UNIVERSAL PHYSICAL THERAPY, P.C.
2565 S. Rochester Road, Suite 108A
Rochester Hills, MI 48307
Phone(248) 844-2644
Fax (248) 844-2645

UNIVERSAL PHYSICAL THERAPY,PC
PATIENT INFORMATION

We want to provide you with the very best health care possible. We realize your time is valuable and our staff will try to attend to you as quickly as possible. Please take a few minutes and complete the information below. This will enable us to maintain accurate information in your life. Thank You!

PATIENT'S LAST NAME:_____ FIRST NAME:_____ SEX: M or F

ADDRESS:_____ APT#_____ CITY:_____

STATE:_____ ZIP:_____ CLIENT RESIDES: HOME___ SNF___ OTHER_____ MARITAL STATUS: S M W D

HOME PHONE:_____ ALT. PHONE:_____ BIRTHDATE:_____ S.S.#_____

EMERGENCY CONTACT#_____ EMERGENCY CONTACT NAME:_____ RELATION:_____

CELL PHONE#_____ E-MAIL ADDRESS _____

IS THIS INJURY/ILLNESS WORK RELATED? (If yes answer questions #1-#10) YES:_____ NO:_____
1. EMPLOYER'S NAME:_____ EMPLOYER'S #_____
2. EMPLOYEE WAS: FULL TIME___ PART TIME___ RETIRED WHEN INJURY/ILLNESS BEGAN___

IS INJURY/ILLNESS CAUSED BY AN ACCIDENT? YES:___ NO:___
3. WHEN OCCURED:_____ WHERE OCCURRED:_____
4. HOW?_____
5. REPORTED? YES___ NO___, IF YES TO WHOM:_____ DATE REPORTED:_____
6. ACCIDENT INSURANCE NAME:_____
7. TYPE OF INSURANCE: AUTO___ WORKER'S COMP___ LIABILITY___ OTHER_____
8. INSURANCE / POLICY NUMBERS:_____
9. CLAIM NUMBER:_____
10. CONTACT PERSON:_____ PHONE#_____

PRIMARY INSURANCE:_____ (*IF MEDICARE / MEDICAID SEE BELOW)**
CONTRACT #_____ GROUP#_____ SERVICE CODE_____
SUBSCRIBER'S NAME:_____ SUBSCRIBER'S BIRTHDATE:_____
MEDICARE: PART A___ PART B___

SECONDARY INSURANCE:_____ (*IF MEDICARE / MEDICAID SEE BELOW)**
CONTRACT #_____ GROUP#_____ SERVICE CODE_____
SUBSCRIBER'S NAME:_____ SUBSCRIBER'S BIRTHDATE:_____
MEDICARE: PART A___ PART B___

*****FOR MEDICARE / MEDICAID ONLY: ***NOTE: PRIOR AUTHORIZATION MAY BE REQUIRED!**
IS MEDICARE / MEDICAID PART OF AN HMO? YES___ NO___ IF YES NAME OF HMO_____
IS MEDICARE / MEDICAID PART OF A PPO? YES___ NO___ IF YES NAME OF PPO_____

YOUR PHYSICIAN'S NAME:_____ PHONE #_____

WHOM MAY WE THANK FOR REFFERING YOU?_____

*****PATIENT OR RESPONSIBLE PARTY AUTHORIZATION FOR P.T OR O.T.*****

I, as the patient or responsible party authorize any holder of medical or other information about the patient named above, to be released to the Social Security Administration or its intermediaries or carriers of information for this or a related Medicare Claim and/or any other insurance claims. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits for P.T. or O.T. treatments be made to the Provider.

PATIENTS SIGNATURE (OR RESPONSIBLE PARTY):_____ DATE:_____

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PATIENT INSURANCE INFORMATION

PRIMARY INSURANCE:_____ SUBSCRIBER'S NAME:_____
SUBSCRIBER'S BIRTHDATE:_____ SUBSCRIBER'S RELATIONSHIP TO PATIENT:_____
SUBSCRIBER'S EMPLOYER:_____ SUBSCRIBER'S WORK #_____
INSURANCE POLICY NUMBER:_____ GROUP NUMBER:_____

SECONDARY INSURANCE:_____ SUBSCRIBER'S NAME:_____
SUBSCRIBER'S BIRTHDATE:_____ SUBSCRIBER'S RELATIONSHIP TO PATIENT:_____
SUBSCRIBER'S EMPLOYER:_____ SUBSCRIBER'S WORK #_____
INSURANCE POLICY NUMBER:_____ GROUP NUMBER:_____

I herby authorize UPT P.C. billing agent to bill for all services rendered to my insurance company. My signature represents full authorization to release medical information to my insurance company(s) for processing of all medical claims. I also understand I am fully responsible for any and all non-covered services, and I am aware that my policy is between my medical insurance company and myself, and I fully understand my coverage. Finally, I understand that a fee of $40.00 will be charged to my account for all returned checks. EFFECTIVE 04/15/2010 A 5% WILL BE ADDED IF THE BALANCE DUE IS NOT RECEIVED WITHIN 30 DAYS FROM THE DATE OF THE STATEMENT.

_____ _____
PATIENTS/LEGAL GUARDIAN SIGNATURE **DATE**

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PATIENT BILL OF RIGHTS

- **PATIENTS SEEKING REHABILITATION SERVICES OFFERED AT THIS FACILITY WILL BE FAIRLY AND EQUALLY TREATED, REGARDLESS OF RACE, CREED, COLOR, SEX, NATIONAL ORIGIN, AGE, HANDICAP, OR ABILITY TO PAY.**
- **ANY TREATMENT THAT A PATIENT IS TO RECEIVE WILL BE FULLY EXPLAINED TO THE PATIENT. THE PATIENT HAS THE RIGHT TO REFUSE ANY TREATMENT, IN WHICH CASE, THE REFERRING PHYSICIAN WILL BE NOTIFIED. THE PATIENT HAS A RIGHT TO QUESTION ANY TREATMENT THAT HE / SHE IS TO RECEIVE.**
- **THE PATIENT HAS THE RIGHT TO HAVE EXPLAINED TO HIM / HER ANY CHARGES INCURRED AT THE FACILITY.**

ACKNOWLEDGMENT

_____ _____

PATIENTS/LEGAL GUARDIAN SIGNATURE **DATE**

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UNIVERSAL PHYSICAL THERAPY,PC
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 ("HIPPA"), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. I UNDERSTANDTHAT THIS INFORMATION CAN AND WILL BE USED TO:

- **CONDUCT, PLAN, AND DIRECT MY TREATMENT AND FOLLOW-UP AMOUNG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THAT TREATMENT DIRECTLY AND INDIRECTLY.**
- **OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.**
- **CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.**

I HAVE RECEIVED, READ AND UNDERSTAND YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OS THE USES AND DISCLOSURES OF MY HEALTH INFORMATION. I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY CONTACT THIS ORGANIZATION AT ANY TIME AT THE ADDRESS ABOVE TO OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES.

I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS. I ALSO UNDERSTAND YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THE CONSENT.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE:_____

OFFICE USE ONLY

I ATTEMPTED TO OBTAIN THE PATIENTS SIGNATURE IN ACKNOWLEDGEMENT ON THE NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT, BUT WAS UNABLE TO DO AS DOCUMENTED BELOW:

DATE:_____ INITIALS:_____ REASON:_____

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UNIVERSAL PHYSICAL THERAPY,PC
PATIENT MEDICAL HISTORY

PATIENT NAME:_____
DATE:_____

PLEASE MARK AN "X" ON THE APPROPRIATE LINE IF IT APPLIES:

	YES	NO	N/A
HEART TROUBLE (HEART ATTACK, CHEST PAIN)	_____	_____	_____
PACEMAKER	_____	_____	_____
SEIZURES	_____	_____	_____
NEUROLOGICAL CONDITIONS (STROKE, PARKINSON'S, M.S., M.D., HEAD INJURY)	_____	_____	_____
RESPIRATORY CONDITIONS (SHORTNESS OF BREATH, EMPHYSEMA, BRONCHITIS, ASTHMA)	_____	_____	_____
BROKEN BONES	_____	_____	_____
ANY METAL IMPLANTS (PINS, SCREWS, PLATES, IUD)	_____	_____	_____
CANCER; LOCATION:_____	_____	_____	_____
ALLERGIES (HAY FEVER, MEDICINE, IODINE)	_____	_____	_____
HIGH BLOOD PRESSURE	_____	_____	_____
DIABETES	_____	_____	_____
MAJOR ACCIDENTS	_____	_____	_____
MAJOR SURGERIES	_____	_____	_____
CURRENTLY PREGNANT **NUMBER OF PAST PREGNANCIES**_____	_____	_____	_____
ANY OTHER CONDITIONS **IF YES PLEASE EXPLAIN:**	_____	_____	_____

_____
_____
_____

PLEASE USE THIS SPACE TO ELABORATE ON ANY OF THE ABOVE STATEMENTS:

_____
_____
_____

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PAIN HISTORY

DATE OF ONSET PRESENT PAIN, ILLNESS, OR INJURY:_____

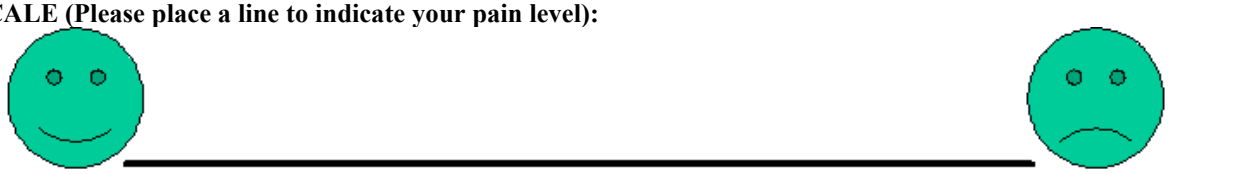
PLEASE DESCRIBE HOW THE INCIDENT OR ONSET OCCURRED:

_____

_____

_____

PAIN SCALE (Please place a line to indicate your pain level):

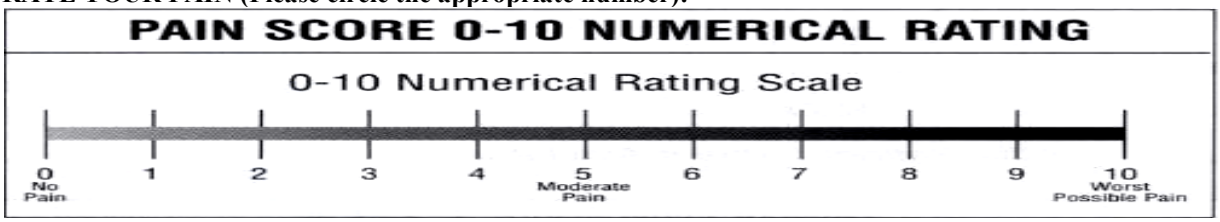


No pain **Worst pain ever**

PAIN DESCRIPTION: (Circle **ALL** descriptors of your pain**)**

1. **Is your pain VARIABLE or CONSTANT?**
2. **Is your pain worse with SITTING or STANDING?**
3. **Is your pain worse in the MORNING or EVENING or AFTER ACTIVITY?**
4. **Do describe your pain as SHARP or DULL ACHE or STABBING or BURNING or RADIATING?**

DO YOU HAVE ANY NUMBNESS? YES___ NO___ IF YES,WHERE?_____
PLEASE RATE YOUR PAIN (Please circle the appropriate number):



LIST ANY MEDICATIONS YOU TAKE REGULARLY OR ARE CURRENTLY TAKING_____

_____

_____

_____ _____
PATIENTS/LEGAL GUARDIAN SIGNATURE **DATE**

_____ _____
THERAPIST SIGNATURE **DATE**