REHAB SOLUTIONS

ADVANCED PHYSICAL THERAPY

# PATIENT INTAKE FORM

**DATE** _____

## PATIENT INFORMATION

**NAME** _____

LAST FIRST M.I.

**DATE OF BIRTH**_____**AGE**_____ **SEX** ☐ M ☐ F **SOCIAL SECURTITY #**

## CONTACT INFORMATION

**MAILING ADDRESS** _____

STREET APT #

_____

CITY STATE ZIP

**PHYSICAL**_____

_____

CITY STATE ZIP

**PHONE NUMBERS**

HOME_____WORK_____CELL_____

Appointment Reminder: (Home / Work / Cell ) ( Call / Text)

**EMAIL** **EMPLOYOR**

_____

## Responsible Party

NAME _____

PHONE NUMBER _____

MAILING ADDRESS _____

CITY _____ STATE_____ ZIP_____

SSN: _____ DOB: _____

RELATIONSHIP _____

## EMERGENCY CONTACT

NAME_____

RELATIONSHIP _____

PHONE NUMBER _____

## INSURANCE INFORMATION

*Please provide only the names of your insurances. We will copy your ins. cards for additional info.*

PRIMARY _____

SECONDARY _____

Do you have Wyoming Miners Insurance ( YES / NO )

**SUBSCRIBER INFORMATION** (If different then patient)

Name: _____

SSN: _____DOB: _____

Relationship to patient: _____

IS YOUR CURRENT COMPLAINT DUE TO INJURIES SUSTAINED DUE TO:

☐ **WORK** _____

☐ **AUTOMOBILE** _____

☐ **OTHER** _____

DATE OF ONSET_____

REHAB SOLUTIONS
ADVANCED PHYSICAL THERAPY

Name: _____

DOB: _____

(For office use only) ID# _____

**PATIENT CONSENT FORM Page 1 of 2**

## ACKNOWLEDGEMENT OF HIPAA & PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have certain rights to privacy regarding my protected health information. I understand this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Business planning and development, such as conducting cost-management and planning analyses related to managing the business entity.

The **Notice of Privacy Practices** is posted in the Rehab Solutions office showing a more complete description of the uses and disclosures of patient health information. I have been given the right to review such **Notice of Privacy Practices** prior to signing this consent. I understand that this organization has the right to change it **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment, or health care options. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying this consent.

**Initials: _____**

## CONSENT TO TREATMENT AND PAYMENT

I hereby consent to any necessary medical evaluation and/or treatment for myself, or the below-named minor for whom I am legally responsible. I authorize the release of medical information to any insurance carrier and direct payments to Rehab Solutions Physical Therapy for any examination or treatment rendered. I understand that I am responsible for paying any copayments or patient responsibility balances set by my insurance carrier at the conclusion of each visit. I hereby acknowledge and accept financial responsibility for payment of charges for medical services rendered.

**Initials: _____**

## PATIENT OUTCOME DATA

I agree that my outcome data may be pooled with all other patient data in this clinic, and may be used de-identified in presentations and for publishable studies.

**Initials: _____**

## WORKER'S COMPENSATION (If Applicable)

WORK RELATED INJURY: I hereby claim that this visit is because of a WORK RELATED INJURY and I authorize Rehab Solutions to release any and all information concerning this visit to my employer.

**Initials: _____**

## OPEN TREATMENT AREA

I agree to the open treatment area used by Rehab Solutions, and I agree that, due to this open format, unauthorized individuals may have the opportunity to learn of my protected health information. A private treatment area is available by request.

**Initials: _____**

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Name: _____

DOB: _____

(For office use only) ID# _____

## PATIENT CONSENT FORM Page 2 of 2

### CANCELLATION/MISSED APPOINTMENT POLICY

Our goal is to provide quality individualized care in a timely manner. "No-shows" and late cancellations inconvenience the clinic and other patients. This policy enables us to better utilize available appointments for our patients and to fulfill patient's scheduling needs.

Cancellation of an appointment:
To cancel appointments, please call 307-686-8177. If you do not reach the receptionist, you may leave a detailed message on our voicemail and we will call you to schedule the next available appointment time. If 24 hours' notice is not given a fee of $25.00 will be billed to your account. This fee is not covered by insurance

No Show Policy:
A "no-show" is someone who misses an appointment without cancelling it in an adequate manner. A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "no-show." A fee of $25.00 will be billed to your account. This fee is not covered by insurance.

**Initials: _____**

### DISCLOSURE OF HEALTH INFORMATION

If you want someone besides you and your doctor (such as a spouse, child, coach, etc.) to have access to your physical therapy treatment records, please provide their name and relation below.

***I authorize Rehab Solutions Physical Therapy clinic to disclose my protected health information to the following persons:***

Name Relation to Patient

_____

**PATIENT NAME:**
_____

**PARENT/GAURDIAN NAME:** _____

**SIGNATURE:** _____ **DATE:**_____

REHAB SOLUTIONS
ADVANCED PHYSICAL THERAPY

**Rehab Solutions Physical Therapy**
1103 E. Boxelder Rd., Suite U
Gillette, WY 82718 USA
Phone: 307-686-8177 Fax: 307-686-9484

Today's Date: / /

Name: _____ Age_____

Occupation: _____

Hobbies: _____

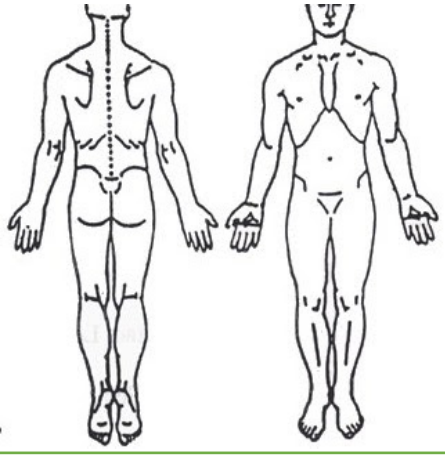
Date of Injury: _____ Sudden ☐ or Gradual Onset ☐

Referring Doctor: _____

Diagnosis:

_____ Surgery:

_____Date: _____



**Please mark your painful locations above.**

**Please place an X on the line below to indicate pain level and function.**

**Pain Level**

**0—1—2—3—4—5—6—7—8—9--10**

**Percent of Normal Function**

0%----------100%

Please provide us with your **Past Medical History** below:

Surgical History:

_____

_____

_____

Current Medications:

_____

_____

_____

**Please read and mark all that apply**

| | | | | | |
|---|---|---|---|---|---|
| Vision or Hearing Difficulties | ☐ | Heart attack/surgery | ☐ | Contagious Disease | ☐ |
| Cancer | ☐ | Coronary Heart Disease | ☐ | Infectious Disease | ☐ |
| Diabetes | ☐ | High Blood Pressure | ☐ | Asthma | ☐ |
| Dizziness/Fainting | ☐ | Pacemaker | ☐ | Pregnant | ☐ |
| Stroke/Mini Stroke | ☐ | Blood Clots | ☐ | Metal Implants | ☐ |
| Shortness of Breath | ☐ | Seizures/Epilepsy | ☐ | Smoker | ☐ |
| Chest Pain | ☐ | Thyroid Dysfunction | ☐ | Bowel and Bladder Problems | ☐ |
| | ☐ | | ☐ | | ☐ |

**Primary Complaint:**_____

**Goals for Physical Therapy:**_____