REHAB SOLUTIONS PHYSICAL THERAPY & SPORTS MEDICINE CENTER

www.rsiphysicaltherapy.com

PERSONAL INFORMATION

Patient's Name: _____ Today's Date: _____

Address: _____ Birth Date: _____ S.S. _____

City _____ State _____ Zip_____ Parent(s) Name *(if minor)*:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

In the event that you cannot answer your phone is it okay for Rehab Solutions to leave a message? ☐ Yes ☐ No

Please provide an e-mail address. We would like to e-mail you concerning health and wellness education, clinical newsletters, fitness tips and more!:

E-mail Address: _____

Is it ok for Rehab Solutions to send you email appointment reminders? ☐ Yes ☐ No

Employer's Name: _____ Occupation: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact Name: _____ Relationship: _____ Phone No._____

Name of Referring Physician: _____ Phone No.:_____ Last Visit Date: _____

Primary Care Dr.'s Name: _____ Phone No.:_____ Last Visit Date: _____

How did you hear about our office? Physician • Friend • Brochure • Yellow Pages • Outside Sign • Website • Internet • Other _____

INSURANCE INFORMATION

Skip this section if you are providing a copy of insurance card(s).

PRIMARY INSURANCE

Insurance Name:_____

I.D.#_____ Group#_____

Plan Type: _____ Payer:_____

Billing Address:_____

City_____ State_____ Zip_____

Phone No. for Providers:_____

Name of Insured:_____

S.S.#_____

Relationship to Patient:_____

SECONDARY INSURANCE

Insurance Name:_____

I.D.#_____ Group#_____

Plan Type: _____ Payer:_____

Billing Address:_____

City_____ State_____ Zip_____

Phone No. for Providers:_____

Name of Insured:_____

S.S.#_____

Relationship to Patient:_____

WOKMAN'S COMP / AUTO ACCIDENT / PERSONAL INJURY

Fill out if applicable and please provide a copy of your insurance card(s). This is necessary to keep on file in the event we do not get paid.

Case Manager Name: _____ Phone No. / Ext.:_____ Fax: _____

Adjuster Name: _____ Phone No. / Ext.:_____ Fax: _____

Date of Injury: _____ Claim No.:_____

Cert. Authorization # *if known*_____ # of Visits Approved *if known*: _____

Claims Address: _____ City_____ State_____ Zip_____

Patient's Employer's Name: _____ Phone No.:_____

Employer Address: _____ City_____ State_____ Zip_____

Attorney Name: _____ Phone No.:_____ Fax: _____

Attorney Address: _____ City_____ State_____ Zip_____

MEDICAL INFORMATION

Due to the nature of the treatments that could be rendered, **the following information is necessary**. Please fill this information as completely as possible to assist our therapist in treating you. If you have any questions, please ask.

CONDITION

What symptoms are you having that caused you to seek medical advice? (i.e.: Back Pain, Headaches, Numbness)

_____

When did you first noticed the condition? : _____

If Applicable: Auto Accident Date:_____/_____/_____ Work Accident Date: _____/_____/_____

PAIN *Please specify your present condition:*

PAIN IN: ☐Neck ☐Low Back ☐Mid Back ☐Upper Back ☐Shoulders ☐Knees ☐Hip ☐Ankle

PAIN RADIATING TO: ☐Right Leg ☐Left Leg ☐Right Arm ☐Left Arm ☐None ☐Other_____

FREQUENCY: Constant • Frequent • Occasionally • Intermittent

SEVERITY: Min • Mild • Moderate • Severe • Extreme

CHARACTER: Dull • Sharp • Achy • Shooting • Tingling • Burning • Numb • Boning • Lancing

PAIN SCALE *Please circle your pain grade*

0 1 2 3 4 5 6 7 8 9 10

No Pain — Feel Pain but Able to Ignore it During Activity — Unbearable Pain

BETTER WITH: Sitting Standing Lying Down Walking Rest Use _____

WORSE WITH: Sitting Standing Lying Down Walking Lifting Bending Rest Movement _____

PRECAUTIONS *Please circle your current information to the following:*

Are you pregnant? N/A YES NO
(*Important*: If you become pregnant, let your therapist know)

Do you have electronic implants such as a pacemaker inside your body? YES NO

Do you have any metal implants inside your body? YES NO

Do you have open wounds or open area on your body? YES NO

Have you ever been a patient here before? YES NO
If YES, approximately when? _____

Are you allergic to anything? YES NO
If YES, please describe: _____

Are you currently taking Rehab / Physical Therapy or Nursing Treatment? YES NO
If YES, what environment? Home Clinic Other: _____

Any previous treatment for current condition? (Chiropractic, Physical Therapy, etc.):

When?_____ Where? _____

Please list your current medications to the best of your knowledge: _____

_____

MEDICAL INFORMATION *CONTINUED*

MEDICAL PROBLEMS *(Please Check if Applicable)*

☐ Headaches	☐ Polio	☐ Numbness	☐ Sinus Trouble	☐ Scoliosis
☐ Concussion	☐ Digestion	☐ Depression	☐ Neck Pain/Stiffness	☐ Anemia
☐ Epilepsy	☐ Backaches	☐ Heart Trouble	☐ Syncope	☐ Blood Clot
☐ Asthma	☐ Arthritis	☐ Nervousness	☐ Sciatica	☐ Leg Pain
☐ Over Weight	☐ Tingling/Numbness	☐ Diabetes	☐ Dizziness	☐ Cancer
☐ Multiple Sclerosis	☐ Diabetes Diet Control	☐ Insulin Dependant	☐ Mid Back Pain	
☐ Low Back Pain	☐ High Blood Pressure	☐ Rheumatism	☐ Pain between Shoulders	
☐ Venereal Disease	☐ Other _____			

PRESENT COMPLAINTS *(Symptoms you are currently experiencing to seek medical advice)*

☐ Anxiety	☐ Palpitations	☐ Loss of Memory	☐ Equilibrium / Balance Problem	
☐ Tension	☐ Depression	☐ Nausea, Vomiting	☐ Nervousness	☐ Neuritis
☐ Loss of Smell	☐ Fatigue	☐ Swelling	☐ Fainting	☐ Loss of Taste
☐ Numbness	☐ Sensitivity to Light	☐ Dizziness	☐ Double Vision	☐ Loss of Focus
☐ Difficult Gait	☐ Insomnia	☐ Ears Ringing	☐ Shortness of Breath	☐ Posture
☐ Irritability	☐ Sinus Trouble			

Difficulty Lifting: ☐Light ☐Moderate ☐Heavy ☐Repetitive

MEDICARE SECONDARY PAYER SCREENING (*For Medicare Patients Only*)

1. Are you covered by the Veteran's Administration (VA), the Black Lung Association Program or Workman's Compensation?
   - ❑ No. Proceed to Question #2.
   - ❑ Yes, Bill the other insurer prior to Medicare.

2. Is the illness or injury due to any type of accident? i.e.: Auto, Workman's Comp, Personal Injury?
   - ❑ No. Proceed to Question #3
   - ❑ Yes. Bill to the accident Insurance.

3. Are you at least 65 years old and employed, or was the spouse employed at the time of service?
   - ❑ No. Proceed to Question #4
   - ❑ Yes. Bill to spouse or patient's primary insurance.

4. Are you under 65 years old and covered under any Employer Groups Health Plan (EGHP) or Large Group Health Plan (LGHP)?
   - ❑ No. Proceed to Question #5
   - ❑ Yes. Bill to Group Health Plan.

5. Are you currently taking Rehab, Physical Therapy, Nursing Services at home?
   - ❑ No.
   - ❑ Yes. *Home Health Services* ***need to be discharged*** *before we can begin treatment.*

     Home Health Company's Ph.# _____ Contact Person:_____

Note: **If you are receiving therapy services at home and also attending an outpatient clinic, Medicare will not approve visits for both and you may end up with a financial burden.**

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AUTHORIZATION FOR TREATMENT, RELEASE INFORMATION, ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY AND ACKNOWLEDGMENT OF PRIVACY PRACTICES.

1. I hereby authorize the release of information acquired in the course of examination or treatment to any insurance company with whom claims are to be filed for my dependants or me. I permit copy of this authorization to be used in place of the original.

2. I hereby authorize payment of benefits otherwise payable to me, to be made directly to Rehab Solutions Physical Therapy & Sports Medicine Center (REHAB SOLUTIONS) for any insurance claims processed by Rehab Solutions Physical Therapy & Sports Medicine Center.

3. I certify that the medical information and all of the private healthcare information about me and/or the insured, including any and all of the insurance coverage information, given to this provider, is completely true and verifiable. I further certify that my benefit eligibility is current, and any claims, or portions thereof, that are not covered by my insurance, becomes my responsibility, including deductibles, co-payments or any money owed to REHAB SOLUTIONS if for any reason my insurance company does not pay the claims.

4. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I understand that REHAB SOLUTIONS utilizes the services of both any outside and inside billing agency and an electronic data clearinghouse to process claims, and that they will have limited access to my private healthcare information (PHI). For irreconcilable accounts requiring collections, such information necessary to secure pay could be shared with an additional entity for the purpose of securing payment. All reasonable and prudent measures are being taken to protect the privacy of our patients in these transactions. All facsimile transmissions will contain text admonishing all parties to protect your privacy and our billing entity has included that in their communication to us as well. I am accepting the PHI policy of this practice and if for any reason the information provided to REHAB SOLUTIONS is found to be incorrect, I will not hold REHAB SOLUTIONS liable for any PHI being received into the wrong hands.

5. I understand in the event if the insurance company sends a check directly to me instead of REHAB SOLUTIONS, I will send the check to REHAB SOLUTIONS for the services rendered by REHAB SOLUTIONS.

6. I also understand that if I have scheduled an appointment and if I cannot make my appointment, I need to call 24 hours in advance. If I do not show up, REHAB SOLUTIONS has an authorization to bill my insurance or me $25.00 (twenty-five dollars) per visit.

7. Please keep all of you personal valuables with you at all times and please do not bring children to your appointments unless they are properly attended to with adult supervision. REHAB SOLUTIONS will not be responsible for any personal valuables or unattended children.

8. All co-pays are due on the date of service before services are rendered.

Signature of Patient / Responsible Party	**Print Name**	**Date**

DG 11/06/13