PATIENT DATA SHEET

First: **MI:** **Last:**

Date of Birth: **Age:** **Gender:** Male ☐ Female ☐

Physical Address:

_____

_____

_____

_____

Mailing Address:

_____

_____

_____

Phone Numbers:	**OK To Call**	**Best Time To Call**
Home: _____	☐	_____
Work: _____	☐	_____
Cell: _____	☐	_____

May we send you text messages for your appointment reminders to the number(s) listed above? ☐ Yes ☐ No

May we send you text messages for Marketing Materials, including Patient review requests to the number(s) listed above? ☐ Yes ☐ No

By marking "Yes" above, you understand that text messages may NOT be secure, with a risk of unauthorized access to your information

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that email communications may NOT be secure, with a risk of unauthorized access to your information.

Email: _____

Preferred language: EN English **Interpreter required?** ☐ Yes

Date of Injury: _____ **Referring Physician:** _____

Injury Area: _____ **Auto or Work Accident:** ☐ Auto ☐ Work ☐ N/A

State Where Accident Occured: _____

Are you currently receiving or have you received Home Health Services (including any therapy, nursing, bathing & dressing, etc) in the last 60 days? ☐ Yes ☐ No

Are you currently receiving or have you received other therapy services in the last 60 days? ☐ Yes ☐ No

Marital Status:

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status:

☐ Full-Time ☐ Part-Time ☐ None

EMPLOYMENT STATUS

Employment Status:

☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

Employer: _____ **Occupation:** _____

Address: _____

_____

Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

Secondary Insurance: _____

Policy Holder's Name: _____ **Holder's Birth Date:** _____

Policy or Certificate #: _____ **Group #:** _____

Policy Holder's Employer: _____

MR #:
Patient Name:

Note: Please provide us with the most updated information below.

EMERGENCY AND OTHER CONTACTS

Name	Phone	Work	Cell	Fax	Type

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

Name _____ Relationship _____

Name _____ Relationship _____

Signature of Patient _____ **Date** _____

Center for Physical Rehab and Therapy LP
PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office #

CONSENT TO TREATMENT
I consent to rehabilitation and related services at:
Center for Physical Rehab and Therapy LP
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. **Initials:**_____

TREATMENT OF MINORS
I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials:**_____

LIABILITY
I know and agree that: Center for Physical Rehab and Therapy LP
is not responsible for loss or damage to personal valuables. **Initials:**_____

WAIVER AND RELEASE
I hereby release, discharge and acquit: Center for Physical Rehab and Therapy LP
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials:**_____

AUTHORIZATION OF PAYMENT
I hereby assign all benefits directly to: Center for Physical Rehab and Therapy LP
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. **Initials:**_____

FINANCIAL POLICY
I understand fully that, in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
To assist in establishing your account, please:
- Supply all necessary information for accurate billing of your claim, including your insurance card, driver's license, employer information, and demographic information.
- Satisfy all insurance co-payments, co-insurance, deductibles, and non-covered services on the day services are rendered.
- Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf. **Initials:**_____

NOTICE OF PRIVACY/PATIENT BILL OF RIGHTS
I acknowledge receipt of Notice of Privacy Practices. **Initials:**_____
I acknowledge receipt of the Statement of Patient Rights. **Initials:**_____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ **Witness Signature** _____ **Date** _____

THE CENTER FOR PHYSICAL REHABILITATION

MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____
PRIMARY CARE PHYSICIAN'S NAME: _____ ARE YOU PRESENTLY WORKING? Y ES NO
CAUSE OF INJURY OR ONSET: _____ DATE OF NEXT MD APPT: _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____
HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____
CURRENT MEDICATIONS: _____
_____

ALLERGIES: Medication _____Reaction_____ Other _____Reaction_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- □ ANEMIA
- □ ARTHRITIS
- □ CANCER
- □ CARDIOVASCULAR PROBLEMS
- □ HOLTER MONITOR - currently wearing?
  - □ PACEMAKER
  - □ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
- □ LOW BLOOD PRESSURE
- □ CURRENTLY PREGNANT
- □ DIABETES □controlled □uncontrolled
- □ DEPRESSION
- □ DIZZINESS/FAINTING
- □ FRACTURES
- □ HEADACHES
- □ HEPATITIS/HIV
- □ KIDNEY PROBLEMS
- □ MRSA (Methicillin Resistant Staphylococcus Aureus)
- □ OSTEOPOROSIS
- □ RESPIRATORY PROBLEMS
  - □ ASTHMA □ controlled □ uncontrolled
  - □ COPD □ controlled □ uncontrolled
  - □ Other
- □ SEIZURES □ controlled □ uncontrolled
- □ THYROID PROBLEMS
- □ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

□ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____

Financial Policy

Thank you for choosing The Center for Physical Rehabilitation as your health care provider. We are committed to providing you with the best treatment possible, on a mutually agreed basis.

Billing and Insurance: Our professional relationship is with you, and not with any insurance carrier. You are responsible for paying the full cost of treatment when it is rendered unless it is covered by insurance. We participate with most major insurance companies and we will submit all authorized claims to the designated insurance carrier, provided we have received all required information prior to the initial treatment. You will be required to pay your estimated co-pay/co-insurance amounts during your first visit, and to make required payments at the time of each treatment session after. (We accept cash, personal check, Visa, MasterCard, and Discover). *We will charge a $25.00 fee for any returned check.* Please note that quoted co-pay/co-insurance amounts are provided by your insurance carrier as estimates only, and do not guarantee payment by your insurance carrier. Some services or treatments might not be covered benefits under your group health or other insurance. You are responsible for payment of any services or treatments not covered by your insurance carrier. Please contact your insurance company to obtain benefits for the outpatient facility physical therapy benefits specific to your insurance plan. If you are in a PPO or HMO plan, you must contact your primary care physician to have your physical therapy authorized in advance. We cannot obtain pre-authorization of physical therapy services for you.

Workers Compensation and Auto Accident Claims: You are responsible for payment for any treatment not covered by workers' compensation or Michigan No-Fault. If your treatment is for an injury or illness covered by workers' compensation, you will not be billed for any amount being disputed through an insurance carrier's utilization review program or which exceeds the maximum amount permitted by the State. If your treatment is covered by Michigan No-Fault (auto) insurance, only the responsible insurance carriers will be billed.

Missed Appointments: You will not be billed for missed appointments if you give us at least 24 hours notice of cancellation, so that we can schedule another patient. However, if you have cancelled or not shown up more than two times it will result in the inability to schedule future therapy appointments. We appreciate your consideration.

Aqua Therapy: Due to heavy volume and space demands of our Aqua Therapy program there will be a $25 charge if you do not show up for your pool appointment and you have not called to cancel in advance. There will be no charge for cancelling if you cancel with a 24 hour notice. However, if you have cancelled or not shown up more than two times it will result in the inability to schedule future pool appointments.

Past Due Accounts: Accounts not paid within 30 days are considered past due. You are responsible for payment of any costs we incur in collecting past due accounts (such as collection agency and attorney fees).

I understand and agree to the terms of this Financial Policy. I authorize The Center for Physical Rehabilitation to bill my insurer(s) for all services rendered and I authorize my insurer(s) to make payment directly to The Center for Physical Rehabilitation for such services.

X_____ _____

Signature of Responsible Party (must be over 18) Date

THE CENTER
FOR PHYSICAL
REHABILITATION

How Did You Hear About Us?

Name:_____ **Patient I.D:**_____

In an effort to better track how our patients are hearing about us please take the time to let us know how you heard about our facility.

☐ Friend or Family Member If so, who: _____

☐ Athletic Trainer If so, who: _____

☐ Physician or Healthcare Provider If so, who: _____

☐ Personal Trainer If so, who: _____

☐ Internet / Google Search

☐ Gazelle Sports

☐ GR Kids

☐ Advertisement If so, where: _____

☐ I have had physical therapy here before.

☐ Other:_____

_____