Rehabilitation Specialists   PATIENT INTAKE FORM

Date of Injury or Onset _______/_______/___________

Is this work-related? Y / N   Automobile Accident/Injury? Y / N   City & State of accident ____________________________

Are you off work due to injury? Y / N   Date last worked _______/_______/___________

Comments ____

____

Have you had, for ANY reason, Physical Therapy, home health services, or other home care services in the last year? Y / N

If YES, please list the provider(s) ____

Date services stopped _______/_______/___________

PATIENT INFORMATION

Patient Name: Last __________________________ First _______________________ MI _____

DoB _______/_______/___________ Age ______ Sex M / F   SSN _______________________________

Address ____

City _______________________________ State _______________________ Zip _________________

Phone Hm (_______)_______-___________ Cell (_______)_______-___________ Wk (_______)_______-___________

Other (_______)_______-___________ E-mail _________________________________

Married Y / N   Spouse's Name ____

Emergency Contact Name & Phone ____

Relationship to patient ____

EMPLOYER INFORMATION

Employer Name _____________________________ Occupation __________________________________

Employer Address ____

City _______________________________ State _______________________ Zip _________________

Phone (_______)_______-___________ Phone (_______)_______-___________ E-Mail ___________________________

REFERRING INFORMATION

Referring Provider ____ Phone (_______)_______-___________

Date last seen by provider ______/______/__________

Primary Care Provider _______________________________________ Phone (_______)_______-___________

INSURANCE INFORMATION: Please have insurance card(s) ready so that we may photocopy them.

Primary Insurance Carrier ____

Policy Holders Name _____________________________ DOB _______/_______/___________

Secondary Insurance Carrier ____

Policy Holders Name _____________________________ DOB _______/_______/___________

Third Insurance Carrier ____

Policy Holders Name _____________________________ DOB _______/_______/___________

Patient/Guardian Signature ____ Date Signed _______/_______/___________

Agency Representative ______________________________________ Date Signed _______/_______/___________

Authorization for Treatment
I, the undersigned, hereby authorize and consent to rehabilitation services provided by Rehabilitation Specialists, including any procedures which may be performed during this visit for: ____

Assignment of Insurance Benefits and Release of Information
I hereby assign and authorize direct payment to Rehabilitation Specialists of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received. I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payer, and managed care organization or to any other insurance carrier, including worker's compensation claims. I authorize a copy of the authorization to be used in place of the original

Medicare Patient Certification
I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf

Medicaid Authorization and Assignment
I request that payment of authorized Medicaid, Medigap or other Medical Assistance programs be made on my behalf to the above provider for services furnished to me by the provider/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable to be released to my insurance carrier. My signature certifies that I have received a service beginning with the date below. I understand that payment for this service will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Law.

Personal Valuables/Dependents/Visitors
It is understood and agreed that Rehabilitation Specialists is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, small children will not be allowed in the treatment area of the clinic. If older children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children

Financial Agreement, Guarantee of Account
I, the undersigned agree whether I sign as parent, guardian, spouse, agent, guarantor or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of Rehabilitation Specialists in accordance with the regular rates and terms of the Facility. I understand that therapy services are rendered and charged to the patient and not to the insurance company, and the facility cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement. I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that Rehabilitation Specialists is not a party to any lawsuit I may have due to litigation. I further understand that although information will be provided to my attorney, I am fully responsible to the provider for payment in full under the regular terms of the practice. Should the account be referred to an agency or attorney for collection, I shall pay actual attorney's fees and collection expense.

Notice of Privacy Practices
Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. Our Notice of Privacy Practices is posted in the waiting area, but you may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS

____ ___________________________________ ________/_______/_________
Signature of Patient or Responsible Party Relationship to Patient Date Signed

____ ________/_______/_________
Agency Representative Date Signed

Rehabilitation Specialists

Patient History and Physical Questionnaire

Name________________________________ DOB____/____/________

Please describe the nature of your condition____
____
____

Please indicate if you have any current or previous history of the following conditions:

Heart Attack	Y	N	Diabetes	Y	N
Heart Disease	Y	N	Kidney Disease	Y	N
Stroke	Y	N	Cancer	Y	N
Head Injury	Y	N	Tumor	Y	N
Asthma	Y	N	Vascular Disease	Y	N
High Blood Pressure	Y	N	Immune Disorder	Y	N
Gastrointestinal Disorder	Y	N	Tuberculosis	Y	N
Spinal Injury or pain	Y	N	Lung/Pulmonary Disease	Y	N
Joint Injury or Pain	Y	N	Do you smoke?	Y	N
Hepatitis	Y	N	Are you Pregnant?	Y	N

Any other disorder(s)____
____

Please list all **medications** that you are taking____
____

Have you had Physical or Occupational therapy before? Y / N
If yes, for what condition?

Please inform us and write below, the name, phone/fax, and/or address of any additional physicians that you wish to be furnished with a copy of your evaluation. Your Referring physician will routinely be furnished with a copy.
Physician information

____
____
____

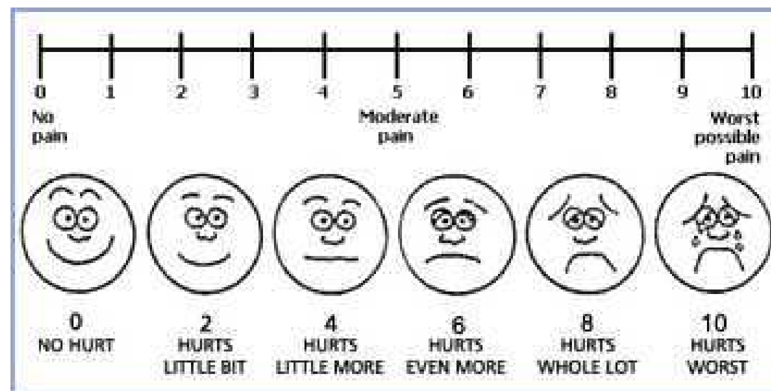
I am aware of my diagnosis and wish to receive treatment at Rehabilitation Specialists. I permit its employees and all other persons caring for me to treat me in ways they judge to be beneficial to me. I understand that this care may include evaluation, testing, and treatment. No guarantees have been made about the outcome of this care.

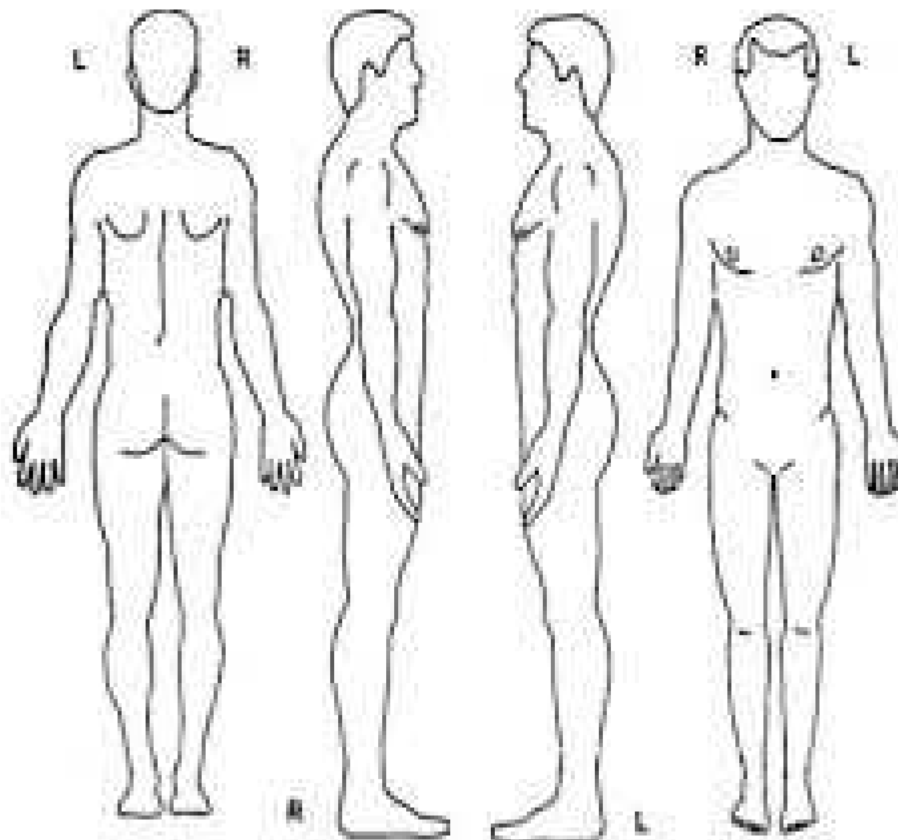
_________________________________ ______/______/_________
Patient / Guardian signature Date

_________________________________ ______/______/_________
Agency Representative Date

Name: ____________________________ DOB: ____/____/______ Today's Date: ____/____/______

Age: ________ Height: ______ Weight: _____





Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas.

A= Ache B=Burning N=Numbness P=Pins and &Needles S=Stabbing

Please feel free to list any questions you would like answered during today's visit:

1. ____

2. ____

3. ____