

WELCOME TO VALLEY REHABILITATION ASSOCIATES, INC.

No Show/Cancellation Policy:

Valley Rehabilitation Associates, Inc. understands that emergencies happen. However, in order to obtain all benefits that your therapy has to offer, and which your doctor has prescribed, attendance at all scheduled therapy appointments is important. If you should need to cancel, out of courtesy to our other patients, we ask that you call to notify our office no less than 24 hours in advance. Due to the increased volume of canceled and no showed appointments and to remain courteous of other patients waiting to be seen, if you fail to call 24 hours prior and/or do not show for a scheduled appointment, you may be charged a \$25.00 No Show fee.

Compliance:

We care about your progress as our patient; therefore, we are obligated to inform your insurance company, case worker, and physician if you are non-complaint with your therapy and/or therapy attendance.

Appointments:

To achieve the most out of your therapy program, it is important that you attend all of your scheduled appointments. As a courtesy to other patients, as well as the staff treating you, we ask that you please be on time for each appointment. If you show more than 15 minutes late to an appointment, the therapist will use his/her discretion whether or not you will be seen or rescheduled for another day.

Attire:

Due to the nature of therapy exercise programs, loose fitting or athletic attire is suggested. A changing area is available for patient use.

Insurance:

As an extended service to you, a claim will be filed with your primary insurance carrier for every service you receive at Valley Rehabilitation Associates, Inc. Although we are happy to assist you in filing a claim with your insurance carrier, it is important for you to remember that you are the insured. You, or your employer, have selected the carrier and your coverage. It is your responsibility to question your insurance carrier regarding delays in payment and/or the amounts paid. We will make every effort to follow up on the claims we have filed on your behalf, but we cannot accept the responsibility for insufficient coverage or slow payment.

Please be aware that VRA requires payment for all co-pays, deductibles, coinsurances, and supplies that your insurance will not cover at the time of service. VRA will file for any covered supplies allowed by your insurance.

In the event that your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or parent will be responsible for the principal amount owed and all reasonable costs associated with the collection of this debt, including: collection service fees, attorney's fees, court costs, and additional legal expenses associated with the recovery of the debt, up to and to include 33% above the principal amount owed.

In assisting you to file your insurance claims, we will need complete and accurate information. If for any reason, your insurance coverage should change, please inform us immediately.

Electrodes:

Electrical stimulation is used for pain management and inflammation reduction, which promotes the healing of tissue. This process requires the use of electrodes. We ask that if electrical stimulation is used in your treatment plan, you pay a \$7.00 fee. These electrodes will remain in your chart, be used solely to treat your injury/diagnosis, and will be yours to keep.

All staff at Valley Rehabilitation Associates, Inc. is committed to providing you the ultimate quality of care. The outcome of your therapy is based on a partnership between you and your therapist and your commitment to your therapy plan. Please feel free at any time to ask our staff questions or discuss concerns.

I _____ have read and understand the policies and will comply with the recommendations.

Patient/Guarantor Signature

Date



Name: _____ Date: _____

Age: _____ Height _____ Weight: _____

Diagnosis: Right / Left _____

Date of injury: _____ Date of surgery: _____

Physician for this injury: _____ Next appt: _____

Occupation: _____ Employer: _____

Currently Working: Yes / No Date last worked: _____

How did the injury occur?: _____

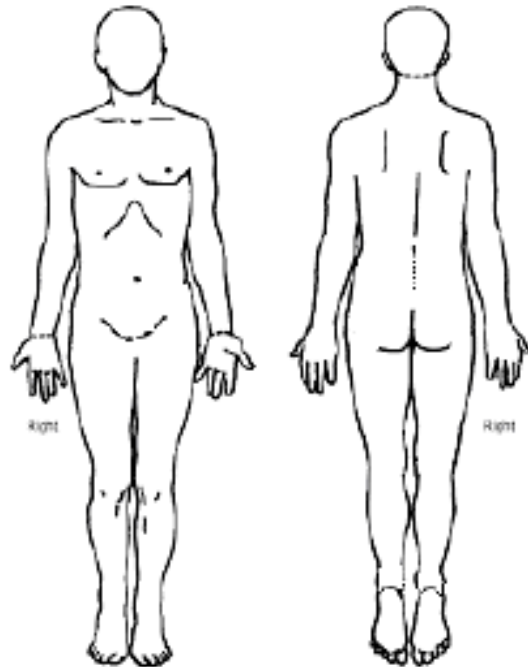
Have you had previous treatment for this injury? Yes / No

Please describe: _____

Have you ever been diagnosed with any of the following?:

Circle affected areas:

- | | | |
|---|-----|----|
| Cancer (type) _____ | Yes | No |
| Heart Problems | Yes | No |
| High Blood Pressure | Yes | No |
| Asthma | Yes | No |
| Emphysema | Yes | No |
| Thyroid Problems | Yes | No |
| Diabetes | Yes | No |
| Multiple Sclerosis | Yes | No |
| Osteoarthritis | Yes | No |
| Rheumatoid Arthritis | Yes | No |
| Hepatitis | Yes | No |
| Tuberculosis | Yes | No |
| Stroke | Yes | No |
| Kidney Disease | Yes | No |
| Anemia | Yes | No |
| Epilepsy | Yes | No |
| Insomnia | Yes | No |
| Are you currently pregnant | Yes | No |
| 1 st Trimester 2 nd Trimester 3 rd Trimester | | |
| Other _____ | | |



Please list all medications you are currently taking: _____

Allergies: _____

Please list previous injuries or surgeries:	Date
_____	_____
_____	_____
_____	_____

Indicate activities that are difficult, and rate pain level (0 no pain, 10 severe pain)

Personal hygiene	_____	Pain	_____
Dressing	_____	Pain	_____
Household chores	_____	Pain	_____
Meal preparation	_____	Pain	_____
Yard work	_____	Pain	_____
Walking	_____	Pain	_____
(stairs, curbs, incline, decline, uneven ground, distance)			
Transportation	_____	Pain	_____
Exercise	_____	Pain	_____

Are you having any problems coping with your accident/injury/
disability? Yes No

Have you noticed any symptoms since your accident/injury which
cannot be attributed to physical causes? Yes No

Have you experienced any of the following symptoms since your
accident/injury?

Extreme Anxiety	Yes	No
Panic Attacks	Yes	No
Difficulty sleeping	Yes	No
Loss of appetite	Yes	No
Loss of energy	Yes	No
Loss of motivation	Yes	No
Sleeping much more than usual	Yes	No
Difficulty attending to grooming or hygiene on a daily basis	Yes	No

Therapist Initials: _____

VALLEY REHABILITATION ASSOCIATES, INC.

NOTICE OF PATIENT INFORMATION PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to this information. Please review it carefully.

VALLEY REHABILITATION ASSOCIATES, INC. LEGAL DUTY

Valley Rehabilitation Associates, Inc. is required by law to protect the privacy of your personal health information. We provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Valley Rehabilitation Associates, Inc. uses your personal health information primarily for: treatment; obtaining payment for treatment; conducting internal administrative activities, and evaluating the quality of care that we provide. For example, *Valley Rehabilitation Associates, Inc.* may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you.

Valley Rehabilitation Associates, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, and for emergencies. We also provide information when required by law.

In any other situation, *Valley Rehabilitation Associates', Inc.* policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures, at any time.

Valley Rehabilitation Associates, Inc. may change its policy at any time. When changes are made, a new 'Notice of Information Practices' will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our 'Notice of Information Practices' at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of insurances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. *Valley Rehabilitation Associates, Inc.* will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that *Valley Rehabilitation Associates, Inc.* may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on *Valley Rehabilitation Associates', Inc.* health information practices or if you have a complaint, please contact using the following information:

Valley Rehabilitation Associates, Inc.
20940 N. Tatum Blvd., Suite 200, Phoenix, AZ 85050
Telephone: (480) 502-5361 Fax: (480) 502-5369