Welcome to Hope Therapy Center. We would like to thank you for choosing us for your outpatient rehabilitation.

Our goal is to help you maximize your health, independence and well-being in a warm and inviting environment where a professional team makes meeting your needs our #1 priority. As our patient, your care will be individually evaluated and matched with a trained therapist who has the experience and knowledge that best fits your area of need.

To serve you efficiently and respect your time, please answer all the questions on the enclosed documents. Bring the completed packet of forms along with your insurance card, a photo ID and your doctor's prescription for therapy to your appointment.

The packet includes 4 items:

2. Patient Cancellation and No Show Policy/Notice of Health Information Privacy Practices (Page 3)
3. Medicare Part B Outpatient Therapy Limitations (Page 4)
4. Health History Information Sheet (Pages 5 & 6 – It is important to fill out ALL information on both pages)

The above tools enable our therapists to review your medical history with you, complete your evaluation, develop your treatment plan and begin your therapy, all at this initial appointment.

In order to maximize the benefits of your therapeutic session, please wear comfortable and loose fitting clothing. If applicable, take your pain medicine as prescribed by your physician. Additionally, you may be fatigued after the initial session so plan your transportation accordingly.

Again, thank you for choosing Hope Therapy Center. We look forward to meeting you and assisting in your rehabilitation progress. Please let us know if you have any questions prior to your visit. We can be reached at (970) 339-0011.

Sincerely,

Hope Therapy Center

Appointment Date ____________ Appointment Time ____________ Therapist ____________

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TO ENSURE ALL NEEDED DOCUMENTS ARE COMPLETED, OR CALL 24 HOURS PRIOR IF YOU CANNOT MAKE THIS APPOINTMENT!

1  2/1/2016
BILLING POLICY AND BILLING AUTHORIZATION

Patient Name: __________________________ Date of Birth: ____________ SS#: ____________

Street Address: __________________________ Apt#: ____________ City: ____________ State: ____________ Zip: ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

If Minor, Responsible Party: ____________ Relationship: ____________ SS#: ____________

Street Address: ____________ City: ____________ State: ____________ Zip: ____________ Phone: ____________

Primary Insurance Co.: ____________ Secondary Insurance Co.: ____________ Auto Accident? Yes or No

Emergency Contact: ____________ Relationship: ____________ Phone: ____________

Please be aware of your therapy benefits before your evaluation. You may have a copay due at each visit.

PARTICIPANT RELEASE

I understand that there are risks, both foreseeable and unpredictable, associated with Physical Therapy, Occupational Therapy, and the use of the pool. I am aware of the risks and agree that my participation is at my own risk. I hereby release Hope Therapy Center, its employees and agents from any and all liability connected to my participation in the programs at the Hope Therapy Center. I furthermore consent to therapy treatment at Hope Therapy Center.

Please initial here if you HAVE READ and UNDERSTAND the above paragraph.

BILLING POLICY AND BILLING AUTHORIZATION

As a courtesy, Hope Therapy Center will obtain benefits from your insurance company. Benefits quoted by your insurance company are not a guarantee of payment. Payment will be considered at the time a claim is received by the insurance company. The patient/parent/responsible party will be responsible for verifying therapy benefits with your insurance.

Although Hope Therapy Center will attempt to obtain payment from third party payers, it is understood that any amount not paid by the health care plan, insurance or other third party payer of the patient will remain the responsibility of the undersigned. I further understand that Hope Therapy Center will charge interest on all patient responsibility balances 30 days after the original statement date. If payment is not received from the patient/responsible party within the 30 days as stated, interest will accrue at 1.5% per month (18% per year) and charged to the patient's account.

PRIVATE PAY PATIENTS: Hope Therapy Center WILL NOT FILE or BILL patient’s insurance company after they have agreed to the Private Pay terms. Payments MUST be received at time of service ONLY.

CO-PAY: Co-pay is due at the time of service. Arrangements can be made to establish terms of payment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical benefits associated, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Hope Therapy Center, a Division of Greeley Center for Independence, Inc. This assignment will remain in effect until revoked by me in writing. I hereby agree to pay any and all charges that exceed or that are not covered by insurance. I hereby authorize said assignee to release all information to secure payment. To ensure continuity of care, I hereby authorize the release of all medical records to my primary and referring physicians. I authorize Medicare, private insurance, and any other health plan to furnish said assignee any information regarding payment of my claim.

Signature of Patient or Responsible party __________________________ Date ____________

Witness/HTC (GCI) Representative __________________________ Date ____________

These therapy benefits were quoted by your insurance company. They are not a guarantee of payment. Please contact your insurance with questions.

Deductible: ____________ Copay: ____________ Covered % ____________ Out of Pocket Max ____________ Max. Visits per year per incident ____________

2/1/2016
Hope Therapy Center
A Division of Greeley Center for Independence

Patient Cancellation and No-Show Policy

Failure to attend your appointment may hinder your recovery process. If you are more than 10 minutes late for your appointment, you may not be treated and it may be considered a late cancellation.

If you are unable to attend your appointment as scheduled, YOU MUST PROVIDE 24 HOURS ADVANCE NOTIFICATION TO HOPE THERAPY CENTER. Failure to attend or cancel an appointment within this timeframe will result in one or more of the following:

- **A $50 late cancellation or no call, no show fee charged to you**, not your insurance provider, for each missed appointment. This fee applies to ALL appointments including initial evaluation appointments.
- Your therapist reserves the right to discontinue your therapy if you show a pattern of irregular appointment attendance.
- Two unattended/no call, no show appointments will result in discharge from therapy and fees will be billed to you.
- Your physician will be notified of the reason for discharge from therapy.

I understand the Patient Cancellation and No-Show Policy of Hope Therapy Center and know my responsibilities.

__________________________________________  ______________________________
Patient Signature                                      Date

__________________________________________  ______________________________
Witness Signature                                    Date

Notice of Health Information Privacy Practices

I have been given the option of a copy of Hope Therapy Center’s Notice of Health Information Privacy Practices according to HIPAA guidelines.

**I DO or DO NOT** (circle one) want a copy

__________________________________________  ______________________________
Patient Signature                                      Date
HISTORY INFORMATION SHEET

PLEASE FILL OUT 2 PAGES COMPLETELY

PATIENT NAME: __________________________________________________________________________
TODAY'S DATE: __________________________________________________________________________
EMERGENCY CONTACT: _____________________________________________________________________
PHONE# __________________________________________________________________________________

The following information is needed in order for your treating therapist to understand why you are here and how they can best help you. Please answer all questions to the best of your ability.

MEDICAL HISTORY

List Surgeries/Hospital Admissions and Dates: __________________________________________________
List Medical Allergies: ___________________________________________________________________
List Current Medications: __________________________________________________________________

Check the following conditions that apply to you:

_____ Diabetes  _____ Cancer  _____ Hepatitis  _____ Fractures  _____ Vision Problems
_____ COPD/Respiratory  _____ Vascular Disease  _____ Osteoporosis  _____ Back/Neck Injury  _____ Menier's
_____ CHF/Mi/Heart  _____ Neuropathy  _____ Arthritis  _____ Fusion  _____ Dizziness/Vertigo
_____ CVA/TIA/Stroke  _____ Fibromyalgia  _____ Jt. Replacement  _____ Headaches  _____ Hearing Loss
_____ Pacemaker  _____ MS/ Parkinson’s  _____ Skin Problems  _____ Head Injury  _____ Depression
_____ High Bld Pressure  _____ Muscle Weakness  _____ Incontinence  _____ Seizures  _____ Panic Attacks
Other: ________________________________________________________________________________

PAIN DIAGRAM

Below is a body diagram. Please mark the areas where you feel symptoms.

[Diagram of body with areas to mark]

Height __________ Weight __________

SYMPTOM HISTORY

When did your problem start? __________ Cause of pain: ____Auto  ____Work  ____Sports
____Daily Life  ____Surgery

Pain Scale: 0 = no pain and 10 = emergency pain 0------------------------5------------------------10
Pain at rest: _____  Pain w/daily tasks: _____  Average Pain: _____

Since the onset of your symptoms, are the symptoms: ____ improving  ____ worsening
____ not changing  ____ fluctuating  ____ come and go

2/1/2016
What diagnostic tests have you had?  
- X-rays  
- CT Scan  
- Bone Scan  
- MRI  
- Arthrogram  
- Discogram  
- Other  

Results:  

Have you previously had therapy for this diagnosis?  Y / N  

Below is a list of words. Please check the ones that best describe your symptoms.  
- lightheaded  
- sharp  
- hot/burning  
- radiating  
- stiff  
- unsteady  
- stabbing  
- cold  
- tingling  
- constant  
- nauseous  
- shooting  
- deep  
- numb  
- intermittent  
- spells  
- pinching  
- dull  
- heavy  
- ringing in ear/fullness  
- dizzy  
- swollen  
- ache  
- pressure  
- disabling  

### OPTIMAL INSTRUMENT  
#### Difficulty-Baseline  

<table>
<thead>
<tr>
<th>Instructions: Please circle the Level of difficulty you have for each activity today.</th>
<th>Able to do without any difficulty</th>
<th>Able to do with little difficulty</th>
<th>Able to do with moderate difficulty</th>
<th>Able to do with much difficulty</th>
<th>Unable to do</th>
<th>Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Lying Flat</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>2. Rolling over</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>3. Moving-lying to sitting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>4. Sitting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>5. Squatting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>6. Bending/stooping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>7. Balancing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>8. Kneeling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>9. Walking-short distance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>10. Walking long-distance</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>11. Walking outdoors</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>12. Climbing stairs</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>13. Hopping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>14. Jumping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>15. Running</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>16. Pushing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
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<tr>
<td>17. Pulling</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
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<tr>
<td>18. Reaching</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>19. Grooping</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>20. Lifting</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>21. Carrying</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>9</td>
</tr>
</tbody>
</table>

22. Thinking about all the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.  

I have extreme difficulty doing any of the activities that I would like to do.  

I have no difficulty doing any of the activities that I would like to do.  

23. From the above list, choose 3 activities that are being affected by the problem you are currently receiving therapy for, and that you would like to be able to do without any difficulty. (For example: If you would most like to be able to climb stairs, kneel, and hop without any difficulty, you would choose: 1. 12  2. 8  3. 13)  

1.  
2.  
3.  

Patient Signature  

Date  

2/1/2016
POOL THERAPY
at Hope Therapy Center

During your course of therapy you may have some appointments in our Warm Water Pool.

POOL RULES for therapy patients:

- Sign in at the pool desk after you have signed in at the reception front desk. (This will help us track who is in the pool)
- You may get changed for your therapy session, however you are not permitted in the pool until you are with your therapist.
- Once your therapy session is over, please get dressed in an appropriate amount of time and check out from your appointment.
- If you want to stay longer in the pool, you will need to purchase/use a pool pass.
- **If you borrow a lock from the pool desk, please don’t forget to return it when you leave.**

We look forward to working with you and assisting with your therapy needs!

Any questions, please call 970-339-0011

Welcome and we will see you soon!