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 _____

Cell Phone _____ Home Phone _____

Email Address _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Other

Gender _____ Social Security # _____ Date Of Birth _____

Age _____

Employer _____ Occupation _____

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 Number _____

Telephone # For Providers(Found on Back of Your Insurance Card) _____

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

Patient Name_____

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 Smoke

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 dosages, if known. If no medications are currently taken, check here: ☐

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

9) _____ 10) _____

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 Type (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 low back spine in the past 28 days? ☐ Yes ☐ No

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

Patient Name_____

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 **$250.00,** 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 must immediately notify our office of any change in your insurance coverage.
- You may be charged **$50**.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 EVANSVILLE REHABLITATION, PC to furnish information to all insurance carriers or other health care providers converning my treatment and I hereby assign to the practitioners all payments for services rendered to my dependents or myself.

I/We understand that if any unpaid balance is assigned to a third party collection agency for collection or placed with an attorney to obtain judgment or otherwise satisfy payment of my account, a collection fee equal to 33$^{1/3}$ % of the unpaid balance will be added to my account. I/We agree to pay that fee. I/We further agree to pay reasonable attorney fees and court costs if a judgment is granted against me/us.

_____ _____

Signature of Responsible Party *Date*

_____ _____

Signature of Responsible Party *Relationship*

_____

Date of Birth

Chief Complaint And History Of Present Condition Patient Name: _____

First Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Second Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Third Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____

Fourth Complaint: _____
Pain Level (0 – 10) Now ____ At its Worst ____ On average throughout the day? _____
Is the pain Getting Better? ☐ Worse? ☐ Same? ☐
When did the problem start? _____
What caused the problem? _____
What has made the problem worse? _____
What has made the problem better? _____
Does the pain travel? _____
Is the pain worse at any particular time of day? _____