The Recovery Project, LLC
20000 Victor Parkway
Suite 100
Livonia, MI 48152

East Side Clinic Location
15500 19 Mile Road
Suite 330
Clinton Twp., MI 48038

Toll Free: 855-877-1944
Telephone: 734-953-1745
Fax: 734-953-1743

Aggressive Neurological Rehabilitation

THERAPY SCHEDULE

Patient Name: _____

Welcome to The Recovery Project! You are scheduled to start therapy at the **Livonia / Clinton Township** clinic on: _____/_____/_____. Please see the maps on the back of this form. Your weekly schedule is listed below and will remain the same each week unless you and your therapist make changes.

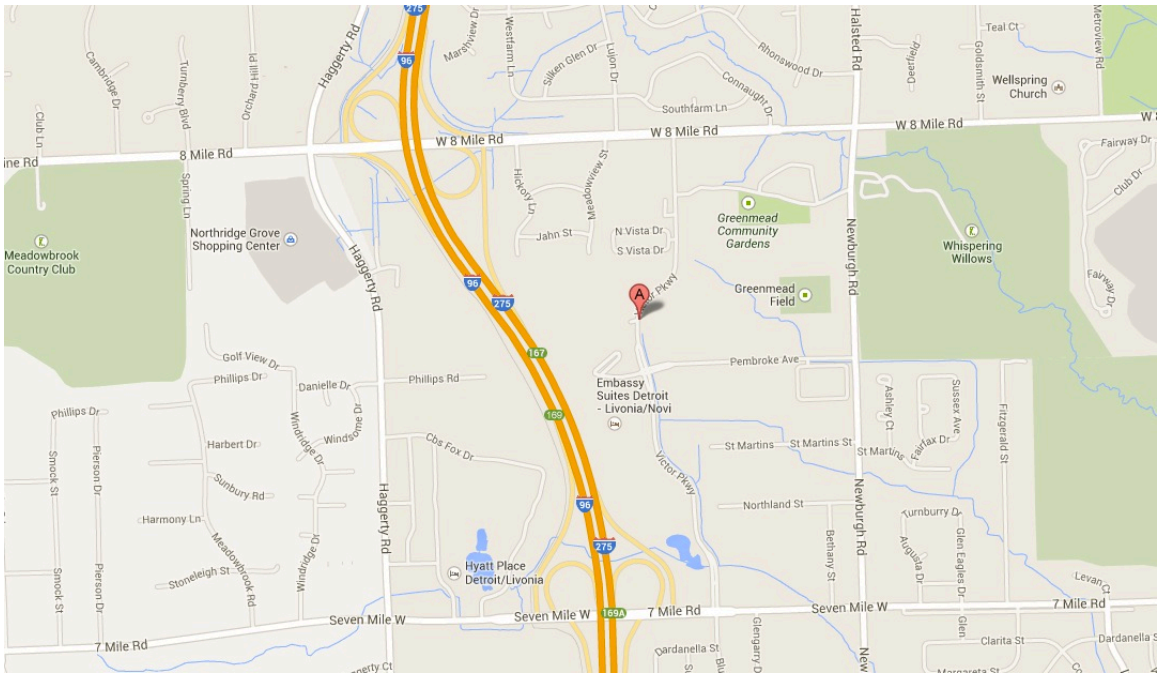
	TIME	THERAPIST
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

Our attendance policy is as follows:

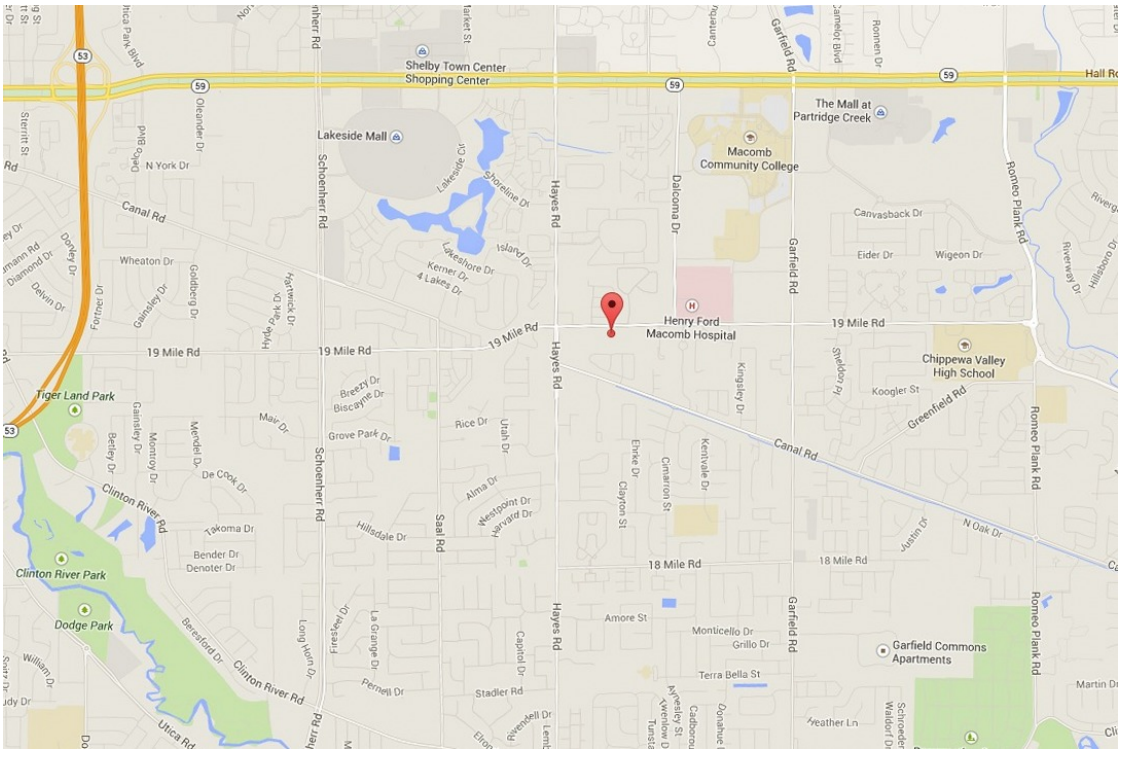
- When it is necessary to cancel a therapy appointment, please call 24 hours in advance, otherwise a $25.00 fee may be assessed.
- If an appointment is cancelled, ask to reschedule that appointment within the same week.
- Poor attendance may result in your therapy session being doubled booked with another client or discharge from therapy.

Thank you for choosing The Recovery Project as your rehabilitation provider. We look forward to working with you!

LIVONIA CLINIC
20000 Victor Parkway
Suite 100
Livonia, MI 48152



MACOMB CLINIC
15500 19 Mile Road
Suite 330
Clinton Twp., MI 48038



THERAPY EXPECTATIONS

Your Initial Visit

Please plan to arrive 15 minutes before your appointment with your completed new patient paperwork you received in the mail. This paperwork will provide important information to your therapist about your injury, current functional limitations, and medical history. For your first visit, be sure to bring the following:

- All insurance card(s) or insurance information.
- Your photo identification card/driver's license.
- The referral or prescription from your physician.
- Completed New Patient Paperwork

Your Therapy Appointments

You will be treated one-on-one by a licensed physical therapist and/or occupational therapist for every appointment at The Recovery Project. For your initial visit, your therapist will evaluate your condition and identify the source of your pain, or physical injury. Your therapist will examine the muscles, nerves, tendons, ligaments, bones, and tissues as they pertain to your physical complaints or limitations.

After your initial evaluation, your therapist will develop a treatment program that will often address physical deficits, such as strength, posture, flexibility, neurological status, joint motion, and functional limitations with activities of daily living. Physical therapy treatment may include the use of manual therapy techniques and exercise. Therapeutic modalities may be used to decrease swelling, decrease pain and/or soothe injured muscles. You will receive instruction on a home exercise program. The home exercise program may include: education on proper body mechanics, posture to prevent re-injury, exercise instruction, cold/heat therapies and general self-care. Your therapist will plan, implement, and monitor your progress throughout the treatment program.

How You Can Make the Most of Your Appointments

- Arrive 5 minutes before each appointment.
- Wear comfortable clothes and tennis shoes.
- Eat a proper meal before your appointment.
- Be hydrated – drink plenty of water always.
- Bring any bracing you wear.
- Work on your personal home exercise program as directed by your therapist.

Length of Appointments

The initial evaluation will last approximately 60 - 75 minutes. Subsequent appointments are scheduled for 60 minutes.

Cancellation Notice

If you are unable to keep an appointment, please call 734-953-1745. We require at least a 24 hour cancellation notice.

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CONSENT FOR TREATMENT

Patient Name:_____

1. **CONSENT:** I consent to therapeutic treatment as deemed necessary by my providers. I recognize that while in The Recovery Project, LLC (TRP) clinics the patient is under the care of his/her attending provider and TRP personnel render services to patients pursuant to the instructions of the providers. I know if I have questions about my medical care, I should be sure to ask the staff about them. I know it is up to me to tell the staff about any health problems or allergies I have. I must also tell the staff about drugs or medications I am taking. Further, I acknowledge, agree and understand that: Physical Therapy, conditioning, fitness and related activities can be hazardous and may result in injury to others or me. In consideration of the permission given to use these facilities and undergo treatment, I agree as follows:

I assume all risks of injury incurred or suffered while on and/or upon the premises of TRP, while undergoing treatment, conditioning, fitness or using the equipment of TRP, or its lessor. I release, covenant not to sue and hold harmless TRP, its agents, employees, officers, members, independent contractors, lessors or anyone connected with TRP, of and from any claim, liability, damages, costs or cause of action which I may have or in the future could have as a result of injuries or damages sustained or incurred while on and/or upon the premises of TRP, or while undergoing treatment, conditioning, fitness or using the equipment of TRP, or its lessor.

2. **CONTRACT FOR SERVICES:** I agree to pay in full any and all charges for TRP and provider services not covered by insurance benefits. I assign and authorize payment to be made directly to TRP and/or providers of all healthcare benefits otherwise payable to me. I understand that providers may bill separately. I certify that any and all information provided by me in furtherance of my application for healthcare benefits are true. TRP reserves the right to perform a credit check if needed.

3. **RELEASE OF INFORMATION:** I authorize TRP and each provider who treated me, to release to any party responsible for payment for the patient's care, such as information from the medical records as is required in order for TRP to obtain payment and to any participants in audits of such payments. This authorization to release information for purposes of payment includes all records, including those records protected under regulation in Code 42 of the Federal Regulations, Part 2, and Michigan Public Act 488 of 1988 of Alcohol and Drug Abuse and or Treatment, records of psychological services, and records of social services, including communications regarding communicable diseases, including Acquired Immune Deficiency Syndrome (AIDS), HIV infections, AIDS Related Complex, and Hepatitis A, B or C. This authorization is effective only so long as necessary to obtain complete payment or reimbursement and will end when complete payment or reimbursement is received. This authorization to release medical information may be withdrawn as it applies to alcohol or drug abuse only, except such information regarding alcohol and drug abuse as has been released before withdrawal. In the event that I am transferred from TRP to be treated at a hospital, extended care, or other facility I hereby consent and direct medical and other information be released by TRP as may be necessary or useful in by obtaining further care and treatment. I further specifically authorize any and all other hospitals and healthcare providers whom I have received services in the past to release the before specified medical information to TRP upon written request for same, but only during such time as I am a patient of TRP.

4. **NO GUARANTEE:** I understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the result of treatment at TRP. I understand that no contract, warranty, guarantee, or promise concerning the results of medical service is made. This consent to treatment form is not a contract, nor is it an offer to contract, nor is it an acceptance of an offer. I further understand and agree that TRP will not be liable for the loss or damage to any personal property.

5. **NOTICE OF PRIVACY PRACTICES:** I have been informed of the HIPAA Notice of Privacy Practices for The Recovery Project. This notice has been made available to me via hard copy.

Photo static copies of this agreement, and the signature below, shall be considered the same as the original. I HAVE READ THIS FORM. IT HAS BEEN FULLY EXPLAINED TO ME, AND ALL OF MY QUESTIONS ABOUT THE FORM HAVE BEEN ANSWERED. I UNDERSTAND ITS' CONTENTS.

SIGNATURE OF PATIENT/GUARDIAN	WITNESS	DATE

PATIENT HISTORY FORM

NAME:_____ DATE OF BIRTH:_____/_____/_____ SEX: Male/Female

STREET ADDRESS: _____ CITY, STATE: _____ ZIP CODE: _____

PHONE #:_____ EMAIL:_____

EMERGENCY CONTACT INFORMATION
Name: _____ Relationship: _____ Phone #: _____

GUARDIAN/POWER OF ATTORNEY STATUS: Self___ Other___ Name: _____

Relationship & Phone #:_____

PHYSICIAN'S NAME:_____ PHYSICIAN'S PHONE #:_____

CASE MANAGER'S NAME:_____CASE MANAGER'S PHONE #:_____

HOW WERE YOU INJURED? Auto Accident ___ Work ___ Progressive Disease___ Fall Prevention____

Not Sure___ Other_____

DATE OF ACCIDENT/DATE SYMPTOMS BEGAN:_____/_____/_____

PRIMARY INSURANCE:_____ CLAIM/CONTRACT #:_____

SUBSCRIBER NAME & BIRTHDATE:_____ _____/_____/_____ GROUP #:_____

SECONDARY INSURANCE:_____ CLAIM/CONTRACT #:_____

EDUCATION: High School ___ Some College ___College Graduate ___Graduate School ____ Other ____

CULTURAL/RELIGIOUS: Do you have any customs or religious beliefs /wishes that might affect care? Yes / No
If yes, please explain._____

JOB/SCHOOL/PLAY: What is/was your Occupation?:_____ Please check all that apply below.
Work full-time outside home___ Work part-time outside home___ Work full-time from home___
Work part-time from home___ Homemaker___ Student___ Retired___ Unemployed___ Other___

TRANSPORTATION: Do you use a transportation company to get you to and from your appointments? Yes /No
If yes, who provides your current transportation? _____
Do you need transportation to get to your appointments? Yes/No

REFERRAL: Who referred you to The Recovery Project?_____
Please describe how you found us (circle): Print Ad___ Friend___ MDA___ Doctor___ Case Manager___
Google Search___ TRP Website___ Senior Event___ Returning Client___ Other_____

WHO DO YOU LIVE WITH? Alone___ Spouse only___ Spouse and other(s)___ Child (no spouse)___
Other relative(s) ___ Group setting___ Personal Care Attendant___ Other_____

WHERE DO YOU LIVE? Private home___ Private apartment___ Rented room___ Nursing home___
Assisted living/group home___ Other_____

ASSISTED LIVING/GROUP HOME RESIDENT? If yes, list facility contact name and number:
_____

DOES YOUR HOME HAVE?: Stairs, no railing___ Stairs, railing___ Ramps___ Elevator___ Uneven terrain ___
Assistive devices (i.e. Bathroom)___ Any obstacles___

DO YOU USE ANY OF THE FOLLOWING?: Cane___ Walker___ Manual wheelchair___ Motorized wheelchair___
Glasses, hearing aids ___ Other_____

FUNCTIONAL STATUS/ACTIVITY LEVEL. Please check all that apply.
Difficulty with self-care (bathing, dressing)_____
Difficulty with bed mobility ___
Difficulty with community and work activities ____
Difficulty with transfers (i.e. moving from bed to chair) _____
Difficulty with walking on level surfaces __ on stairs__ on ramps__ on uneven terrain__ around obstacles__
Difficulty with home management (household chores, shopping, driving)___
No difficulties_____

What is your dominant hand? Right ___ Left___

Please rate your health: Excellent ___ Good ___ Fair ___ Poor___

Do you smoke? Yes / No Do you drink alcohol? Yes / No Do you use street drugs? Yes / No

Have you had any major life changes in the past year? (i.e. new baby, job change, death of family member)
Yes / No If yes, please describe._____

Do you exercise beyond normal daily activities and chores? Yes / No
If yes, describe the exercise and how many times per week.:_____

Describe why are you seeking therapy?_____

Prior to coming to The Recovery Project, have you been treated by a physical, occupational, speech and/or massage therapist for the same condition you are seeking treatment for? Yes / No
If yes, please list and date:_____

Who completed this form? Patient____ Caregiver ____ Parent_____ Spouse_____ POA/Guardian_____

Patient/Guardian Signature:_____ Date:_____/_____/_____

The Recovery Project, LLC

MEDICAL HISTORY FORM

Please indicate whether or not you have a family history of the following diseases. Please indicate with an "X" who had the disease and age of onset, if known.

			Self	Mother	Father	Sibling	Grandparent
Heart Disease							
Hypertension							
Stroke							
Diabetes							
Cancer							
Psychological							
Arthritis							
Osteoporosis							
Other							
Any hereditary disease in your family's history? Yes / No If yes, describe:							

Have you been diagnosed with any of the following? Please check all that apply.

Head Injury ___
Skin Disease ___
Seizures ___
Depression ___
Thyroid Problems ___
Multiple Sclerosis ___
Muscular Dystrophy ___
Heart Problems ___
Lung Problems ___
Broken Bones/Fractures ___
Parkinson Disease ___
Circulation/Vascular Problems ___
Development/Growth Problems ___
Other_____
AIDS/HIV/hepatitis___
Blood Disorder___
Digestive Issues ___
Low Blood Sugar ___

Within the past year, have you had any of the following symptoms? Please check all that apply.

Chest Pain __
Pain at Night ___
Cough ___
Hoarseness ___
Headaches___
Night Sweats ___
Difficulty Sleeping ___
Heart Palpitations ___
Nausea/Vomiting ___
Difficulty Swallowing ___
Dizziness/Blackouts ___
Numbness/Tingling ___
Other_____
Difficulty Walking ___
Weakness in Arms/Legs ___
Weight Loss or Gain ___
Joint Pain/Swelling ___
Coordination Problems ___
Fever ___
Short of Breath ___
Visual Problems ___
Hearing Problems ___
Loss of Balance ___
Loss of Appetite ___

Have you ever had surgery? Yes / No If yes, please list surgery and date._____
_____
_____

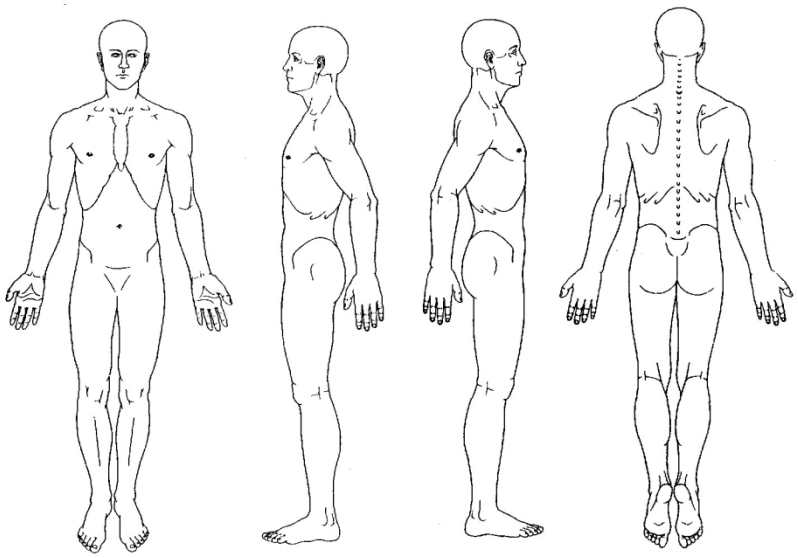
Within the past year, have you had any of the following tests? Please check all that apply.

Angiogram __
Biopsy___
CT scan___
MRI___
Blood Test ___
X-rays ___
Arthroscopy ___
Spinal tap ___
Bone scan___
Myelogram ___
Echocardiogram ___
Pulmonary function test ___
EKG ___
EMG ___
EEG___
Other _____

Are you seeking help from anyone else for the problem(s)? Please check all that apply.

Acupuncturist ___
Chiropractor ___
Podiatrist ___
Massage therapist ___
Occupational Therapist ____
Family Practitioner ___
Other_____
Cardiologist ___
Dentist ___
Neurologist ___
Orthopedist ___
Durable Medical Equipment Provider___

Using the KEY, please indicate on the diagrams below where your symptoms occur:



KEY: Pain = //////
Tingling = ::::::
Numbness =

Rate your pain below:

0 1 2 3 4 5 6 7 8 9 10

No pain Moderate Pain Worst Pain

When did the problem(s) begin?/What happened?_____
_____
Have you ever had the problem(s) before? _____
How are you taking care of the problem now? _____
What makes the problem better? _____
What makes the problem worse? _____
What are your goals for therapy?_____

MEDICATIONS. Do you take any medications or supplements? Yes / No
If yes, please list all prescription and non-prescription medicines/supplements you take below, or provide a copy of your current medications list.

ption Name	e	ncy	f Medication (pill, injectio , etc.)

List any known allergies, including allergies to medicines: _____

Do you have a latex allergy?: Yes / No

Who completed this form? Patient____ Caregiver ____ Parent_____ Spouse_____ POA/Guardian_____

Patient/Guardian Signature:_____ Date:_____/_____/_____

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LEGAL RELEASE
TESTIMONIAL

Permission is hereby irrevocable granted to The Recovery Project, LLC to use my name and/or photographic likeness, statements made by me, or any reasonable modification thereof, for use in newsletters, promotional pieces, advertisements or the internet, with primary focus to promote The Recovery Project, without restriction as to frequency or duration.

I certify that I am 21 years of age or older and that the foregoing statement(s) reflect in spirit and content my true experience with the product our service mentioned.

This consent and release shall be binding upon my heirs, next of kin and personal representatives.

_____ _____
Name (Printed) Signature

_____
Address

_____
City, State and Zip Code