3530 Springdale Rd
Cincinnati, Ohio 45251
info@beyondlimits.com
Phone: 513-245-0100
Fax: 513-245-2372

Beyond Limits Rehabilitation- Medical History/Questionnaire **Today's Date_____**

To be completed by the patient or guardian—Please print

Name: _____ D.O.B. _____ Sex: _____

Driver's License: _____SSN: _____Email: _____

Home Phone: _____ Cell: _____

Address: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Employer: _____ Phone: _____

Referring Physician: _____ Date of next Physician's Visit: _____

Chief Complaints: (What problems are you having?)

_____

_____

How did you hear about us? _____

Date of Injury/when pain started? _____ Date of surgery (if applicable): _____

Have you had physical therapy or chiropractic treatment this year? Y N If yes, where: _____

Do you drink alcohol? Y N How much? _____

Do you regularly exercise? Y N

Do you have any drug allergies? Y N Please specify_____

Please list your current medications: If additional space is needed, please use the reverse side of page.

Name of Medication	Dosage	Directions	Date Stopped	Reason/Doctor who Prescribed

Have you ever had the following? (Circle yes or no, leave blank if uncertain)

Anemia	**Y**	**N**	**Dizziness or Fainting Spells**	**Y**	**N**	**Pacemaker**	**Y**	**N**
Arteriosclerosis	**Y**	**N**	**Epilepsy**	**Y**	**N**	**Phlebitis**	**Y**	**N**
Arthritis	**Y**	**N**	**Gastrointestinal Problems**	**Y**	**N**	**Pneumonia/Respiratory Problems**	**Y**	**N**
Asthma/Emphysema	**Y**	**N**	**Heart Disease**	**Y**	**N**	**Pregnant Currently**	**Y**	**N**
Back/Neck Trouble	**Y**	**N**	**Hernia**	**Y**	**N**	**Skin Disease/Rashes**	**Y**	**N**
Bleeding Tendency	**Y**	**N**	**High or Low Blood Pressure**	**Y**	**N**	**Stroke**	**Y**	**N**
Blood Clots	**Y**	**N**	**Incontinence**	**Y**	**N**	**Thyroid Disease**	**Y**	**N**
Cancer	**Y**	**N**	**Kidney Disease**	**Y**	**N**			
Circulatory Condition	**Y**	**N**	**Metal Implants**	**Y**	**N**			
Depression	**Y**	**N**	**Migraines**	**Y**	**N**			
Diabetes	**Y**	**N**	**Mitral Valve Prolapse**	**Y**	**N**			

If you answered yes to any of the items above, please briefly explain and give the date. Include pertinent information regarding your past medical history:

_____
_____
_____
_____

Previous Surgeries (Please state year and what illness/surgery you had)

Date/Year	**Illness/Operation**	**Date/Year**	**Illness/Operation**

___I authorize Beyond Limits Rehabilitation to render appropriate evaluation and therapy services in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed, and trained health professional. I recognize, agree, and understand that I have the right to refuse treatment or terminate services at any time in writing. In addition, Beyond Limits Rehabilitation reserves the right to discontinue services with written notice.

_____ _____

Patient Name (Please print) Date

_____ _____

Patient/Guardian Signature Date

Did this condition result from a work injury? _____Yes _____No
If yes, what was the date of the accident? _____
Did this condition result from a motor vehicle accident? _____Yes _____No
If yes, what was the date of the accident? _____
Are you currently receiving home health? _____Yes _____No
If yes, from whom? _____
(i.e. any healthcare worker/aid assisting you or your home)
Do you live in a nursing home? _____Yes _____No
If yes, what is the name? _____
Are you covered:

a. Under Black Lung Disease? _____Yes _____No
b. End Stage Renal Disease? _____Yes _____No
c. Large Group Insurance? _____Yes _____No
d. Veterans Affairs? _____Yes _____No

Please list your primary care doctor: _____

Phone Number: _____

Payment Authorization: Initials required for all 3 statements

____ **Assignment of Insurance Benefits**

I authorize that the payment of my insurance benefits be made directly to Beyond Limits Rehabilitation for all services delivered; paid directly, I will promptly pay Beyond Limits Rehabilitation all the monies paid to me.

_____ **Guarantee of Payment**

I understand that all payments designated as "the patient's responsibility" such as co-pays and deductibles are due and payable at the time of service. I guarantee I will pay the amount deemed my responsibility by my insurer by the statement due date.

_____ **Certification of Information**

I certify that the information I have provided Beyond Limits Rehabilitation for payment including, but not limited to, related accidents, illnesses, or other insurer is accurate and truthful.

I attest to the best of my knowledge that the above information is accurate and true.

Signature/Date:

Patient's Name: _____ Date: _____

Patient's or Legal Representative's Signature: _____

BEYOND LIMITS REHABILITATION

Insurance and Patient Responsibilities

Thank you for choosing Beyond Limits Rehabilitation for your therapy needs. We are committed to providing the highest quality of care for our patients. To do so, we need your assistance and acknowledgement of our policies.

Insurance/Billing Policies

- Please provide us with the most recent copy of your insurance card(s) and a photo ID. If you are the insurance subscriber, we will need the name, date of birth and employer information concerning the subscriber.
- You authorize the payment of medical benefits to Beyond Limits Rehabilitation. You understand that you are financially responsible for all co-payments, deductibles, coinsurance, and services NOT COVERED by your benefit plan.
- We will verify your insurance benefits as a courtesy to you. We rely on your insurance company to give us proper information but cannot guarantee accuracy, so if you feel there is a discrepancy, please bring it to our attention or contact your insurance company.
- If your insurance company requires preauthorization and/or a referral for therapy, it is your responsibility to ensure that the referring physician or your PCP has obtained the necessary referral. Beyond Limits Rehabilitation will obtain the necessary preauthorization for services from your insurance company as outlined by our participation agreement. If we do not have the proper authorization or referral at the time of your visit, it may be necessary to reschedule your appointment, or you will be required to pay for your visit in full. In the event that we are paid for the service by your insurance company, you will be reimbursed for the visit, less any applicable co-pay, co-insurance and/or deductible.
- We require co-pays, deductibles and supply charges be collected at the time of service and that patient remits payment for any balance due to continue service. A $10 administration fee will be assessed if this agreement is not met. If you have any questions regarding this process, please speak to our billing specialist.
- Failure to abide by this policy or if we do not receive payment within 30 days will result in the necessary action to collect payment. You authorize Beyond Limits Rehabilitation to contact you by phone or email regarding delinquent accounts(s). You authorize Beyond Limits Rehabilitation and its agents, representatives, attorneys (including collection agencies) to use automated telephone dialing equipment, artificial pre-recorded voice or text messages, and personal calls and emails in their effort to contact you for the purpose of collecting any portion of your account which is past due.

- Your credit card may be asked to be placed on file if the account is not paid within 30 days. See credit card policy for more information. A copy can be provided to you at any time upon request.

Cancellations/Late Fees

Your full attendance to therapy is the best way to an efficient recovery. Beyond Limits Rehabilitation expects you to make every effort possible to be on time for your scheduled appointment. Furthermore, cancellations are detrimental to the success of our clinic.

We require a minimum of 24-hour notice for any cancelled or rescheduled appointment.

Initial Evaluations

Evaluation appointments are reserved exclusively for new cases.

Patients who miss an initial evaluation without notice may be subject to discharge from scheduling privileges at the discretion of clinic management. A "no show" is defined as missing an appointment without notifying the clinic.

If you cancel your initial evaluation with less than a 24-hr notice, you will have 1 opportunity to reschedule this visit.

Treatment Appointments

If you cancel 2 appointments with less than a 24-hour notice within a 3-month lookback period, you will only have access to same day scheduling.

If you cancel with less than 24-hour notice for a 3rd time, you will be discharged from services at Beyond Limits Rehabilitation.

*Exceptions may be made at the discretion of clinic management for illness, emergencies, severe weather, or other unforeseen circumstances.

_____ _____

Patient/Guardian Signature Date

BEYOND LIMITS REHABILITATION

HIPAA Release Form

Release of Information: (Initials Required)

_____ I authorize the release of information including any diagnosis, records, examination notes and claim information. This information may be released to the following:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Or

____ Do not release to anyone

This release will remain in effect until terminated by me in writing

Messages:

Please call: ____ Home ____Cell _____ Work ____ Other

If unable to reach me:

____ You may leave a detailed message

____ Leave a message asking me to return your call

____ Do not leave a message

Patient Name (Please Print): _____

Patient/Guardian Signature: _____

Employee Signature: _____

Notice of Privacy Practices

Beyond Limits Rehabilitation provides each of our patients with a NOTICE OF PRIVACY PRACTICES (effective January 1, 2019).

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 Beyond Limits Rehabilitation and each of its subsidiaries, affiliates, and entities managed or controlled by Beyond Limits Rehabilitation Health Alliance LLC, 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. Use or disclose pursuant to this Notice may include electronic transmittal or disclosure of your personal health information.

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 Beyond Limits 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 the Privacy Officer, Beyond Limits Rehabilitation, 3530 Springdale Road, Cincinnati, Ohio 45251.

Use 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 services provided to you. We may use your 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 involved in caring for you or in 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 out 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 voicemail 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 Privacy Officer, Beyond Limits Rehabilitation, 3530 Springdale Road, Cincinnati, Ohio 45251.

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 limits their use and disclosure of patient information.

Other Uses and Disclosures

We are permitted and/or required by law to make certain other uses and disclosure or 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 administration 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 the 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.
- To worker's compensation agencies for workers' compensation benefit determination.

Rights You Have Regarding Your Personal Health Information

Access to your personal Health Information: You have the right to a 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 desk. If you request a copy of your personal health information, 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 desk 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 January 1, 2019. Requests must be made in writing and signed by you or your legal

representative. “Accounting Request Forms” are available at the front desk or the 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 healthcare operations. We are not required to agree to your restriction request but wil 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 who is responsible for medical records.

Workers’ Compensation: For patients whose medical treatment is covered under a state workers’ compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state’s workers’ compensation is governed by the state workers’ compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for worker’s compensation purposes, nor may you restrict our use or disclosure of your PHI for worker’s compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state worker’s compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, Beyond Limits Rehabilitation, 3530 Springdale Road, Cincinnati, Ohio 45251. 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 to your rights. There will be no retaliation for filing a complaint.

Further Information: If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, Beyond Limits Health Alliance, 8595 Beechmont Ave, #204, Cincinnati, Ohio 45255. Telephone: 513-474-4123.

_____ _____

Patient Name (Please print) Date

_____ _____

Parent/Guardian Signature Date

BEYOND LIMITS REHABILITATION

Appointment Reminders

Beyond Limits Rehabilitation is to provide automatic reminders by email OR cell phone text message. In the event the reminders to not work, you will still be responsible for remembering your appointments.

__ I consent to receiving text messages from Beyond Limits Rehabilitation to the number provided. This may include appointment reminders. I recognize normal text messaging rates may apply.

Cell Phone #_____

__ I consent to receiving email messages from Beyond Limits Rehabilitation to the email address provided. This may include appointment information. I understand that these emails are not encrypted and are not secure.

Email Address_____

We would like to thank you in advance for your cooperation and understanding of these policies, and for choosing Beyond Limits Rehabilitation.

_____ _____

Patient Name (Please print) Date

_____ _____

Patient or Guardian Signature Date