Established Patient Update

Welcome to Tristate Functional Wellness / Evansville Rehabilitation

For our office to better serve you, please provide the following information.

Please print

Date_____/_____/_____

Last Name_____ First Name_____ M.I._____

Nickname_____

Street Address_____ City_____ State____ Zip_____

Home Phone(____)_____-_____ Marital Status: Single Married Widow Divorced Other

Gender_____ Social Security #_____-_____-_____ Date Of Birth_____/_____/_____

Employer_____ Occupation_____

Employer Address_____ Work Phone(_____)_____-_____

Emergency Contact_____ Contact Phone(_____)_____-_____

Primary Care Physician_____ Date of Last Visit_____

Referred by:_____

Insurance Information

Primary Insurance

Insurance Company_____ Insured Name_____

ID Number_____ Group #_____

Insured Date of Birth_____/_____/_____ Relationship to insured: Self Spouse Child Other

Secondary Insurance

Insurance Company_____ Insured Name_____

Insured Employer_____ ID#_____ Group #_____

Insured Date of Birth____/_____/_____ Relationship to insured: Self Spouse Child Other

If your condition is accident related, will a claim for workmen's compensation be filed? Yes / No

For automated appointment reminders, we need all of the following information.

Email address_____

Cell Phone Number_____

Cell Phone Provider_____

Choose when you want to be reminded about your appointment:

1 hour prior 2 hours prior 1 day before 2 days before

Please list names of people and their relationship to you, that we may release your health information to:

Name_____ **Relationship**_____

Name _____ **Relationship**_____

Name _____ **Relationship**_____

Name _____**Relationship**_____

Do you currently smoke tobacco of any kind? __Yes __Never been a smoker __Former Smoker

If yes, how often do you smoke? __Current Everyday smoker __Current Some-day smoker

If yes: What is your level of interest in quitting smoking? 1 2 3 4 5 6 7 8 9 10 N/A

List current medications including dosage, if known. If no medications are currently taken then check here: __

1)_____ 2) _____

3)_____ 4) _____

5)_____ 6) _____

7)_____ 8) _____

List any known allergies that you have to any medications. If no allergies are known then check here: ___

1)_____ 2) _____

3)_____ 4) _____

What are your main health problems? Briefly list the name of your problem(s):

_____

Has any doctor diagnosed you with Hypertension presently? ___ Yes ___No If yes, what kind? _____

Has any doctor diagnosed you with Diabetes presently? ___ Yes ___No If yes, what kind? Type I or II ?

If yes to Diabetes, was your blood lab-work test for hemoglobin A1c > 9.0%? Yes ___ No___ Not Sure___

Has any doctor diagnosed you with any type of significant health syndrome presently? Yes ___ No___ Not Sure__

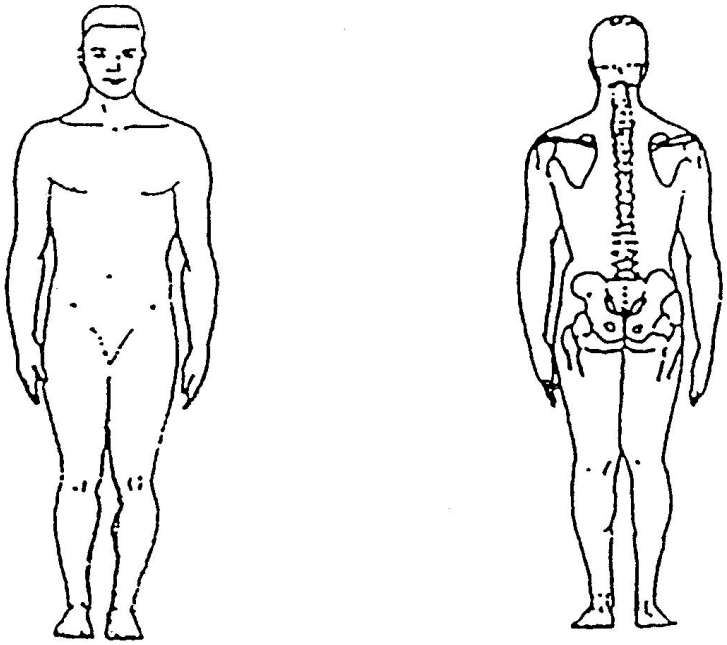
If yes, what kind? _____

Have you had an X-ray or CT scan or MRI of your <u>low back</u> spine in the past 28 days? Yes _____ No ____

To be performed by clinic staff: Height:_____ ___ inches Weight: _____ pounds BP:_____/_____

Chief Complaint and History of Present Condition **Patient Name**_____

1. Where is your pain (indicate on figures) If it is more than one area, **NUMBER in order of priority with the worst first.**



2. What type of pain is it? Indicate which number/area has which type of pain

_____Sharp _____Ache _____Dull _____Burning _____Throbbing

3. Rate pain on a scale of 0-10 (10 being severe pain): 1)_____ 2)_____ 3)_____ 4)_____

4. How long have you had this pain?

   1)_____ 2)_____

   3)_____ 4)_____

5. What makes the pain worse?

   1)_____ 2)_____

   3)_____ 4)_____

6. What makes the pain better?

   1)_____ 2)_____

   3)_____ 4)_____

7. Does the pain travel?_____ If so, where?_____

8. Is pain worse at any particular time of day? _____

Evansville Rehabilitation d/b/a/ TriState Functional Wellness
Financial Policy

It is the goal of TriState Functional Wellness to render the highest quality health care to our patients. We will verify your benefits with your insurance company at the time of your visit. This is not a guarantee of payment by them but it lets us be aware of your coverage and benefits. If your insurance changes it is critical for us to know so we may contact the new carrier concerning your new policy. Please review the following statements so that you will have a clear understanding of our procedures so we may serve you better.

- As a service to you, our office will file your claims with your primary insurance company.
- Claims for any secondary insurance coverage are to be filed by you. Full payment for the amount of secondary insurance coverage is still expected at the time of service.
- THE PATIENT IS RESPONSIBLE FOR MONITORING THEIR NUMBER OF VISITS.
- Co-payments and un-met deductibles are to be paid at the time of service.
- Any service not covered by your insurance company will be your financial responsibility.
- Any service incurred after you have reached your benefit maximum is considered a non-covered service. Therefore, we are not obligated to take the insurance discount normally written off for covered services. You are responsible for the full amount charged.
- TriState Functional Wellness accepts cash, personal checks, Visa, Discover or MasterCard.
- It is necessary to keep your balance current. If your balance exceeds $200.00, a payment will be required before another appointment can be scheduled for you or a family member unless you have made special arrangements with the billing department concerning your account. A monthly plan may be arranged with the insurance department.
- Insurance is a contractual agreement between you and your insurance company. Our office will not enter into a dispute with your insurance company or attorney concerning your coverage.
- You will immediately notify our office of any change in your insurance coverage.
- You may be charged $25.00 if you do not call to cancel your appointment at least four hours prior to the given appointment time.
- In the event that you have an account become delinquent and are referred to an outside collection agency, you will be responsible for all collection fees, legal fees, and court costs incurred.

I understand and agree that health and accident insurance policies are an arrangement between myself and the insurance carrier and that I am personally responsible for payment of any and all services, covered or non-covered. I hereby authorize EVANCVILLE REHABILITATION, PC to furnish information to all insurance carriers or other health care providers concerning my treatment and I hereby assign to the practitioners all payments for services rendered to my dependents or myself

_____ _____

Signature Date

Parent or Guardian's Signature_____ Date_____