UNITED REHAB PHYSICAL THERAPY P.C.

Patient Demographic Form

Demographics: Please fill out or copy of Photo ID:

First Name: _____ Middle Initial: _____

Last Name: _____ DOB:_____

Address:_____

_____

How did you hear about us? _____

Reason for this Visit:_____

Referred By:_____

Contact Information:

Home Phone:_____ **Cell:**_____

E-Mail:_____

Marital Status: Single / Married / Other / NA

Employment Status: Employed / Full time/ Part time Student

Emergency Contact Name & Phone Number:

_____

_____

Insurance Information

Primary Insurance: Fill out or copy of insurance card

Insurance Carrier: _____

ID Number: _____

Relationship to insured:_____

Provider Relations Ph#: _____

Secondary Insurance: fill out or copy of insurance card

Insurance carrier: _____

ID Number: _____

Relationship to insured: _____

Provider Relations Ph#:_____

Is the reason for you visit related to: □ Auto injury □ Work injury □ other injury, then please provide the following info:

Insurance Carrier:_____ Claim Number:_____ Date of njury:_____

Attorney Address: (if any) Attorney Name:_____Phone:_____

Attorney Address:_____

I certify that all of the following information above is true and accurate to the best of my knowledge

Patient/ Guardian Signature

_____

Date:

_____

Authorization for Treatment, Release of Information, Assignment of Benefits & Acknowledgement of Receipt of Notice of Privacy Practices, Financial Policy and/or Medicare Financial Responsibility Disclosure

Patient Name: **Date of Birth:**

Release of Information & Consent for Treatment

All information
provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment UNITED REHAB PHYSICAL THERAPY P.C. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to Physical Therapy and related services and I understand, acknowledge and affirm that such Physical Therapy, rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to UNITED REHAB PHYSICAL THERAPY P.C. to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.
I authorize UNITED REHAB PHYSICAL THERAPY P.C. to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment. The signature below certifies that I have read and understand the above information.

Initial: _____

Assignment of Benefits

I authorize payment directly to UNITED REHAB PHYSICAL THERAPY P.C. for services and to bill and release payment directly to UNITED REHAB PHYSICAL THERAPY P.C. for any physical therapy, rehabilitation, orthotic or prosthetic services provided. This is a direct assignment of my rights and benefits under this policy.

A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for UNITED REHAB PHYSICAL THERAPY P.C. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initial _____

Payment Guarantee

I agree to pay UNITED REHAB PHYSICAL THERAPY P.C. for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances. The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of UNITED REHAB PHYSICAL THERAPY P.C.

Initial _____

Financial Policy and/or Medicare Financial Responsibility Disclosure (Acknowledgment)

I hereby acknowledge that I have received a copy of the Financial Policy and/or Medicare Financial Responsibility Disclosures.

Initial: _____

Patient or Guardian Signature: **Date:**

WORKERS COMPENSATION INFORMATION FORM

Patient Name: _____

EMPLOYER INFORMATION

Employer's Name:_____

Employer's Address:_____

Employer's Telephone #_____Injury verified by:_____

Contact Person:_____

CARRIER INFORMATION

Workers Compensation Carrier:_____

Carrier Address:_____

Carrier Phone #:_____

Adjuster:_____

Claim #:_____

INJURY INFORMATION

Date of injury:_____ Place of injury:_____

Was Accident Reported To Employer? Yes_____ No_____

Name of person who took accident report:_____

How did accident happen? _____

Have you lost time from work? Yes_____ No_____ How much time? _____

Have you seen another Physician for this condition? Yes ____ No____

Doctors Name: _____

Were X-Rays/MRI taken: Yes____ No____ Other test? Yes ____ No ____

If yes, please explain, list test and by whom:

_____

ATTORNEY INFORMATION

Do you have and Attorney or Legal Representation for this injury? Yes____ No____

Attorneys or Firm Name: _____ Ph No: _____

Attorneys Address: _____

AUTHORIZATION

I hereby assign, transfer, and set over to _____ all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This Authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature: _____ Date:_____

Patient Intake Questionnaire

Chief Complaint/Current Complaint

Name:_____ D.O.B:_____

Reason for your visit? _____

Date of onset of your current symptoms? ____/_____/_____ or since how long? ____ Days/Weeks/Months/Years

Type of injury: Is your current health injury/symptoms related to any of the following

□ Car Accident □ Workers compensation injury □ Exacerbation of previous injury □ Slip & Fall

□ Sports injury □ Other injury/ medical condition _____

Is your current condition related to Post OP/Surgery? □ No □ Yes -Date of surgery ___/_____/_____

Type of Surgery?

_____

History of current condition:

How did your symptoms start? □ Sudden □ Progressive worse □ Exacerbation of previous injury

Is your problem getting worse since it started? □ Yes □ No

Did you experience similar symptoms in the past? □ No □ Yes - when_____

Are any other doctor/chiropractor/ others treating you for this problem? □ No □ Yes - who_____

Have you had any X-rays, MRI's, CAT Scans for your current condition/injury? □ No □ Yes – where_____

What treatments are you currently receiving for your current problem? □ Medications □ Injections □ Chiropractic

□ Physical Therapy □ Acupuncture □ Massage Therapy □ Other:_____

Did you have any history of prior injuries? □ Car accidents □ Work injuries □ No □ Yes - when_____

Past Medical History

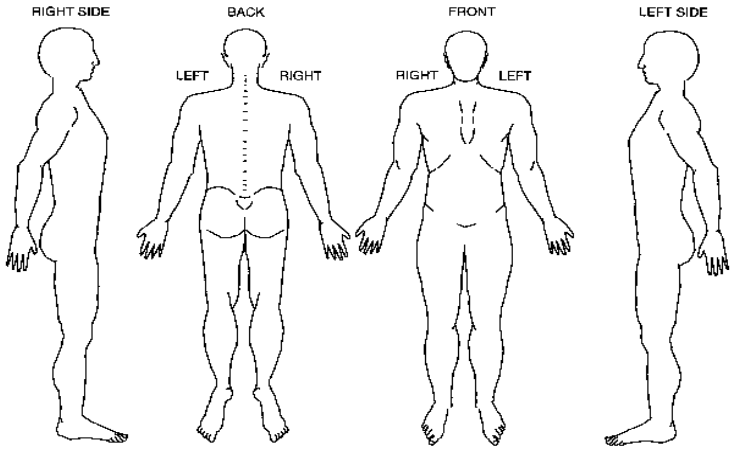
□ Heart disease	□ Hypertension	□ Stroke/CVA	□ Diabetes
□ Seizures/Epilepsy	□ Arrhythmias	□ Bleeding disorder	□ Neuropathy
□ Weight gain/loss	□Asthma	□HIV/AIDS	□Cancer
□Systemic Lupus	□Hepatitis	□Rheumatoid Arthritis	□Arthritis
□Tobacco packs/day_____	□Drug or Alcohol Dependence	□Other: _____	

□Latex Allergy **□Pacemaker** **□Pregnancy** **□Metallic Implants**

Pain History

On an average day, how intense is your pain? **(No pain)** 0 1 2 3 4 5 6 7 8 9 10 **(Unbearable pain)**

MARK ON PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



How often do you experience pain?

□(A) Constant (76%-100%)

□(B) Frequent (51%-75%)

□(C) Occasional (26%-50%)

□(D) Intermittent (25% or less)

What activities increase your pain?			**Type of pain:**	
□ Bending	□ Lifting	□ Morning	□ Aching (1)	□ Radiates (5)
□ Reaching	□ Running	□ Afternoon	□ Burning (2)	□ Sharp (6)
□ Sitting	□ Standing	□ Evening	□ Deep (3)	□ Stabbing (7)
□ Walking	□ Working	□ Night	□ Dull (4)	□ Stiff (8)

Functional Scores					
NECK DISIABILITY INDEX;		DASH;		LEFS;	
SPADI;		OSWESTRY;		Other;	

Functional Limitations

Neck; Turning the neck, bending the neck, looking up and down	□Mild	□Moderate	□Severe
L-Spine; Sitting, bending, lifting, twisting	□Mild	□Moderate	□Severe
Shoulder; Reaching overhead, reaching behind, washing, lifting/carrying, pushing/pulling	□Mild	□Moderate	□Severe
Elbow; Lifting, carrying, pulling, pushing	□Mild	□Moderate	□Severe
Hand; opening a tight jar, turning key/doorknob, prepare a meal, push/pulling, lifting/carrying	□Mild	□Moderate	□Severe
Knee; Standing, walking, stair climbing, running	□Mild	□Moderate	□Severe

Prior Level of Function

□No limitations □Mild Limitation □Moderate □Severe

Occupation:_____ **Right Handed?**____ **Left Handed?**____

Current Work Status; □Working □Not Working Last Date Worked; _____