Center for Neuromuscular and Massage Rehabilitation

Date:_____
Name:_____**Birth Date:**_____
Email Address (**required field**, no spamming): _____
SSN: _____Phone: (__)_____wk(__)_____cell(__)_____
Home address:_____City:_____
State:___Zip:_____
Employer:_____Occupation:_____
Referring Doctor:_____Phone:_____
Are you currently receiving legal counsel for your condition?____
Do you currently suffer from ANY infectious diseases? ___Y___N
Attorney's Name:_____Phone:_____
Emergency Contact:_____Phone:_____
How did your injury occur:_____
Insurance Company Name:_____ ID Number:_____
Insurance Phone Number:_____
Group Number:_____Name on Insured:_____
Secondary Carrier (if Applicable):_____

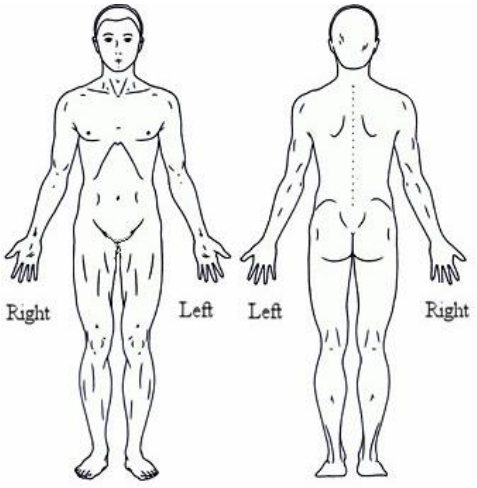
IF YOUR INJURY IS FROM A MOTOR VEHICLE ACCIDENT, PLEASE FILL OUT THIS SECTION
Name of YOUR insurance carrier:_____Claim number:_____
Insured person:_____Date of Injury:_____
Location of accident:_____
Name of Adjuster for your claim:_____Policy number:_____
Attorney name: _____ Phone number:_____

INFORMED CONSENT TO TREATMENT: I hereby authorize the Center for Neuromuscular and Massage Rehabilitation to administer all pertinent therapy treatment, and I am knowledgeable of the charges for this treatment. I am directly responsible for all medical bills that are not paid by insurance company, and any necessary bills of collection. I agree to assign benefits from all insurances, third party claims, worker's compensation, motor vehicle accidents, and any other payor source to CNMR. When in the case of insurance denying or not allowing for the billing of any service rendered by CNMR or its associates, CNMR reserves the right to bill the patient for its services on a 'fee for service' basis. This includes deductibles, copayments, any and all modalities. Terms such as 'copayment', 'fee for service', or 'encounter fee' all refer to the amount of money collected for any medical services rendered at CNMR and are due at the time of service. OUTSTANDING BILLS WILL COME VIA EMAIL. *I accept also that CNMR may, at need only, move my appointment to another therapist to suit triage.* IN ADDITION, I REALIZE THAT SHOULD I CANCEL, RESCHEDULE OR FAIL TO SHOW FOR MY APPOINTMENT WITHOUT **24 HOURS NOTICE**, CNMR WILL CHARGE $50 FOR THE VISIT.

Patient's Signature:_____

Please describe your present reason for seeking care:_____
_____

Mark the location of your symptoms with an X for pain, N for numbness and O for other:_____



Please describe the severity your symptoms:

On a scale of 0-10 in terms of severity, circle the RANGE of symptoms (example: 2-3-4)

0 1 2 3 4 5 6 7 8 9 10

What *aggravates* your symptoms:_____
What *relieves* your symptoms:_____
What sleeping positions are *least* comfortable:_____
What functional activities are the most difficult?_____
Medications:_____
Family history of symptoms: health of parents:_____
GENERAL SYMPTOMS: Explain if you have any problems with:
Bodily organs:_____
Cardiovascular system:_____
Gastrointestinal system:_____
Nervous System:_____
Circulatory System:_____
Reproductive System:_____PREGNANT Y/N/?
Endocrine System:_____
Respiratory System: _____
Previous trauma, injuries, or motor vehicle accidents:
_____
_____
Surgeries, and dates:_____
Other pertinent information_____

I hereby certify that I have completely represented the state of my current health, such as it may be, to the best of my ability. I also understand that omitting information regarding my health may affect the course of treatment. I agree to allow CNMR to examine me.

_____ _____
Signed date

CNMR's Covenant and Agreement

I agree to the following terms with regards to the management of my healthcare while receiving treatment at CNMR:

I will be informed of ALL recommendations regarding my healthcare, and at any time if I have questions, I may voice them.

I will undergo periodic reevaluations to monitor my progress and changes in symptoms.

I am the head of the healthcare team, and though my decisions may be guided by the therapists here, I have the greatest say regarding my treatment. I have the right to refuse services and treatments, and my decisions will be respected.

I will be informed regarding the risks and benefits of the treatments, and expected time frame for improvement.

I reserve the right to change therapists at my own discretion, should the need arise.

My medical privacy will be respected at all times.

I will address any and all issues regarding quality and satisfaction to the manager on duty, who will respect my time and handle any situation to the best of his/her ability at the time of service. If we fail to provide you with quality service, we want to know. We have an open door policy which welcomes both compliments and complaints.

In return for these, I also hereby agree to the following:

I will give CNMR notice of 24 hours should I need to cancel or reschedule, under all but the most emergent of circumstances.

Failure to do so will result in a reminder phone call, with no penalty.

A second failure to do so will result in another warning.

Upon my third failure to adequately plan for my schedule, I agree to be charged $50, and be possibly removed from the schedule. This is italicized, in bold, and underlined for purposes of clarity...

Our ultimate goal is to respect your time and efforts to better your conditions, in ANY and ALL manners possible. Please respect our time and efforts accordingly.

Signed/date: Witnessed:

Authorization and Assignment:

I hereby authorize and direct you, my insurance company, and/or my attorney, to pay directly to CENTER FOR NEUROMUSCULAR AND MASSAGE REHABILITATION, LLC (CNMR, LLC). such sums as may be due and owing to this office for services rendered by CNMR, LLC, both by reason of accident or illness, and by reason of any other bills that are due this office, and to withhold such sums from any disability benefits, medical payments benefits, no-fault benefits, health and accident benefits, worker's compensation benefits, or any other insurance benefits obligated to reimburse me or from a settlement, judgment or verdict on my behalf as may be necessary to adequately protect this office. I hereby further give a lien to said office against any and all insurance benefits named herein, and any and all proceeds to the settlement, judgment or verdict which may be paid as a result of the injuries or illness for which I have been treated by said office. This is to act as an assignment of my rights and benefits to the extent of the office's services provided.

In the event my insurance company obligated to make payments to me upon the charges made by this office for their services, refuses to make such payments, upon demand by me or this office, I hereby assign and transfer to this office any and all causes of action that I might have or that might exist in my favor again such company and authorize this office to prosecute said cause of action either in my name or in the office's name and further, I authorize this office to compromise, settle or otherwise resolve said claim or cause of action as they see fit.

I understand that I remain personally responsible for the total amounts due this office for their services. I further understand and agree that this Assignment, Lien and Authorization do not constitute any consideration for the office to await payments and they may demand payments from me immediately upon rendering services at their option. I am directly responsible for all medical bills that are not paid by insurance company, and any necessary bills of collection, including but not limited to court costs, attorney fees, and collections agency fees.

I authorize the office to release any information pertinent to my case to any insurance company, adjuster or attorney to facilitate collection under this Assignment, Lien and Authorization. I agree that the above mentioned office be given power of attorney to endorse/sign my name on any and all checks for payment of my healthcare bills.

By signing below you acknowledge and agree to all of the terms contained within this Agreement: Patient (print name):_____

Patient Signature: _____ Date: _____

Attorney agrees to the abovementioned terms and will dutifully disburse funds promptly (within 14 days of settlement) to CNMR, LLC.

Attorney (print name):_____

Attorney Signature: _____ Date: _____