PRIME REHAB CENTER
PHYSICAL THERAPY | OCCUPATIONAL THERAPY

PATIENT INFORMATION

Name:_____ DOB: _____ Sex: M F

Address: _____ Soc. Sec#: _____

City:_____Zip:_____ Phone#:_____

INJURY /ILLNESS

Please describe how you were injured **or** how your pain began, including any related surgeries:

_____

_____

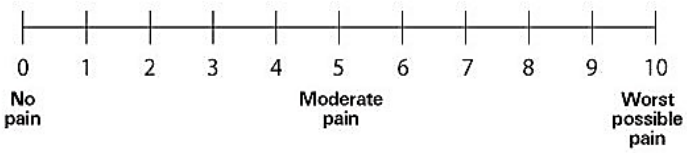
_____

Date of Injury: _____

Injured Body Part(s): _____

Pain Location:_____

Pain scale (1-10):

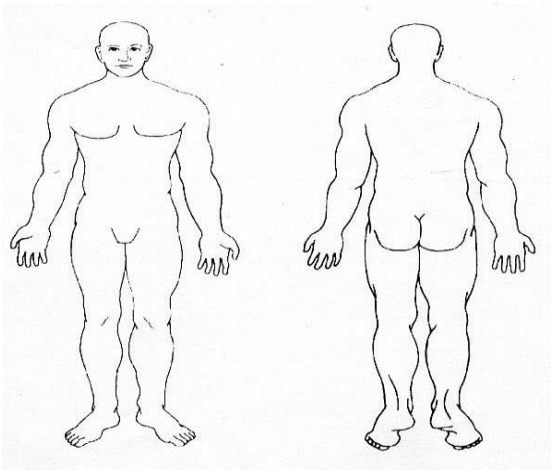


Have you recieved treatment for this in the past?
Please explain and include any dates._____

_____

_____

Place an "X" on pain areas



INSURANCE INFORMATION :

Primary Insurance : _____ Member ID : _____

Secondary Insurance : _____ Member ID : _____

Medicare Only : Within the last 3 months, have you received Home Health Services? _____ Yes , ____ No

If yes, please provide dates:_____

Worker's Compensation Only :

Employer : _____ Job Position/ Duty : _____

Employment Status (please check) : Regular (Full) Duty | Light (Modified) Duty | Out of Work | Not Working | Retired

If you are currently not working (out of work), when was the last date you worked ? : Last Date _____

I certify the information on this page is true and correct.

Patient Signature / Legal Guardian: _____**Date:** _____

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Medical History Questionnaire

Name: _____ Preferred Language: _____

Medical History:

Your responses to the following questions will assist us in your treatment. Thank you for your cooperation.

Have you ever been diagnosed with any of the following conditions? **Please check "Yes" or "No" to all.**

Cardiac Conditions	Yes |No	Liver Disease / Hepatitis	Yes | No
Pacemaker / ICD (Defibrillator)	Yes | No	Kidney Disease	Yes | No
Stroke	Yes | No	Emphysema	Yes | No
Type 1 Diabetes	Yes | No	Asthma	Yes | No
Type 2 Diabetes	Yes | No	Osteoporosis / Osteopenia	Yes | No
High Blood Pressure	Yes | No	Arthritis (OA / RA)	Yes | No
Cancer	Yes | No	Epilepsy	Yes | No
If so, please specify type: _____		Depression	Yes | No
Active / Not Active		Tuberculosis	Yes | No
		MRSA / VRE	Yes l No

Is there any additional medical history that we should know about? ____ Yes ____ No

If yes, please explain:_____

Any known allergies? _____

Are you taking any medication (prescribed/over the counter)? _____ Yes _____No

_____

Please list any hospitalizations or surgeries you have had: _____

_____

_____

Is there any chance you may be **pregnant**? _____ Yes, _____ No **(*Please notify us if your status changes.)**

Additional Comments or Concerns: _____

_____

Emergency Contact :

Name : _____ Phone # : _____

Relation to Patient : _____

I certify the information on this page is true and correct.

Patient Signature / Legal Guardian: _____**Date:** _____

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Physical & Occupational Therapy Consent Form

Patient's Name: _____

Please initial the following consent:

____ **Consent**: I consent to and authorize Prime Rehab Center Physical Therapy, (including students in training), to administer physical and/or occupational therapy treatment under the direction and supervision of the physical or occupational therapist. I understand and am informed that, as in the practice of medicine, physical and occupational therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the physical therapist, occupational therapist, or staff about any health problems or allergies I have, as well as medications I am taking.

____**Release of Information**: Prime Rehab Center Physical Therapy, releases patient health care information for purposes of treatment or payment, or to other health care organizations, as explained in our HIPAA Notice of Privacy Practice. I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

Please specify any specific entities as needed (Example: attorneys, pain management, etc.):

Name: _____

Street: _____**City**: _____ **State/Zip**: _____

____ **No Guarantees**: I understand that the practice of physical and occupational therapy is not an exact science and that no guarantees have been made to me as a result of treatments or examinations by the physical therapist, occupational therapist or support staff. I understand that no contract, guarantee, warranty, or promise concerning the results of the therapy services is made.

____ **Public Parking:** Park at your own risk. Prime Rehab Center is not responsible for personal injury, theft/loss, or damage to parked vehicles, equipment, or contents.

____ **Interferential Current Therapy (ICT, IFC):** I acknowledge that ICT/IFC may cause abnormal skin irritations, purple marks, and bruising, and/or minor blisters. I acknowledge that these marks may begin to fade after several days, but can remain for about two to three weeks.

____ **Insurance Coverage:** I understand and agree that while Prime Rehab Center may verify my benefits**,** it is my responsibility to know if my insurance has any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive and I agree to make payment in full, if applicable.

____ **Returned Checks/Liens**: Returned checks are subject to a $20.00 administrative charge, as well as the bank's charge for bounced checks.

____ **Minor Patients Only:** The parent or legal guardian accompanying a minor is responsible for any payment of services. Unaccompanied minors (under 18) will be denied non-emergency treatment, unless the parent or legal guardian provides consent to treat the unaccompanied minor without their presence. **By initialing here_____**, I hereby authorize Prime Rehab Center and its employees to evaluate and provide treatment without the presence of a parent/legal guardian. I release Prime Rehab Center and its employees against any and all liability that may occur on the premises while a parent or legal guardian is not present.

I grant permission to Prime Rehab Center to provide an evaluation and treatment that is deemed necessary by the treating therapist. I grant permission to exchange information with physicians, insurance providers and/or other people as deemed necessary. I understand that by signing this form I release Prime Rehab and employees from liability for any personal injuries that may occur on the premises. I acknowledge that I have reviewed a copy of the privacy policy notice. I understand that co-pays, co-insurance or applicable deductable fees are due at the time of service, as well as, any fee not covered by my insurance.The undersigned patient or responsible party acknowledges that he/she has read and agrees to the information printed above.

I certify the information on this page is true and correct.

Patient Signature / Legal Guardian: _____Date: _____

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Therapy Attendance Policy

Prime Rehab Center Physical Therapy strives to provide each patient with the highest quality of care while attempting to accommodate your schedule for your convenience. Therefore, we provide reserved time slots for each patient in order to minimize your waiting time and assure continuity of your treatment. Your consistent attendance of the planned treatment regimen is paramount to your full recovery.

While we are sensitive to the fact that an emergency may occur in a rare instance, cancellations, especially last minute ones, along with patient no-shows, decrease our ability to accommodate the scheduling needs of the other patients. As respect to your therapist and fellow patients, we must ask for your full cooperation with the following policy:

- ***If you are more than 15 minutes late for your appointment and fail to notify us, treatment may be cancelled or rescheduled. (Emergencies will be considered on a case by case basis.)***
- A scheduled appointment must be canceled 24 hours before your scheduled time.
- Failure to show up for three (3) consecutive appointments without notifying us, ("NO SHOW") will result in the cancellation of all remaining scheduled appointments.
- Frequent cancellations and no-shows will be documented in your medical record and appropriately reported to your physician and insurance/third party payer.
- Repeated failure to comply with the ATTENDANCE POLICY will result in your name being placed on a "Schedule Based on Availability" list. We will do everything possible to accommodate you, as space on the schedule permits.

We believe that this policy is necessary for the benefit of all of our patients, so that we may continue to provide high quality treatment and fair service to everyone.

Our staff at ***Prime Rehab Center Physical Therapy*** appreciates your anticipated adherence and cooperation with this policy. We wish you the best of luck with your treatment. We are here to help you attain your therapeutic goals and optimize your return to your pre-injury activities.

I certify the information on this page is true and correct.

Patient Signature / Legal Guardian: _____ **Date:** _____