DOB \_\_\_\_\_

I hereby consent to medical care and to the use and disclosure of my personal health information to those of my family listed below and healthcare providers for the purposes of treatment, payment, medication history and health care operations. I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing. I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section for this form. I further understand that this medical facility is not required to accept my restriction request. I understand that I may revoke this consent at any time by contacting this medical facility to sign the revocation section on this form. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

I authorize this medical facility to release/discuss my medical information with:

Name:	Relationship:
_____	_____
_____	_____
_____	_____

Patient Signature (Guardian Signature if Minor Patient) \_\_\_\_\_

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**COMPLETE THIS PART ONLY IF PATIENT IS A MINOR:**

Primary Contact Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

The individuals listed below have authorization to talk to your staff on the phone and/or bring my child into the office. Both parents will automatically have authorization unless court documents are presented and specifically state one is not authorized.

\_\_\_\_\_ I do NOT want to authorize anyone other than the parents/guardians.

List contacts that you will allow to come with the patient:

Name:	Relationship to patient:	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that authorization to anyone other than myself or the other parent/guardian is voluntary and I can revoke authorization at any time. I also understand that no one other than those listed above can bring my child to the rehabilitation center.

Parent/Guardian Signature: \_\_\_\_\_

**Restriction of Medical Information**

The individuals listed below are restricted from having access to my medical record information. (The parent of a minor can't be restricted from receiving information without legal documentation saying the parent is not allowed medical information).

Name:	Relationship:
_____	_____
_____	_____

**REVOCATION OF ACCESS TO MEDICAL INFORMATION**

I hereby revoke access from receiving medical information from the following:

Name:	Relationship:
_____	_____
_____	_____

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

## 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.**

This therapy facility is required by law to maintain the privacy of your health information and to provide you with a 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 the privacy practices at this facility please contact:

Privacy officer/Office Manager, 308 Amelia Street – Rayne, La 70578 Phone 337-393-6289

### 1. How this facility may Use or Disclose Your Health Information

This facility collects health information from you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this facility, but the information in the medical record belongs to you. This facility protects the privacy of your health information. The law permits this facility to use or disclose your health information for the following purpose

1. Treatment: We may disclose your health information to doctors, nurses, technicians' medical students and medical personnel for the purpose of treatment. Ex. Johnny came into doctor's office with right side pain. Doctor sent Johnny to lab technician for blood work (disclosure was made to lab for purpose of treatment)

2. Payment: We may disclose your health information as necessary to yourself, your insurer, or third-party such as Medicare or Medicaid for the purpose of payment of medical service.

Ex: Johnny came into doctor's office for medical care. He had an office visit. When they filed his office visit with date, procedure and diagnosis codes to his insurance carrier for payment of his service. (disclosure made for purpose of payment)

3. Regular Health Care Operations: We may disclose your health information to your health carrier in order to review treatment and services and in order to evaluate the performance of staff. This includes quality assurance, peer review and credentialing. Medication History: We may run a medication reconcile to verify medication.

Ex: PPO Health Plan Company sends out a nurse to review charts. They may ask provider to pull five charts for review. Mrs. Jones' chart is pulled and a representative from her insurance company comes in to check record keeping, office policies, clinic and quality of care given. (disclosure made for purpose of health care operations)

4. Information provided to you.

5. Notification and communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgement in communication with your family.

6. Required by law: As required by law, we may disclose your health information.

7. 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, report domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications and reporting disease or infection exposure.

8. Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

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

10. Law Enforcement: We may disclose your health information to a law enforcement official for the purpose 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.

11. Deceased Person Information: We may disclose your health information to coroners, medical examiners and funeral directors.

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

13. Research: We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board or this facility privacy board.

14. Public Safety: We may 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 the general public.

15. Specialized Government Functions: We may disclose your health information for military, national security, prisoner and government benefits for Medicare, Medicaid, Tricare or another affiliated federal insurance/agency. (Note that disclosures for government benefits purposes are limited to health plans only)

16. Workers' Compensation: We may disclose your health information as necessary to comply with workers' compensation laws.

17. Change of Ownership: In the event that this facility is sold or merged with another organization, your health information/record will become the property of the new owner.

18. Records: We may disclose medical records with the person written in the consent signed only.

### II. When this facility may not Use or Disclose Your Health Information.

Except as described in this Notice of Privacy Practices, this facility will not use or disclose your health information without your written Authorization. If you do authorize this facility to use or disclose your health information for another purpose, you may revoke Your authorization in writing at any time.

### III. Your Health Information Rights.

1. You have the right to request restrictions on certain uses and disclosures of your health information. This facility is not required to agree to the restriction that you requested.
2. You have the right to receive your health information through a reasonable alternative means or at The Ellington Rehabilitation Center, 308 Amelia St, Rayne, La 70578 by request in writing with proper signed authorization and upon payment of a reasonable copying charge. \$1.00 first 25 pages, .50 cents per page for 25-500 pages, .25 cents per page thereafter, \$7.50 handling charge and actual

postage. The Ellington Rehabilitation Center, must provide your medical records within a reasonable time not to exceed 15 days from the date

of your request and payment.

3. You have the right to inspect and copy your health information.

4. You have the right to request that this facility amend your health information that is incorrect or incomplete. The Ellington Rehabilitation Center is not required to change the health information and will provide you with information about this facility denial and how you can Disagree with the denial.

5. You have the right to receive an accounting of disclosures of your health information made by this facility except that this facility does not Have to account or the disclosures described in Part I, # 1. Treatment, 2 Payment, 3. Health care operations, 4. Information provided to you, And 16. Certain government functions of Section I of this Notice of Privacy Practices.

6. You have the right to a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights Or if you would like to exercise one or Moe of these rights, contact our privacy officer.

#### **IV. Change to this Notice of Privacy Practices**

This facility reserves the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, this facility Is required by law to comply with this notice. Covered entity will provide individuals with new notice of changes when they come into us Office.

#### **V. Complaints**

Complaints about this Notice of Privacy Practices or how this facility handles your health information should be to our privacy officer.