PATIENT INFORMATION FORM

Patient Information

Last Name | First Name | M.I. | Home Phone | Cell Phone

Mailing Address | Apt. # | City | State | Zip | Email Address

Are you currently employed? Y☐ N☐ _____
Employer | Occupation

Date of Birth: _____ S.S.N: _____ Gender: F☐ M☐ Marital Status: S☐ M☐ D☐ W☐

Emergency Contact Name | Telephone No. | Relationship

Medical Information

Referring Physician: _____

Have you had prior physical therapy this year? Y☐ N☐

Date of Injury: _____ If yes: When: _____ Where: _____

Body Part: _____

Is injury work ☐ or auto related ☐ or other ☐ _____

Have any of the following procedures been done for the diagnosis you are being referred for therapy:
Diagnostic Tests: (x-rays, MRI, etc.) Y☐ N☐ When: _____ Type: _____
Surgery: Y☐ N☐ When: _____ Type: _____

Please list all medications you take (Prescription and non-prescription drugs). Please include dose and frequency.

_____ _____

_____ _____

Please use back of page to list more medications

Please check if you have or ever had:

☐ Asthma/Allergies	☐ High Blood Pressure	☐ Headaches/Migraines	☐ Hypoglycemia
☐ Cancer	☐ Head Injury	☐ Muscular Dystrophy	☐ Osteoporosis
☐ Diabetes	☐ Multiple Sclerosis	☐ Seizures/Epilepsy	☐ Skin Disease
☐ Lung Problems	☐ Repeated Infections	☐ Stomach Ulcers	☐ Circulation/Vascular Problems
☐ Parkinson's Disease	☐ Thyroid Problems	☐ Broken Bones	☐ Infectious Diseases (TB, Hepatitis, HIV)
☐ Stroke	☐ Blood Disorders	☐ Kidney Problems	☐ Developmental/growth Problems
☐ Arthritis	☐ Depression	☐ Heart Problems	☐ Other

Insurance Information

Primary Insurance | Insurance Group No.

Telephone No. | Claim/I.D. No. | Adjustor

Name of Insured | Insured Date of Birth

Insured SSN | Insured Employer

Insured's relationship to patient: _____

Secondary Insurance | Insurance Group No.

Telephone No. | Claim/I.D. No. | Adjustor

Name of Insured | Insured Date of Birth

Insured SSN | Insured Employer

Insured's relationship to patient: _____

MEDICARE PATIENTS ONLY:
Are you currently receiving home health care for any reason? Yes ☐ No ☐
This would include anyone going to your home to bathe you or provide dressing changes, etc. If yes, provide the name of agency, dates of treatment and **sign a Medical Release Form**:

Name of Agency: _____ Dates of Treatment: _____

WORKER'S COMPENSATION ONLY:
By signing below, I authorize Rehabiliteis to contact my employer to obtain authorization that this is a workers compensation claim and to obtain a job description and/or a list of essential job functions to further assist in my rehabilitation process. Should my employer not approve this as a workers compensation benefit, I will supply my personal medical insurance information to Rehabilities and authorize Rehabilities to file my claims with my insurance company. I further understand if for some reason my insurance carrier does not pay for services rendered, I will be responsible for paying Rehabilities. In addition, I authorize and direct my insurance benefits to be paid directly to Rehabilities.

_____ _____
Patient Signature Date

CONSENT FOR CARE AND TREATMENT

I agree and give my consent for Rehabilities to furnish medical care and treatment to the patient that is considered necessary and proper in diagnosing or treating his/her physical condition.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and/or surgical benefits to include major benefits to which I am entitled, including Medicare, Medicaid, Worker's Compensation, private insurance and treating physician to Rehabilities. I hereby authorize the release of all information necessary, including Medical Records.

FINANCIAL POLICY STATEMENT

As a courtesy to me, Rehabilities will bill my insurance carrier. I further understand if for some reason my insurance carrier does not pay for services rendered, I will be responsible for paying Rehabilities. Should my insurance company make a direct payment to me, I understand that I am responsible for paying Rehabilities. I have made payment arrangements for any co-pay, co-insurance and/or deductible I may be responsible for.

I have read and fully understand the above information and my insurance benefits.

_____ _____
Patient/Guardian/Responsible Party Date

CANCELLATION AGREEMENT POLICY

Rehabilities requires at least a 12 -hours notice in the event of a cancellation. There is a $25.00 charge for a cancellation without proper notice. This charge also applies to a no-show. The charge will not be covered by insurance, but is your responsibility. The staff may exercise discretion in certain circumstances on a first "no-show" or improper cancellation. If you are a patient who is normally punctual and has some unforeseen problem, they may choose to overlook it the first time. However, a second such instance will be billed, and after a third and fourth such instance, we have to question your commitment to the program.

When you don't show as scheduled, three people are hurt:

1. You, the patient because you don't get the treatment you need as prescribed. If you are not here we can't help you get better.
2. The therapist who now has an empty space in their schedule since the time was reserved for you.
3. Another patient who could have been scheduled for treatment if there had been proper notice.

To cancel or reschedule your appointment please call 915-595-4500.

After Hours: Please leave message

OUR ON-TIME GUARANTEE

We understand that your time is just as important, if not more important than ours. That is why we guarantee that you will not have to wait to be seen. To back up our statement we are putting our money where our mouth is. For every 15 minutes past your appointment time that you are not seen we will give you $25(up to $100). If we waste your time by having you sit in our waiting room we will pay you for that time.

I have read and/or had the above policy explained to me. I understand and will abide by the policy above.

_____ _____

Patients Signature Date