Close physical therapy

Physical Therapy and Rehabilitation Centers

PATIENT INFORMATION:

DATE_____

NAME_____
Last First M.I.

ADDRESS_____
Street City State Zip Code

HOME PHONE_____CELL PHONE_____DOB: _____ SS#_____

☐ MALE ☐ FEMALE ☐ SINGLE ☐ MARRIED

IN CASE OF EMERGENCY PLEASE CONTACT:

NAME_____PHONE_____ RELATIONSHIP:_____

REFERRING PHYSICIAN_____DATE OF INJURY OR ILLNESS_____

TYPE OF INJURY: ☐ work ☐ auto ☐ sports ☐ other BODY PART (S)_____

****MEDICARE PATIENTS**: HAVE YOU RECIEVED HOME HEALTH WITHIN THE PASS 6 MONTHS?

YES___ NO____ IF YES: NAME OF COMPANY_____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID #_____ Name of insured_____

SECONDARY INSURANCE _____ ID#_____ Name of insured_____

Cancellation/No-show:

I understand that if I do not show up for my scheduled appointment or do not call to cancel my appointment within 24 hours or in a timely manner, I will be charged a $25 fee. **The patient is responsible for paying the fee NOT THE INSURANCE.**
Initial_____

HIPAA:

****Initial to acknowledge that you have read and understood our Notice of Privacy Practices** _____

AUTHORIZATION AND RELEASE

I authorize Close Physical Therapy to release my medical records to the referring physician and to bill my insurance company. I authorize my insurance company to pay Close Physical Therapy directly. **If my insurance company do not pay, I will be responsible for all services rendered.**

X_____DATE_____

SERVING LAS VEGAS FOR OVER 40 YEARS

PATIENT MEDICATION LIST

Patient Name:

Date:

Medication	Dosage	Times/day

Teachers Health Trust

P.O. Box 96238, Las Vegas, Nevada 89193-6238

Providing Service to Participants at: 2950 East Rochelle Avenue, Las Vegas, Nevada 89121

Phone: (702) 794-0272 **Fax:** (702) 794-2093

E-mail Address: serviceteam@teachershealthtrust.org

TEACHERS HEALTH TRUST

I. **If the services received were NOT the result of an injury/accident, please give details concerning how the condition occurred, sign where indicated, and return this document to the Trust. You do not have to complete the remainder of this Agreement.**

Details: _____

_____

_____ _____

Participant Signature *Date*

II. **If the injury is a result of an accident, please complete the remainder of this document in its entirety, sign where indicated, and return this Agreement to the Trust, ALONG WITH A COPY OF THE POLICE REPORT (if any), and the AUTOMOBILE DECLARATION PAGE (The first page of your auto insurance policy). If the Agreement is missing any information, it will be returned to you for completion.**

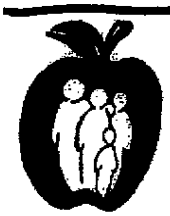
INJURY/ACCIDENT INFORMATION SHEET AND SUBROGATION AGREEMENT

The Teachers Health Trust has a subrogation provision which requires that the plan be reimbursed for benefits paid to you or on your behalf when you have a valid and collectible claim against either the person reponsible for your injuries (whether or not that person has automobile or homeowners insurance) or under the Uninsured/Underinsured motorist provision of any applicable policy. This provision applies regardless of whether or not you have been made whole after your claim has been resolved.

I request the Trust to pay covered medical expenses at this time without awaiting a determination that any other person may be liable. I agree that if the award of damages or the settlement does not specify the portion applicable to medical (or dental) expenses, the Trust will consider the amount due from the responsible person to be applied to medical (or dental) expenses first. I agree to promptly reimburse the Trust for any payments received from the responsible person for medical or dental expenses after deducting allowable attorney fees and court costs. If I fail to do so, I authorize the Trust to deduct or offset the amount not reimbursed from any future benefits to which I may be entitled under the Plan.

I agree if there is Medical Payments coverage as part of my policy of my automobile insurance policy, **and/or as part of the insurance policy of the driver of the vehicle I was a passenger in when I was injured,** the Trust will not pay benefits for injuries I sustained in an accident until **any and all** Med-Pay benefits from **all applicable insurance policies** have been exhausted and the Trust is furnished with written proof of payment by the insurance company**(ies)**.

I understand that the Trust may file a Notice of Lien against any monetary recovery with me and/or my attorney. I hereby authorize the filing of said Notice of Lien by the Trust without further notice to me. I also agree to obtain the full and complete cooperation of my attorney or representative in connection with the Trust's efforts to obtain reimbursement under the agreement.



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Each question below must be answered completely. **The claim(s) cannot be processed without a complete police report, if applicable, and the automobile declaration page.** Please include a copy with this form.

The following information is provided in accordance with plan requirements:

1. Date of accident: _____ Time of accident: _____ a.m./p.m.

   Location of accident: _____

   At work: *Yes___ No___

   ** If the injury/accident happened at work, **you must file a claim with Workers' Compensation***

   List other family members that were injured in the accident/incident:

   _____

   _____

   Describe how the injury/accident occurred and what injuries you sustained (attach a separate page, if necessary):

   _____

   _____

   _____

   _____

2. Name, address, phone number, and policy number of the insurance company of the **other parties** involved in the injury/accident; e.g., other driver, store name, property owner.

   Name of person involved: _____

   Name of insurance company: _____

   Address: _____

   Phone Number: _____ Policy Number: _____

3. Name of your attorney. Please indicate who is representing you in this case.

   My Attorney's Name: _____

   Address: _____

   Phone Number: _____

Pain Disability Index

Pain Disability Index: The rating scales below are designed to measure the degree to which aspects of your life are disrupted by chronic pain. In other words, we would like to know how much pain is preventing you from doing what you would normally do or from doing it as well as you normally would. Respond to each category indicating the overall impact of pain in your life, not just when pain is at its worst.

For each of the 7 categories of life activity listed, please circle the number on the scale that describes the level of disability you typically experience. A score of 0 means no disability at all, and a score of 10 signifies that all of the activities in which you would normally be involved have been totally disrupted or prevented by your pain.

Family/Home Responsibilities: This category refers to activities of the home or family. It includes chores or duties performed around the house (e.g. yard work) and errands or favors for other family members (e.g. driving the children to school).
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Recreation: This disability includes hobbies, sports, and other similar leisure time activities.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Social Activity: This category refers to activities, which involve participation with friends and acquaintances other than family members. It includes parties, theater, concerts, dining out, and other social functions.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Occupation: This category refers to activities that are part of or directly related to one's job. This includes non-paying jobs as well, such as that of a housewife or volunteer.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Sexual Behavior: This category refers to the frequency and quality of one's sex life.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Self Care: This category includes activities, which involve personal maintenance and independent daily living (e.g. taking a shower, driving, getting dressed, etc.)
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Life-Support Activities: This category refers to basic life supporting behaviors such as eating, sleeping and breathing.
No Disability 0__. 1__. 2__. 3__. 4__. 5__. 6__. 7__. 8__. 9__. 10__. Worst Disability

Signature_____ **Please Print**_____

Date _____