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.

Your medical information is the information gathered by your therapists or other caregivers during the time you are being treated by CORA Health Services, Inc. (“CORA”) professionals. It is private, and no one without a legitimate need to know may have access to it. CORA 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. CORA will promptly notify affected individuals following a breach of unsecured protected health information.

CORA will not use or disclose your health information except as described in this Notice of Privacy Practices (“Notice”). This Notice applies to all of the medical records generated during your participation in CORA programs and services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following categories describe the ways that CORA may use and disclose your health information without a specific authorization from you:

Treatment: CORA will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your medical record information to your physician, consulting physician(s), nurses and other healthcare providers who have a legitimate need for such information in the care and continued treatment of the patient.

Payment: CORA may release medical information about you for the purposes of determining coverage, billing, claims management, medical data processing and reimbursement. The information may be released to an insurance company, third-party payor or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record that are necessary for payment of your account. For example, a bill sent to a third party payor may include information that identifies you, your diagnosis, the procedures and supplies used.

Routine Healthcare Operations: CORA may use and disclose your medical information during routine healthcare operations, including quality assurance, utilization review, internal auditing, accreditation, certification, licensing or credentialing activities of each rehabilitation clinic (“Clinic”), medical research and educational purposes.

Business Associates: CORA may use and disclose certain medical information about you to its business associates. A business associate is an individual or entity under contract with CORA to perform or assist CORA in a function or activity that necessitates the use or disclosure of medical information. Examples of business associates include but are not limited to, a copy service used by the Clinic to copy medical records, consultants, independent contractors, accountants, lawyers, medical transcriptionists and third-party billing companies. CORA requires the business associate to protect the confidentiality of your medical information. In addition, CORA requires any subcontractor of CORA’s business associate to protect the confidentiality of your medical information.

Required by Law: CORA will disclose medical information about you when required to do so by law.

Public Health Activities: CORA may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence: CORA may disclose your health information to a public health authority that is authorized to receive reports of abuse, neglect, or domestic violence. We may make an effort to obtain your permission before releasing this information, but in some cases may be required or authorized to act without your permission.

Health Oversight, Licensing, Accreditation and Regulatory Activities: CORA may disclose your health information to health oversight agencies authorized to conduct audits, investigations, and inspections of our facility. For example, billing practices may be audited by the State Auditor and records are subject to review by the Secretary of Health and Human Services and his/her authorized representatives.

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Judicial or Administrative Proceedings: CORA may disclose your health information if we are ordered to do so by a court or an administrative hearing officer that is handling a lawsuit or other dispute or provided with a valid subpoena.

Disclosures for Law Enforcement Purposes: CORA may disclose your identity to law enforcement. Instances which may result in a disclosure of protected health information to law enforcement include to comply with court orders or assist with ongoing investigations

Coroners, Medical Examiners and Funeral Directors: CORA may disclose protected health information to a coroner, medical examiner or funeral director for the purposes of identifying a deceased person or other duties as authorized by the law.

Organ and Tissue Donation: CORA may share health information about you with organ procurement organizations.

Research: In some instances, CORA can use or share your health information for health research.

To Avert a Serious and Imminent Threat to Health or Safety: CORA may use or disclose your protected health information when necessary to prevent a serious and imminent threat to your health or safety, or the health or safety or another person or the public.

Specialized Government Functions: If you are an inmate of a correctional institution or under the custody of a law enforcement officer, CORA may release your medical record information to the correctional institution or law enforcement official. CORA may also disclose your medical information as required by military command authorities if you are a member of the armed forced.

Workers' Compensation: CORA may release medical information about you for workers' compensation or similar programs that provide benefits for work-related injuries or illnesses.

PATIENT CHOICES

You have the right and choice to tell us which information to share with your family, close friends, or others involved in your care, and if you would like us to share your information in a disaster relief situation.

If you are not able to tell us your preference, for example, if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In the case of fundraising, CORA may contact you for fundraising efforts, but you can tell us not to contact you again.

Except for the situations and exceptions described in this Notice, we will need to obtain your written authorization before using or disclosing your protected health information for other purposes. For example, except as otherwise set forth under State and Federal law, we must obtain your written authorization for most uses or disclosures of any psychotherapy notes related to you, for the use or disclosure of your protected health information for marketing purposes, or for the sale of your protected health information.

PATIENT INFORMATION RIGHTS

Although all records concerning your treatment obtained at CORA are the property of CORA, you have the following rights concerning your medical information:

Right to Confidential Communications: You have the right to receive confidential communications of your medical information by alternative means or at alternative locations. For example, you may request that CORA contact you only at work or by mail.

Right to Inspect and Copy: You have the right to inspect and copy your medical information.

Right to Amend: You have the right to amend your medical information. Any request for amendment should be submitted to CORA in writing, stating a reason in support of the amendment.

Right to an Accounting: You have the right to obtain an accounting of the disclosures of your medical information made during the preceding six (6) year period.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your medical information. CORA is not required to honor your request except where: (i) the disclosure is for the purpose of carrying out payment or healthcare operations and is not otherwise required by law, and (ii) the medical information pertains solely to a healthcare item or service for which you, or person other than the health plan on your behalf, has paid CORA in full.

Right to Receive a Paper Copy: You have the right to receive a paper copy of this Notice, even if you have previously agreed to receive the Notice electronically.

Right to Receive Electronic Copies: You have the right to receive electronic copies of your medical information.

Right to Transfer Records: You may also initiate the transfer of your records to another person by completing a written authorization form.

Right to Revoke Authorization: You have the right to revoke your authorization to use or disclose your medical information, except to the extent that action has already been taken in reliance on your authorization. A request to exercise any of these rights must be submitted, in writing, to CORA Health Services, Inc. Forms to help you make your request are available in the Clinic, online at our web site www.corahealth.com or by contacting CORA at (419) 221-3004.

FOR MORE INFORMATION OR TO REPORT A PROBLEM

If you have questions and would like additional information, you may contact our HIPAA Privacy Officer, at (419) 221-3004. If you believe your privacy rights have been violated, you may file a complaint with CORA or with the Secretary of the Department of Health and Human Services. To file a complaint with CORA, please contact the Front Desk located near the front entrance to the Clinic. All complaints must be submitted in writing. Forms are available in the lobby of the Clinic. There will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE

CORA will abide by the terms of the Notice currently in effect. CORA reserves the right to change the terms of its Notice and to make the new Notice provisions effective for all protected health information that it maintains. An updated version of the Notice may be obtained at the Clinic and on our web site at www.corahealth.com.

NOTICE EFFECTIVE DATE

This Notice is effective as of May 2016.

Acknowledgement of Receipt of Notice of Privacy Practices and Release Authorization

I certify that I have received a copy of CORA Rehabilitation Clinics' Notice of Privacy Practices. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance of CORA Rehabilitation Clinics health care operations. The Notice of Privacy Practices also describes my rights and CORA Rehabilitation Clinics' duties with respect to my protected health information. The Notice of Privacy Practices is also posted in the Front Desk area and on CORA Rehabilitation Clinics website at www.corahealth.com.

CORA Rehabilitation Clinics reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail, asking for one at the time of my next appointment or accessing CORA Rehabilitation Clinics' website.

Patient Name (print): ________________________________ Date of Birth: _____________________

Mailing Address: ____
House number street name City State Zip code

Driver's License Number: ___________________ Social Security Number: ____________________

By signing this Authorization Form, I understand that I am giving my authorization to CORA Rehabilitation Clinics' designated medical record custodians, database custodians, central billing / collections office personnel to use and/or disclose my protected health information (PHI), as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): ____
Street address: ____
City, State, and zip code: ____
Telephone number: ____
Fax number: ____
Relationship to patient: ____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below:

____

I may revoke this authorization at any time by notifying CORA Rehabilitation Clinics in writing to Attention Collections Manager, 1110 Shawnee Road, Lima, OH, 45805 of my intent to revoke this authorization. However, I also understand that such a revocation will not have any effect on any information already used or disclosed by CORA Rehabilitation Clinics before CORA Rehabilitation Clinics received my written notice of revocation. Unless earlier revoked, this authorization will expire on the 180th day of the signing (or as otherwise specified ____________________).

____ ____
Signature of Patient or Personal Representative Name of Patient or Personal Representative

Thank you for choosing CORA Rehabilitation Clinics for your rehabilitation needs.

Verification of benefits is not a guarantee of payment and financial responsibility is subject to change.

Your primary health insurance carrier had verified that you have a $ _________yearly deductible of which $_________ has been met.

After your deductible has been satisfied, your insurance carrier **estimates** your therapeutic benefits are covered at _______%.

You have an **estimated** responsibility of $ ______ or %______due at each visit.

Your insurance company has advised us that your policy has the following limitations:

We will gladly bill your insurance company according to the information you give us at the time of service. The accuracy of this information is extremely important in order for your insurance to pay on your account. It is the responsibility of the patient to know your coverage and benefits for your outpatient rehabilitation services. If you don't know what they are please contact your insurance company.

Any changes in your insurance needs to be communicated with us immediately.

In order to ensure that we are filing the correct insurance please answer the following questions.

1. Injury related to an auto accident? **Yes / No** If Yes, Name of Auto Insurance Company: ______________________

2. Do you have legal representation (attorney)? **Yes / No** If Yes, please complete attorney information below:

   Attorney Name: _____________________________ Phone Number: ______________________________________

   Do you have a letter of exhaustion from your Auto Carrier? **Yes / No** Can you provide us with a copy? **Yes / No**

   Do you have a medical / health insurance? **Yes / No** If Yes, Name of Health Insurance Carrier

   Insurance Company Name: _________________________________ Phone Number: ________________________________

   Name of Primary Insured: __________________________________ ID number: ____________________________________

3. Injury related to a work accident? **Yes / No** If Yes, Name of Employer and address at time of injury:

   Employer Name: ____________________ Address: ____

4. Have you received therapy for the same illness / injury in the last year? **Yes / No**

   If Yes, name of facility: ____ Dates Treated: ________________________

5. Are you (or have you) currently receiving any type of Home Health services? **Yes / No**

   Name of Home Health Agency: ____ Date Discharged: ____________

6. Name of physician who referred you to therapy: _________________________________ Phone: _______________________

7. Name of primary care physician: ____ Phone: ________________________

Is there anyone involved in the payment of your care? **YES/NO. If yes, Name______________________ Phone# _________________**

Benefits that we have received from your insurance carrier at the time of service are not a guarantee of benefits. The patient, legal guardian or parent (if the patient is under 18 years old) will be responsible for the co-payment and the deductible at the time of service. Per our contract with your insurance company we are required to collect the entire amount of your coinsurance, copay or deductible. Our office accepts Cash, Personal Checks, Visa, MasterCard and Discover. There is a service fee of $40 for any returned checks.

Patient/Guardian Signature: ____ Relationship to the Patient: ___________________________

Print Patient Name: ____ Date: ____

Consent for Treatment in a Group Setting

CORA Rehabilitation Clinics in compliance with Federal HIPAA Regulations is committed to protecting our patient's health information and privacy.

Our therapists and staff will be making every effort to ensure that your protected health information ("PHI") is kept private. However, due to the nature of the open setting of our therapy area, your treatment may be performed in the presence of other individuals. In some instances it is possible that other patients, family members or friends, and staff will overhear information relating to your treatment, diagnosis, and insurance benefits.

Unless you indicate in writing to the contrary, by signing this Consent Form you are agreeing that it is possible for other patients to overhear trivial information regarding your treatment and consenting to the disclosure of this inconsequential information to any other individuals who may be present in the therapy area.

By signing below, I acknowledge and agree to the above conditions.

DATE _________________

________________________________	________________________________
Signature of Patient *(or authorized representative)*	*Print Name of Patient* *(or authorized representative)*

Please explain Representative's relationship to Patient and include a description of Representative's authority to act on behalf of Patient.

____

Medicare Outpatient Therapy Qualification

In order to determine your eligibility for outpatient therapy services please answer the following questions:

Is a Home Health Representative, Nurse, Aide, Therapist or anyone other than a family member currently assisting you in your home with:

-Physical, occupational or speech therapy: ☐ Yes ☐ No

-Wound care: ☐ Yes ☐ No

-Injections or medications: ☐ Yes ☐ No

-Bathing or personal care: ☐ Yes ☐ No

-IV care: ☐ Yes ☐ No

-Any services not listed above: ☐ Yes ☐ No

Has a Home Health Representative, Nurse, Aide, Therapist or anyone other than a family member assisted you in your home with services in the past 30 days: ☐ Yes ☐ No

If you answered **"YES"** to any of the questions above, you MAY NOT qualify for outpatient therapy services as determined by Medicare's guidelines. In order to qualify for our services you will need to be discharged completely from all home care services, which is your responsibility. A copy of the Medicare ABN form provided for you to read and sign. You understand that if claims are denied you will be responsible for these charges.

____

Patient/Guardian Signature Date

To be completed by Front Desk

Did you contact the CBO to verify that patient was not covered under home health?
☐Yes ☐ No **attach email Discharge date ________________________

ABN Form: ☐ Yes ☐ No

____

Signature of employee verifying discharge

FINANCIAL RESPONSIBILITY/ ASSIGNMENT OF BENEFITS (Michigan)

Thank you for choosing CORA Rehabilitation Clinics for your rehabilitation needs. As healthcare benefit and coverage options continue to increase in complexity, we have developed financial policies to assist you in understanding your responsibilities as a patient. This form is intended to communicate your financial responsibilities as a patient.

FINANCIAL RESPONSIBILITY

I understand that my insurance contract is between me, my employer and the insurance company and that CORA Rehabilitation Clinics (CORA) is not a party to that contract. I understand that CORA will contact my insurance company (including Medicare) to verify my benefits, but that it is my responsibility to understand what is covered and required under my policy. I acknowledge that providing accurate insurance and other information is critical to determining patient eligibility and benefits available.

I understand that CORA will bill my insurance carrier (including Medicare) for services rendered upon verification of coverage by my insurance company**. I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change.** If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for medical care and services rendered. If my insurance company does not remit payments, including if I am denied benefits under workers compensation, I understand that I will be responsible for the balance due in full.

I understand that I am responsible for paying my co-payments, co-insurance (including co-insurance from Medicare) and deductibles at the time of service which I acknowledge may be an estimate at that time. Further, I understand that federal and state laws and insurance company contracts prevent CORA from adjusting, writing off or waiving co-payments, co-insurance (including co-insurance from Medicare) and deductibles. I also understand that I am responsible for any balance due after payment by my insurance company.

Pursuant to the assignment of benefits herein; I hereby request that my insurance carrier make payment directly to CORA Rehabilitation Clinics for all services rendered by this facility. If my current policy prohibits direct payment to CORA Rehabilitation Clinics, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to: CORA Rehabilitation Clinics, Inc., 1110 Shawnee Road, Lima, OH 45805. If my insurance carrier makes payments to me I agree to immediately pay over these funds to CORA Rehabilitation Clinics. I also authorize CORA Rehabilitation Clinics to deposit check received on my account when made out to me.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ASSIGNMENT OF BENEFITS

I, the undersigned, hereby assign to CORA Rehabilitation Clinics (hereinafter "Assignee") any and all rights, claims, benefits, and causes of action for medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services, and medical claims resulting from an automobile accident that occurred on ______________. This is to act as an assignment of my rights and benefits to the extent of Assignee's services provided. In the event that I do not have insurance coverage, I understand that I remain personally responsible for payment of services rendered including all costs of collection, including attorney's fees and costs.

DIRECT ACCESS- NO RX REQUIRED

I agree to be evaluated and treated by a therapist without a Rx from a physician or other healthcare practitioner per the State of MI- 21 consecutive days (3 weeks) or 10 visits from date of evaluation. A signed POC OR RX by a Healthcare Practitioner of choice after 21 days or 10 visits would need to be obtained for continued care. Patient Initials ___________

Please call our Billing Office if you have any questions on your account or if you are unable to pay your balance in full they will be able to discuss payment arrangements with you. The number is 866-493-9410.

____
Print Name of Patient

____	____
Print Name of Guardian (if applicable)	Relationship to Patient (if applicable)
____	____
Patient/Guardian Signature	Date

AUTHORIZATION CONSENT FOR CARE AND TREATMENT

CONSENT TO RELEASE ALL MEDICAL RECORDS FOR INSURANCE, MEDICARE, MEDICAID, OR THIRD PARTY REIMBURSEMENT AND CONTINUITY OF CARE AND MEDICARE PATIENTS CERTIFICATION

I hereby give my consent to the facility and/or treating physicians and their agents to release all records, including via electronic transmittal, prepared in the course of my treatment, to any entity which provides financial assistance for my health care, including, but not limited to, insurance companies and their agents, self-insured employers or public welfare agencies. I certify that the information given by me in applying for payment under Title XVII of the social security act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and/or the Medicare program or its intermediaries or carriers, or to the professional standards review organizations any information needed for this or a related Medicare claim. I understand that by signing this form, records of a confidential nature, such as Social Security Numbers and those for HIV testing, AIDS or AIDS related condition, psychiatric problems or substance abuse, will be released to the entities providing financial assistance for my health care. This release includes disclosing data to local, state, federal, other entities for routine operational purpose of regulatory, legal or contract compliance, accreditation, peer review, quality improvement, continuity of care, or processing appeals for claims denials. I also understand that I may revoke this consent at any time and without revocation and that it will expire one year from this date, or if admitted, one year from the date of discharge. I acknowledge that I have been provided and given the opportunity to review the Facility's Information regarding patient's rights and responsibilities. I further acknowledge that I have been provided and given the opportunity to review a complete "Important Privacy Notice" describing the uses and disclosure of my personal health information and my rights with respect to this matter. My signature acknowledges my receipt of "An Important message From Medicare" from the Facility and does not waive my rights to request a review or make me liable for payment.

PATIENT FINANCIAL RESPONSIBILITY In consideration of the services to be rendered by the Facility, I agree that, should the service not be covered or paid by my insurance company, I may be responsible for payment of amounts billed by the facility for the service rendered.

NONDISCRIMINATION POLICY As a recipient of Federal financial assistance, CORA Rehabilitation Clinics does not exclude, deny benefits to, or otherwise discriminate against any person on the ground of race, color, or national origin, or on the basis of disability or age in admission to, participation in, or receipt of the services and benefits under any of its programs and activities, whether carried out by CORA Rehabilitation Clinics directly or through a contractor or any other entity with which CORA Rehabilitation Clinics arranges to carry out its programs and activities.

PERSONAL VALUABLES It is understood and agreed that the Facility will secure any money or valuables upon request. The Facility shall not be liable for loss or damage to any money, jewelry, glasses, dentures, documents, fur garments, or other articles of value, unless deposited with the facility for safekeeping. Patients are urged to retain not more the $10.00 during their Facility admission.

Preparation of Likeness I, the undersigned, hereby authorize CORA Rehabilitation Clinics or its affiliates, its Medical Staff, employees and agents, to photograph, film, videotape, or make such other likeness of the patient whose name appears above and to use the same without limitation as they deem proper.

Assignment of Insurance Benefits I hereby authorize payment directly to CORA Rehabilitation Clinics insurance benefits otherwise payable to me but not to exceed the balance due the facility's regular charges.

Guarantee of Account I agree to pay CORA Rehabilitation Clinics in full any amount due but not to exceed the facility's regular charges.

Assignment of Physician Insurance Benefits I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization submit a claim to Medicare, Medicaid, or another third party for payment to me. I request that payment of authorized benefits be made on my behalf.

Prices for services are available if requested.

The undersigned certifies that he has read the foregoing, and is the patient, or is duty authorized by the Patient as the Patient's general agent to execute the above and accept its terms.

CONSENT FOR FACILITY CARE AND TREATMENT

I hereby authorize CORA Rehabilitation Clinics to provide care and treatment under my physician's direction. I want the physician and their qualified assistants attending to my care to give me such examinations, treatments, diagnostic tests, injections, and medications which they believe are necessary and advisable for me. I acknowledge that every medical procedure involves some risk even if all procedures have been done with due care and further that the practice of medicine is not an exact science and no promises or guarantees have been made to me regarding and Emergency diagnosis and treatment. In the event this document is being executed after commencement of diagnosis and treatment, I hereby ratify the action taken whether emergency or otherwise and acknowledge the necessity of such treatment.

I authorize CORA Rehabilitation Clinics to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

______________________________ ______________________________

Patient or Guardian Signature Relationship to patient

______________________________ ______________________________

Witness Date

PATIENT GUIDELINES AND PATIENT CANCELLATION POLICY

Please arrive for your appointment on time in order to allow all patients adequate time for their appointments. Patients arriving late for a scheduled appointment may not be allotted extended treatment time.

Please sign in upon arrival in order to have your treating therapist notified.

So that we can keep our clinic clean and orderly we would appreciate there being no food, drink or gum in the patient treatment areas.

Patients are asked to wait in the waiting room unless otherwise informed.

In respect of other patients, we request that only one non-patient adult be permitted in the treatment area with patient unless arrangements are made in advance.

Non-patient children are permitted in the treatment area only with prior approval from the therapist, as they may be distracting to other patients being treated.

If you are unable to keep either yours or your child's appointment due to illness, please call to reschedule your appointment at least 24 hours prior to the scheduled appointment time.

Children receiving therapy should be picked up promptly following therapy.

CANCELLATION POLICY

Attending scheduled therapy sessions is one aspect of your recovery that you control. If you are not here, we cannot help you reach your recovery goals. In the event of cancellations and/or no-shows, the following policies are in effect:

It is the policy of all CORA Rehabilitation Clinics to notify a patient's physician office and case manager/insurance company if a patient misses two scheduled appointments without reasonable cause.

A patient will forfeit their scheduled time slot following 2 consecutive cancellations or no-shows without reasonable cause.

A 24-hour prior notification of all cancellations is required and appreciated.

________________________________ ______________

Patient or Guardian Signature **Date**

PATIENT HISTORY SHEET

Name:________________________________ Phone: _____________________ Date: ________________________

Email:________________________________ Height: ____________________ Weight: ______________________

Emergency Contact: **_____________________________________** **Relationship:** **___________________________**

Home:_____________________ **Cell:** **______________________** **Work:** **__________________________**

MEDICAL HISTORY

1. Do you have/had any of the following medical illnesses/concerns? (Please check YES or NO)

	YES	NO		YES	NO		YES	NO
Heart Problems	______	______	Seizures	_______	_______	Pregnant	______	______
High Blood Pressure	______	______	Pace maker	_______	_______	Cancer	______	______
Active Tuberculosis	______	_______	Diabetes	_______	_______	Incontinence	______	______

Other Health Issues, please describe: ____

2. List the medications you are currently taking, the amount and the frequency (ex. Darvocet, 100 mg, every 6 hours):____
3. Do you have any allergies? If yes, please list: ____
4. Please describe your current physical complaint, and when and how it happened. (ex. Back pain, lifted a box at work):
   ____
   ____
5. Have you had any previous therapy for this problem/injury? YES _____ NO _____ If yes, was it helpful?
   ____
6. What other surgeries, injuries, or medical problems have you had in the last five (5) years?
   ____

WORK INFORMATION

1. What is your regular job? ____
2. What is your present work duty status? Please circle one

   Full-time/Regular **Part-time/Regular** **Full-Time/Modified** **Part-time/Modified** **Not Working** **Unemployed** **Retired**
3. Describe the physical requirements of your job. (Please indicate the amount of weight you lift, standing/sitting/walking time, positions you must maintain, and any other job components)
   ____
4. Do you want assistance communicating with your employer? YES _____ NO _____

SOCIAL INFORMATION

1. What goals would you like to achieve in therapy? ____
2. What specific activities have you had difficulty doing since your injury/illness?
   ____

Patient Signature: ____

NOTES: ____