ALLY PHYSICAL THERAPY LLC.
EMPOWER YOUR HEALTH

Welcome to Ally Physical Therapy

Personal Items & Clothing:

Patients are encouraged to wear comfortable clothing when receiving therapy treatments. Appropriate attire typically includes shorts, T-shirts, and gym shoes. Tank tops or halter tops are better for neck and shoulder injuries. Please make sure that the involved body part and surrounding areas are easily exposed. A washroom is available for clothing changes. Please secure all personal items. Ally Physical Therapy is not responsible for any lost or stolen items. If items need to be secured, please see the Facility Manager prior to treatment.

Worker's Compensation Patients:

We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation adjuster and/or Rehabilitation Case Manager of all missed or cancelled appointments. It is also required that all missed visits be rescheduled.

Billing / Payments:

All patients co - pays are to be paid on the same day of treatment session unless other arrangements are made with the front office coordinator. All billing questions should be addressed to our front office coordinator. Please inform us immediately if you have made any changes in your address, phone number or insurance carrier. The patient is ultimately responsible for all outstanding balances. It is Patient's responsibility to verify with their insurance company regarding physical therapy benefits.

Cancellations/No Show Appointments:

In order to treat your injury in a timely and efficient manner, you are expected to attend all scheduled therapy visits. All cancellations are to be at least 24 hours in advance, and rescheduled within the same business week whenever possible. There will be a $25charge to all patients who cancel their appointments with less than 24 hours notice, unless that appointment is rescheduled. There will be a $25 charge to all patients who do not show up for their scheduled appointments. Three consecutive no shows appointments may result in a discharge.

Patient Signature:_____ Date:_____

As a courtesy to other patients, please do not bring children and spouses into the treatment area.

Thank you for choosing Ally Physical Therapy as your physical therapy provider. Our highly skilled staff is looking forward to helping you accomplish your rehabilitation goals in a safe and timely manner.

32858 5 Mile Rd, Livonia, MI 48154 Ph no: 734 525 3000 Fax no: 734 525 3001

Ally Physical Therapy

Statement of Financial Responsibility

Patient Name: _____ Date: _____

Ally Physical Therapy appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. **However, you are ultimately responsible for the payment of your bill.**

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

I have read the above policy regarding my financial responsibility to Ally Physical Therapy for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Ally Physical Therapy. I agree to pay Ally Physical Therapy the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

HIPPA Disclosure Form

I authorize Ally Physical Therapy to disclose my health information that is directly related to my current treatment at Ally Physical Therapy to the individual(s) listed below for the purposes their role in my treatment or payment for the health service that I have received.

Name	Relationship
1.	
2.	
3.	

Signature: _____ (relationship to patient: self - guardian – other) _____

REGISTRATION FORM

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PATIENT INFORMATION			Today's Date:
How did you choose this clinic?			
Patient's Last Name:	First:	M.I	Sex: ( )Male ( ) Female
E-mail:			
Address:	City:	State:	Zip:
Primary Ph #:		Cell Ph #:	
Age: DOB:	SSN#:	Marital Status: S M W D Student Other	
Emergency Contact Name:		Emergency Phone no:	

MEDICAL INFORMATION	
Referring Physician Name:	
Date of Prescription:	Phone #:
Primary Care Physician:	
Date of Next Physician's Visit:	

EMPLOYMENT INFORMATION	
Employer:	Address:
Full Time / Part Time:	Work Ph #:

WORK RELATED			
Insurance Company:		Network:	
Address:		Phone #:	
ID/Claim #:	Adjuster Name:		Phone #:
Employer:			
Address:			
Employer Ph #:			
Rehabilitation Nurse/Case Manager:		Company Name:	
Phone #:		Fax #:	
IS YOUR WORK COMP INJURY DISPUTED BY YOUR EMPLOYER?		YES	NO
If Yes, Attorney Name & Phone #:			

AUTO / COMMERCIAL / MEDICARE (Secondary)					
Circle one:	PPO	HMO	POS	AUTO	OTHER
Insurance Company:				Phone #:	
Subscriber Name:				DOB & Relation to Patient:	
Subscriber Employer:					
ID/Claim #:				Group #:	
Claim Mailing Address:					
Adjuster/Attorney Name & Phone #:					

Please Sign: _____ Date:_____

Print Name: _____

If minor then responsible party or Guardian Signature/Date:

_____

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Patient Medical History and Intake Questionnaire

Patient Name:_____ Age: _____ Sex F____ M ____
What is your main complaint and in what area is it located? _____
Occupation: _____
Are you presently working? Yes _____ No _____ If no—Last Day Worked: _____
Have you ever had these symptoms before? Yes ____ No _____ If so, When? _____
Have you had physical therapy, occupational therapy or chiropractic care for this injury before? Yes_____ No _____
Which one and when? _____

Check all of those which apply to your current condition:

[ ] Work Related Injury	[ ] Sports Injury	[ ] fall
[ ] Motor Vehicle Accident	[ ] Aggravation of Pre-Existing Injury	[ ] Causes Unknown
[ ] Injury Recurrence	[ ] Lifting Injury	

[ ] Other_____

What have you been doing to decrease your pain? _____
On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____
Are your symptoms getting worse/ better/ the same/ since your injury? _____
Are you currently taking any medications? (Please list)

_____

Are you allergic to any medications? (If yes, please list) _____

Do you have or have you had any of the following please check [x]:

[ ] Diabetes	[ ] Cancer	[ ] Metal Implants
[ ] Chest Pain	[ ] Asthma	[ ] Dizziness
[ ] Heart Disease	[ ] Arthritis	[ ] Fractures
[ ] Pacemaker	[ ] Aids/HIV	[ ] Skin Allergies
[ ] Headaches	[ ] Allergies	[ ] Nausea/Vomiting
[ ] Kidney Problems	[ ] Allergies to Cold	[ ] Ear Ringing
[ ] Are You Pregnant	[ ] Seizures	[ ] Hypoglycemia
[ ] Bladder Problems	[ ] Respiratory Problems	[ ] High Blood Pressure

If you answered yes to any of the above, please explain and give an approximate date of occurrence:

_____

Please **circle** tests you have had performed:
None *X Rays* *MRI* *CT Scan* *Bone Scan* *Other (Explain)* _____

Check any of the following activities which you have difficulty with due to your injury:

____Housekeeping	____Lifting	____ Driving	____Shopping	____ Reaching	____Dressing
_____Cooking	____Climbing Stairs	____Child Care	____Bending	_____ Yard Work	_____ Sit to Stand

List all of your surgeries: _____

Is there any other information about your present health that we should know about? _____

_____

Patient Name: _____ Patient's Initials: _____Date:_____

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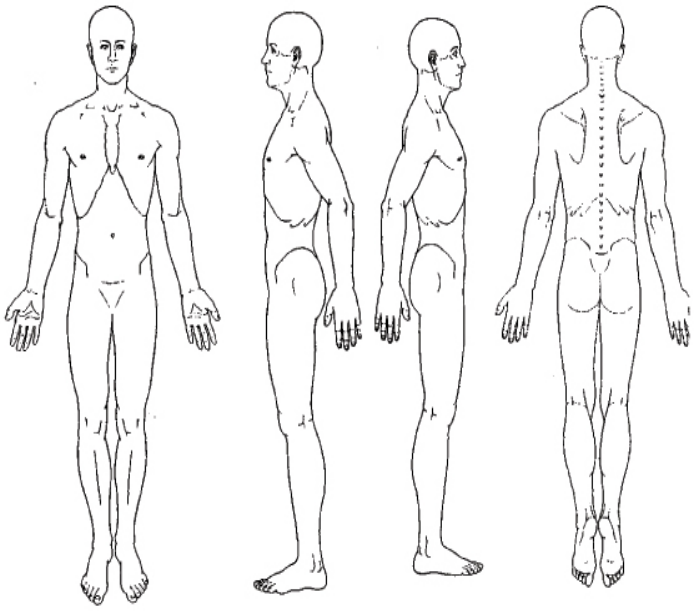
PATIENT HISTORY

PAIN LOCATION



Please mark off the areas of your complaint on the diagram above. Please use the following symbols on the pain diagram to accurately describe your condition.

PPP	Where you experience Pain
NNN	Where you experience Numbness
TTT	Where you experience Tingling
BBB	Where you experience Burning
CCC	Where you experience Cramping

PATIENT SIGNATURE _____ DATE _____

Visual Analog Scale

0_____1_____2_____3____4____5_____6_____7_____8_____9_____10

Mild Moderate Severe

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Notice of Patient Information Practices

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

ALLY PHYSICAL THERAPY LEGAL DUTY

Ally Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Ally Physical Therapy 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, we may use your personal health information to contact you to provide appointment reminders, information about your account status, or information about treatment alternatives or other health related benefits that could be of interest to you.

Ally Physical Therapy 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 (information will not include patient names or social security numbers). We also provide information when required by law.

In any other situation, ALLY Physical Therapy's 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.

Ally Physical Therapy may change its policy at any time. When changes are made a new Notice of Information Practices will be posted in a common area of our office. 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 instances where we have disclosed your personal health information for reason 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. Ally physical Therapy will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Ally Physical Therapy 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 office at the address below. You may also send a written complaint to the U.S. Department of Health and Human Services.

I have read and understand the Notice of Patient Information Practices.

Signature: **Date:**

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INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical therapy involves the use of many different types of physical evaluation and treatment. At ALLY Physical Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by Ally Physical Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

Patient Name: _____ Patient Signature: _____ Date:_____

If Minor name of responsible party/Guardian signature/date: _____

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