

**Welcome to Tri-State Rehab Services  
(Ironton Physical Therapy, Inc.)**

**Ironton   Westmoreland   Louisa   Ashland   New Boston**

Thank you for choosing our facility. To help us meet all your physical therapy needs, please fill out these forms completely. If you have any questions or need assistance, please ask us, we will be happy to help.

**1. PATIENT INFORMATION** (Please print)

Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First) (M.) (Last)

DOB: \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Phone # \_\_\_\_\_

Address: \_\_\_\_\_  
(Street Address) (City) (ST) (Zip)

Email address: \_\_\_\_\_

Male \_\_\_ Female \_\_\_ Minor \_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_

Emergency Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Employer: \_\_\_\_\_ Are you retired? \_\_\_ If yes, date: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(City) (ST) (Zip)

Employer Phone # \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

Date of onset of illness, injury, or accident: \_\_\_\_\_

**2. RESPONSIBLE PARTY IF PATIENT IS UNDER THE AGE OF 18, or COVERAGE IS THROUGH SPOUSE:**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
(First) (M.) (Last)

Soc Sec # \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Address: \_\_\_\_\_  
(City) (ST) (Zip)

Phone # \_\_\_\_\_ Employer: \_\_\_\_\_

Employer Phone # \_\_\_\_\_

**3. INSURANCE INFORMATION**

Is your injury due to (check one of the following):

\_\_\_ Auto \_\_\_ Workers Compensation, if yes, \_\_\_ OH \_\_\_ KY \_\_\_ WV \_\_\_ Other

\_\_\_ Filing Health Insurance

**3. INSURANCE INFORMATION Cont'd.**

Primary Insurance

Secondary Insurance

Name of insured: \_\_\_\_\_

Name of insured: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Relation to patient: \_\_\_\_\_

Date of birth of insured: \_\_\_\_\_

Date of birth of insured: \_\_\_\_\_

Soc. Sec. # of insured: \_\_\_\_\_

Soc. Sec. # of insured: \_\_\_\_\_

**4. AUTHORIZATION & RELEASE**

I authorize consent to treat and I hereby assign, transfer, and set over to Ironton Physical Therapy, Inc., DBA Tri-State Rehab Services all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy for the services rendered by Ironton Physical Therapy, Inc., DBA Tri-State Rehab Services. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization by giving written notice. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I give my permission to use my picture, and likeness on marketing material, and to receive marketing material in the future from Tri-State Rehab Services. DBA Tri-State Services with locations in Ironton, OH, Ashland, KY, Louisa, KY, Huntington, WV and New Boston, OH.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Must be signed by parent or legal guardian if patient is under the age of 18.)

**For Medicare Patients:**

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to be released to the Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf, and I assign the physical therapist or organization furnishing the services or authorize such physical therapist or organization to submit a claim to Medicare for payment on my behalf. I request that payment under the Medicare insurance program be made to Ironton Physical Therapy, Inc., DBA Tri-State Rehab Services.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Health Insurance Claim # \_\_\_\_\_

**Ironton Physical Therapy, Inc.**  
d/b/a Tristate Rehab Services

Consent for use and disclosure of protected health information (HIPAA)

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personal identifiable health information about me by Ironton Physical Therapy, Inc. (the “practice”) for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operation that are permitted in the regulations.
2. I am aware that the practice maintains a privacy notice which sets forth the types of uses and disclosures that the practice is permitted to make under that privacy regulations and sets forth in detail the way in which the practice will make such use or disclosure. By signing this consent, I understand and acknowledge that I have the right to review the privacy notice prior to signing this consent.
3. I understand and acknowledge that in its privacy notice, the practice has reserved the right to change its privacy notice as it sees fit from time to time. If I wish to obtain a revised privacy notice, I need to send a written request for a revised privacy notice to the office of the practice at the following address: 711 South 3<sup>rd</sup> Street, Ironton, OH 45638 Attention: Practice Compliance Director
4. I understand and acknowledge that I have the right to request that the practice restrict how my information is used or disclosed to carry out treatment payment or healthcare operations. I understand and acknowledge that the practice is not required to agree to restrictions requested by me, but if the practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the practice’s use and/or of my health information (leave blank if no restrictions): \_\_\_\_\_
5. I understand and acknowledge that I may revoke this consent at any time by sending a written revocation to the practice at the address set forth in (3) above. However, I also understand and acknowledge that if I revoke this consent, my revocation will not be effective to that extent that the practice has already acted in reliance on this consent.
6. I understand the foregoing provisions, and I wish to sign this consent authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

**By signing this form, I acknowledge that I have reviewed this consent and agree to the practice’s use and disclosure of my protected health information for treatment, payment, and healthcare operations.**

\_\_\_\_\_  
SIGNATURE OF PATIENT OR REPRESENTATIVE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PATIENT’S NAME

\_\_\_\_\_  
NAME OF PERSONAL REPRESENTATIVE

\_\_\_\_\_  
RELATIONSHIP TO PATIENT

**TO BE COMPLETED BY IRONTON PHYSICAL THERAPY, INC.**

The requested restrictions on the use and/or disclosure of the patient’s health information set forth above are:

Accepted     Denied     Not Applicable     Other (explain)

\_\_\_\_\_  
SIGNATURE OF AUTHORIZED CLINIC REPRESENTATIVE

\_\_\_\_\_  
DATE

## PATIENT HEALTH QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
(First) (M.) (Last)

1. Name of physician who referred you to physical therapy . \_\_\_\_\_
2. Date of next scheduled visit with this referring physician \_\_\_\_\_
3. What area(s) will we be treating \_\_\_\_\_
4. Have you been seen by a Physical Therapist / Chiropractor / Occupational Therapist / Speech Pathologist in the past 12 months? No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, where you were seen and how many visits? \_\_\_\_\_
5. If you are a Medicare patient, do you currently receive any home health services? i.e. physical therapy, speech therapy, respiratory therapy, nurse's aid, etc.) No \_\_\_\_\_ Yes \_\_\_\_\_ If yes, who is your home health agency? \_\_\_\_\_
6. What medications are you currently taking? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Was there any particular incident that caused your condition and when did it begin? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
8. Have you had any past surgeries or hospitalizations? Describe and give approx. dates. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
9. On a scale of 1-10, with 10 being the worst, rate your pain at rest.  
1 2 3 4 5 6 7 8 9 10  
  
On a scale of 1-10, with 10 being the worst, rate your pain with activity.  
1 2 3 4 5 6 7 8 9 10
10. What activities, if any, increase your pain? \_\_\_\_\_
11. What activities, if any, decrease your pain? \_\_\_\_\_

## PATIENT HEALTH HISTORY

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**Do you have, or have had in the past, any of the following?** If yes, please explain.

Neurologic Disorders (stroke, MS, etc.)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Visual Disturbance	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Seizures	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Psychological Problems (depression, anxiety)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Respiratory Problems (emphysema, bronchitis)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Heart Problems (chest pain)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
High Blood Pressure	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Cholesterol	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Ulcers	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Colon Problems	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Kidney Problems	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Diabetes	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Bleeding Disorders	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Cancer	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Osteoporosis	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Arthritis	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Dizziness (light-headed)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Balance Problems (frequent falls)	<input type="checkbox"/>	yes	<input type="checkbox"/>	no



## **Ironton Physical Therapy, Inc.**

d/b/a Tri-State Rehab Services

2700 Greenup Avenue

Ashland, KY 41101

ph 800-609-0905

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### **NEW PATIENT ORIENTATION SHEET**

#### ***Ironton***

711 South 3<sup>rd</sup> Street  
Ironton, OH 45638  
Phone 740-534-1156  
Fax 740-534-1158

#### ***Westmoreland***

4120 Waverly Rd.  
Huntington, WV 25704  
Phone 304-429-7381  
Fax 304-429-7383

#### ***Louisa***

172 Town Hill Rd., #5  
Louisa, KY 41230  
Phone 606-638-7848  
Fax 606-638-7849

#### ***Ashland***

2700 Greenup Ave  
Ashland, KY 41101  
Phone 606-326-1844  
Fax 606-326-1877

#### ***New Boston***

4643 Gallia Street  
New Boston, OH 45662  
Phone 740-456-6666  
Fax 740-456-6660

#### ***Billing Office***

2700 Greenup Avenue  
Ashland, KY 41101  
Phone 606-324-0540  
Fax 606-324-0616

#### **PHYSICIAN APPOINTMENTS**

Each time you return to your referring physician, please notify our office at least 48 hours in advance, so we can prepare a progress note regarding your physical therapy treatment.

#### **MEDICARE PATIENTS**

Federal regulations beyond our control require that your referring physician sign a plan of treatment.

#### **KEEPING APPOINTMENTS**

We ask that you arrive on time and keep all scheduled appointments unless a true emergency arises. Missed appointments cause the cost of our services to rise for all customers. Missed appointments, in some cases, have resulted in our patients being denied further worker's compensation benefits. We reserve the right to bill you \$30.00 for missed appointments without a 24-hour advance notice of any appointment change or reschedule. This fee is not covered by insurance carriers and will be your responsibility to pay before your next appointment. Keeping your appointments is very important and we take it serious.

#### **YOUR FINANCIAL RESPONSIBILITIES**

We will call your insurance company on your initial visit to see what your financial responsibilities will be for your physical therapy services. If your insurance policy does not pay 100% of your physical therapy treatments, any co-payments, co-insurance percentage, and/or deductible amounts are due at the time of service. If your insurance coverage changes, please let us know, so that we may re-verify your insurance and make you aware of any changes to your physical therapy benefits. You are ultimately responsible for any charges that remain after your insurance processes your claims. It is your responsibility to know your insurance benefits, and we cannot guarantee the benefits your insurance company gave us. Insurance verifications are not a guarantee of payment by your insurance carrier. If they determine your coverage to be different at the time of processing, any balance due to changes or denial is your responsibility. We accept cash, checks and most major credit cards. A 1.5% monthly finance charge (18% APR) will be applied to all accounts with any remaining patient balances over 30 days from the last insurance payment is received.

**Patient's Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Witness Signature** \_\_\_\_\_

**Date:** \_\_\_\_\_



## **Ironton Physical Therapy, Inc.**

Db a Tri-State Rehab Services  
2700 Greenup Avenue  
Ashland, KY 41101  
800-609-0905

     **IRONTON**  
711 South 3<sup>rd</sup> Street  
Ironton, OH 45638  
Phone: 740-534-1156  
Fax: 740-534-1158

     **WESTMORELAND**  
4120 Waverly Road  
Huntington, WV 25704  
Phone: 304-429-7381  
Fax: 304-429-7383

     **LOUISA**  
172 Town Hill Rd., #5  
Louisa, KY 41230-7848  
Phone: 606-638-7848  
Fax: 606-638-7849

     **ASHLAND**  
2700 Greenup Avenue  
Ashland, KY 41101  
Phone: 606-326-1844  
Fax: 606-326-1877

     **NEW BOSTON**  
4643 Gallia Street  
New Boston, OH 45662  
Phone: 740-456-6666  
Fax: 740-456-6660

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## **CONSENT FOR TREATMENT**

Patient's Name: \_\_\_\_\_

Patient's DOB: \_\_\_\_\_

I consent for treatment of my child in the care of Ironton Physical Therapy Inc., DBA Tri-State Rehab Services as indicated by the physical therapist.

\_\_\_\_\_  
Parent of Child

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date