



# ABEL CENTER FOR REHABILITATION

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## Office Use Only

Past Patient: <input type="checkbox"/> YES <input type="checkbox"/> NO	Financial Class: <input type="checkbox"/> MR <input type="checkbox"/> CH <input type="checkbox"/> MC <input type="checkbox"/> MCC <input type="checkbox"/> CM <input type="checkbox"/> WC <input type="checkbox"/> MV <input type="checkbox"/> LG <input type="checkbox"/> MD <input type="checkbox"/> SP <input type="checkbox"/> CP	Evaluation Date/Time
Diagnosis 1 (Desc/ICD9):	Diagnosis 2 (Desc/ICD9):	Evaluating Therapist: <input type="checkbox"/> PT <input type="checkbox"/> OT <input type="checkbox"/> ST <input type="checkbox"/> other

## Patient Information

Patient Name: (First, MI, Last, - Sr., Jr., etc)		SS #:	
Address:		City:	State: Zip Code:
Telephone/Cell	Date of Birth (mm-dd-yy)	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/> Unknown
Original Date of Injury / Onset Date: ___/___/___	Auto Related: <input type="checkbox"/> Yes-State? _____ <input type="checkbox"/> No	Work Related: <input type="checkbox"/> Yes <input type="checkbox"/> No	Adjustor Name & Telephone # & Address

How did you hear about us?  MD Referral  Community Event  Yellow Pages  Injury Hotline  Other \_\_\_\_\_  
 Family/Friend Referral  Previous Experience

**If Workers Comp:**  
 Have you received Physical Therapy treatment for this condition since the above "Original Date of Injury"?  Yes  No  
 If so, how many treatment sessions do you remember receiving? \_\_\_\_\_

<b>If Workers Comp, was accident with present Employer?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No If No, who was employer? _____	<b>If Workers Comp, Case Worker Name &amp; Telephone #</b>
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## Primary Insurance Information

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Insurance Company Telephone #:	Policy Holder's Work Phone #:	<b>Patient Relationship to Policy Holder:</b> <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other

## Secondary Insurance Information (Backup if Auto, Workers Comp. or Litigation)

Name of Insurance Company:	Policy or Claim #:	Group # / Policy Holders Employer:
Policy Holder Name:	Date of Birth:	Social Security #
Benefits:	OOP/Deductible:	Patient Relationship to Policy Holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Dependent <input type="checkbox"/> Other

## Employer Information

Employer Name:	Employer Phone #:	Employment Status: <input type="checkbox"/> None <input type="checkbox"/> FT <input type="checkbox"/> PT <input type="checkbox"/> Self-Emp. <input type="checkbox"/> Retired <input type="checkbox"/> Student
Address:	City:	State: Zip Code:

## Emergency Contact Information

Contact Name:	Phone #	Relationship to Patient: <input type="checkbox"/> Parent <input type="checkbox"/> Spouse <input type="checkbox"/> Sibling <input type="checkbox"/> Other
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## Physician Information

Name of Referring Physician:	Telephone #:	UPIN #
Address (Only required if new referring Physician):	City:	State: Zip Code:

## Attorney Information

Attorney Name	Telephone #:	Fax #:
Address	City:	State: Zip Code:



## NOTICE OF PRIVACY PRACTICES ABEL CENTER FOR REHABILITATION

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**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

The terms of this Notice of Privacy Practices apply to VibrantCare Rehabilitation and each of its subsidiaries, affiliates, and entities managed or controlled by VibrantCare Rehabilitation, including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by VibrantCare Rehabilitation. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to VibrantCare Rehabilitation, 1090 Sunrise Ave #140, Roseville, CA 95661.

### USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

**Authorization and Consent:** Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or healthcare operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

**Uses and Disclosures for Treatment:** With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

**Uses and Disclosures for Payment:** With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

**Uses and Disclosures for Health Care Operations:** With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

**Individuals Involved In Your Care:** With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Business Associates:** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Appointments and Services:** We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to VibrantCare Rehabilitation, 1090 Sunrise Ave #140, Roseville, CA 95661.

**Research:** In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.



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**Other Uses and Disclosures:**

We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

**RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:**

**Access to Your Personal Health Information**

You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person. You are entitled to one free copy of your personal health information. If you request additional copies you may be charged a nominal fee for copying and postage.

**Amendments to Your Personal Health Information**

You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

**Accounting for Disclosures of Your Personal Health Information**

You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

**Restrictions on Use and Disclosure of Your Personal Health Information:** You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

**Complaints:** If you believe your privacy rights have been violated, you can file a complaint in writing to VibrantCare Rehabilitation, 1090 Sunrise Ave #140, Roseville, CA 95661. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

**FOR FURTHER INFORMATION:** If you have questions or need further assistance regarding this Notice, you may contact VibrantCare Rehabilitation, 1090 Sunrise Ave #140, Roseville, CA 95661 or 916-782-1212.

\_\_\_\_\_  
Patient (or representative) Signature

\_\_\_\_\_  
Date



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## BUSINESS DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility or the Central Billing Office to inquire about your personal health information or billing information. Please take a few moments to complete this form.

**I authorize VibrantCare Rehabilitation to disclose my health information that is directly related to my current treatment at VibrantCare Rehabilitation to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.**

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

**I do not wish to have my health information disclosed to individuals involved in my care.**

NAME	RELATIONSHIP

\_\_\_\_\_  
**Signature of Patient (or Patient's Representative)**

\_\_\_\_\_  
**Date**

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

- Power of Attorney
- Guardian
- Surrogate Decision-Maker
- Executor of Legal Rep.
- Parent
- Other (please specify) \_\_\_\_\_

Provide documentation or explanation of your authority to act for the patient:

\_\_\_\_\_  
\_\_\_\_\_



# PAST MEDICAL HISTORY FORM ABEL CENTER FOR REHABILITATION

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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Are you presently working?  Yes  No

Date of next physician's visit: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of injury / onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever had these symptoms before?  Yes  No

Check which apply to your symptoms:

- Work related injury
- Motor vehicle accident
- Cause unknown
- Recurrence of previous injury
- Injury related to lifting
- Athletic / recreational injury
- Injury related to falling
- Other: \_\_\_\_\_

Have you had a related surgery?  Yes  No

Do you have, or have you had any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies / Poor tolerance to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Recent Fractures	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>
Smoking	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke/CVA	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____		

**If yes on any of the above, please briefly explain and give approximated date:**


Is there any other information regarding your past medical history that we should know about?


Are you presently taking Medication?  Yes  No

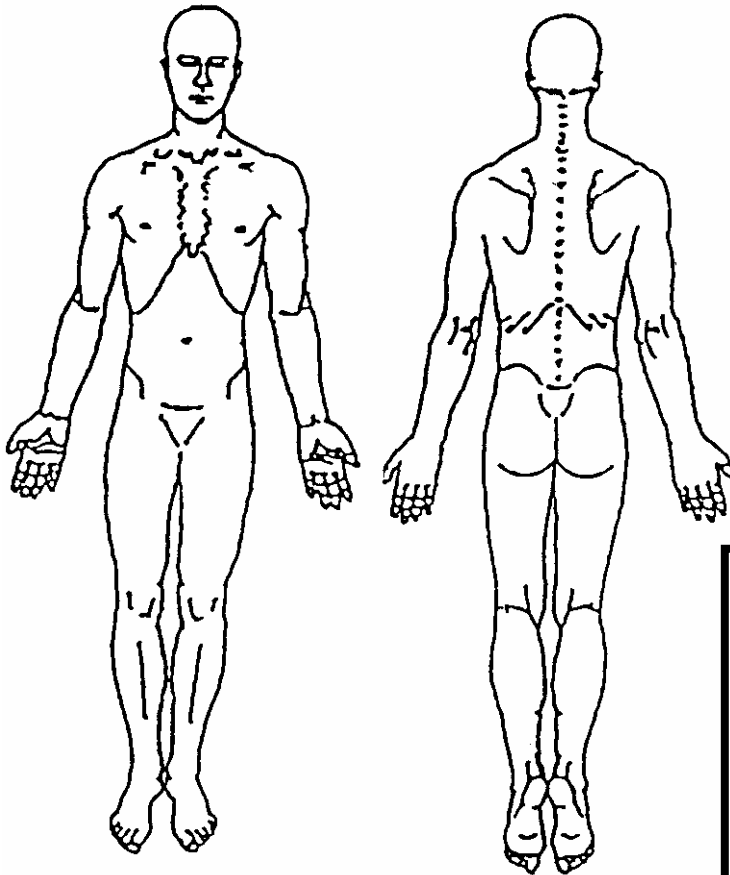
If yes, please list what medications and for what condition:


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Do you participate in any sports, exercise programs, or activities on a regular basis?  Yes  No

The services of a social worker are available through VibrantCare.  
Please indicate if you feel you have need of such services.  Yes  No

Please indicate below where your symptoms are located.



**KEY:**

**Numbness** =====

**Pins & Needles** ooooooo

**Burning Pain** xxxxxxxx

**Stabbing Pain** //////////////

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible: \_\_\_\_\_.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Guardian if patient is a minor

\_\_\_\_\_  
Date

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date



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**PAYMENT POLICY AND BILLING PROCEDURES**

- 1. Unless 100% coverage has been verified with no copay, no co-insurance, and no deductible, you are responsible for the copay/co-insurance per visit and/or deductible not covered by your insurance company. This payment is required at the time of each visit.
2. Your verified copay amount is \$ per visit. If you have a Plan with Co-Ins, the verified % covered by your Insurance per visit is % and your % due is %. Your deductible amount is \$. This payment is due in full at the time of your visit.
3. We accept cash or check or Visa, MasterCard and Discover bankcards.
4. There is a \$25 charge for all returned checks
5. You will receive a monthly statement that will show you the status of your account.

**INSURANCE INFORMATION**

As a courtesy to our patients, we will verify and file your claim with your insurance company; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical, occupational or speech therapy coverage. Many insurance companies have stipulations that limit the benefit in some way, such as # of visits, supplies, deductibles, co-insurance, copays, etc. These stipulations should be noted in your policy manual. Final determination of benefits and your financial responsibility will be determined by your Insurance Carriers Payment to VibrantCare.

**SUPPLIES/MEDICAL RECORDS POLICY**

SUPPLIES: Payment for all supplies not covered by insurance is due at the time of service.
MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible for payment for all supplies used in your treatment at the time of each visit.

ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly.
WORKER'S COMPENSATION benefits will be verified; however, this does not guarantee payment. In the event of denial, this account will become YOUR RESPONSIBILITY.

**CONSENT TO TREATMENT**

I understand that I have been referred for rehabilitative treatment and care to a VibrantCare Center. VibrantCare has described for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. By signing this agreement, I consent to have VibrantCare provide treatment and care as prescribed by my physician and/or recommended by my therapist.

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of VibrantCare. I hereby authorize VibrantCare to furnish my insurance company(s), attorney, or legal representative all information which said parties might request concerning my present illness or injury. I hereby assign VibrantCare all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to VibrantCare. It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. I am financially responsible to VibrantCare for charges not covered by my insurance company. I certify by my signature that I have read and agree to this information.

Patient Name: (Last, First, MI) Please print

Signature: Date:

Relationship to Patient: (Self, Parent or Guardian)

Witness:



# SOCIAL SERVICES QUESTIONNAIRE (CONFIDENTIAL)

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TO OUR PATIENTS

Center: \_\_\_\_\_

At VibrantCare, we realize that physical problems affect a person in a variety of ways. In addition to physical discomfort, the inconvenience and disruption to familiar routine created by an injury creates stress on you and your family, friends, and co-workers, which may increase your recovery time. VibrantCare provides the services of a Social Worker who works in close cooperation with your therapist to effectively deal with this stress. Most social services can be provided to you over the phone, however you also have the option to meet with the social worker in person at this clinic. Your decision to obtain social services, either over the phone or in person, can be changed at any time throughout your rehabilitation program. **The following questionnaire is designed to determine if you may benefit from this service.**

**Your participation in answering these questions is voluntary.**

**Yes**, I voluntarily agree to answer these questions.  **No**, I choose not answer these questions.

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

For what condition are you being treated at this rehabilitation center? \_\_\_\_\_

1) Are you residing?:  Alone  
 With Spouse  
 Family/Relative  
 Friends

7) Are you receiving assistance from any of the following?  
 Church  Family  
 Meals on Wheels  Senior Services  
 American Cancer Society  Diabetes Assoc  
 Veteran's Administration  Social Group  
 Other

2) Will this arrangement meet your needs since your injury/illness?  Yes  No

3) Type of residence:  House  Rent  Own  
 Apartment  Hotel  
 Residential Care Home  
 Other \_\_\_\_\_

8) Do you anticipate having a difficult time keeping your therapy and medical appointments because of:  
 Unreliable transportation  Inability to drive  
 No child care

4) Will this arrangement meet your needs since your injury/illness?  Yes  No

9) **Would you like to discuss these or other concerns with our Social Worker?**  Yes  No  
**If yes:**

5) Are you employed?  No  
 Part / Full Time  
 Currently unemployed  
 Retired

a) What specific concerns: \_\_\_\_\_  
\_\_\_\_\_

6) Due to your current injury/illness, is your income sufficient to meet your daily needs/sustenance (food, shelter, etc.)?  Yes  No

\_\_\_\_\_  
Patient Signature Date

**For Office Use Only:**

Recommend referral to Social Services secondary to: \_\_\_\_\_

By: \_\_\_\_\_ (Therapist) \_\_\_\_\_ (Center) \_\_\_\_\_ (Date)

Social Services needed?  Yes  No If yes, intervention provided: \_\_\_\_\_

\_\_\_\_\_  
Social Worker's Signature Date