



PATIENT INFORMATION FORM

Patient Information

Form fields for Patient Information: Last Name, First Name, M.I., Home Phone, Cell Phone, Mailing Address, Apt. #, City, State, Zip, Email Address, Are you currently employed?, Employer, Occupation, Date of Birth, S.S.N., Gender, Marital Status, Emergency Contact Name, Telephone No., Relationship.

Medical Information

Form fields for Medical Information: Referring Physician, Date of Injury, Body Part, Is injury, Have you had prior physical therapy this year?, Diagnostic Tests, Surgery.

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

Blank lines for listing medications.

Please use back of page to list more medications

Please check if you have or ever had:

Table with 4 columns and 8 rows of medical conditions with checkboxes: 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, Arthritis, Depression, Heart Problems, Problems Other.

Insurance Information

Form fields for Insurance Information: Primary Insurance (Insurance Group No., Telephone No., Claim/I.D. No., Adjustor), 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?

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 Rehabilites and authorize Rehabilites 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 Rehabilites. In addition, I authorize and direct my insurance benefits to be paid directly to Rehabilites.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**CONSENT FOR CARE AND TREATMENT**

I agree and give my consent for Rehabilites 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 Rehabilites. I hereby authorize the release of all information necessary, including Medical Records.

**FINANCIAL POLICY STATEMENT**

As a courtesy to me, Rehabilites 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 Rehabilites. Should my insurance company make a direct payment to me, I understand that I am responsible for paying Rehabilites. 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

Rehabilitations 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