

Patient Medical History



Patient Name: _____

Referring Physician: _____

Patient Occupation _____

Emergency Contact Name: _____ Phone: (____) _____ - _____

Date of first MD visit for this problem or injury _____ Follow-up MD visit for this problem _____

Is this a work injury? Yes No Is an Attorney involved: Yes No

Date of Injury or onset of symptoms _____

How did your symptoms begin (gradually, suddenly, injury specifics)? _____

Have you had surgery for this problem/Injury: Yes No Type of Surgery _____

Date of Surgery _____

List your current medications. Include prescriptions, over-the-counter, herbs, and vitamins.

Table with 6 columns: Medication, Dosage, frequency & route, Medication, Dosage, frequency & route. Multiple rows for listing medications.

Are you allergic to any medications or latex? If yes please specify _____

Please list symptoms you are currently having (pain, swelling, weakness, etc) _____

Body Chart: Please mark the areas on the chart where you feel pain. Includes diagrams of front and back views of a human body and a pain level scale from 0 to 10.

What is your main complaint? _____

Check all the activities that you have trouble performing as a result of your present condition.

- ___ Bathing ___ Child Care ___ Dressing ___ Eating
___ Homemaking ___ Yard work ___ Sitting ___ Sleeping
___ Standing ___ Walking ___ Working

How Long can you tolerate the following? Table with columns: Less than 30 min, 1-2 hours, 3-4 hours, No problems. Rows: Walking, Sitting, Standing.

What treatment have you previously received for this injury/episode? ___ Physical Therapy ___ Occupational Therapy ___ Chiropractic Care ___ Surgery ___ Medications: ___ Other _____

Please circle if you have had any of these test done for this injury/episode: Bone Scan X-Ray MRI CAT Scan EMG- NCV Myelogram Other _____

- Do you have or have you had any of the following? ___ Allergies ___ Dizzy Spells ___ MRSA ___ Anemia ___ Emphysema/Bronchitis ___ Multiple Sclerosis ___ Anxiety ___ Fibromyalgia ___ Muscular Disease ___ Arthritis ___ Fractures ___ Osteoporosis ___ Asthma ___ Gallbladder Problems ___ Parkinsons ___ Autoimmune Disorder ___ Headaches ___ Rheumatoid Arthritis ___ Cancer ___ Hearing Impairment ___ Seizures ___ Cardiac Conditions ___ Hepatitis ___ Smoking ___ Cardiac Pacemaker ___ High Cholesterol ___ Speech Problems ___ Chemical Dependency ___ High/Low Blood Pressure ___ Strokes ___ Circulation Problems ___ HIV/AIDS ___ Thyroid Disease ___ Currently Pregnant ___ Incontinence ___ Tuberculosis ___ Depression ___ Kidney Problems ___ Vision Problems ___ Diabetes ___ Metal Implants

What are your expectations/goals during your Physical Therapy program? _____

Patient/Guardian Signature _____

Date _____

PATIENT NAME _____ **Patient Date of Birth** _____

Home Address _____

City _____ State _____ Zip Code _____

Phone Number (____) _____ - _____

Consent for Care and Treatment

I give my consent for treatment by the staff at PREMIER REHAB for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at PREMIER REHAB.

Signature _____ **Date** _____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to **PREMIER REHAB** for medical benefits to which I am entitled, including Medicare, private insurance, and third party payers for services performed during the course of my treatment at Premier Rehab.

I authorize Premier Rehab to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Rehab staff.

PREMIER REHAB will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other healthcare operations. *Healthcare operations generally include those activities we perform to improve quality of care.*

Signature _____ **Date** _____

Appointment/Cancellation Policy

Premier Rehab requires that all appointments be cancelled and/or rescheduled within 24 hours of your scheduled appointment time. **If you cancel with less than 24 hours notice or fail to keep an appointment, you will be charged a \$25 no-show/late cancellation fee** which is due prior to your next scheduled appointment.

RELEASE OF INFORMATION

I hereby authorize Premier Rehab to release and disclose all Medical History to:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I authorize Premier Rehab staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (____) _____ - _____ and (____) _____ - _____

TEXT MESSAGING CONSENT: I consent to receiving text messages from Premier Rehab to wireless number (____) _____ - _____. *Text messages to the wireless number provided will include appointment reminders.*

EMAIL CONSENT: I consent to receiving email messages from Premier Rehab to the following email address _____@_____. *Email messages will include appointment reminders.*

I also understand that I have the right to terminate this authorization at any time in writing or verbally.

Patient Name (Printed) _____ **Signature** _____ **Date** _____

How did you hear about Premier Rehab? _____

Notification of Patient Responsibility for co-payments/Co-percentages and Deductibles

- We bill insurance carriers solely as a courtesy to the patient.
- Payment is due at each visit as determined by your benefits.
- The amount collected at each visit is only an estimate.
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company.

Please list your health insurance plan(s):

Primary Insurance Name: _____ **ID Number:** _____

Insured Name: _____ **Insured DOB:** _____

Secondary Insurance Name: _____ **ID Number:** _____

Insured Name: _____ **Insured DOB:** _____

It is the patients' responsibility to inform our staff if there is a change in insurance coverage and or contact information to include address and contact phone numbers.

If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of \$40.00 per check plus the original amount of each check.

Please read:

- If you have a secondary or tertiary insurance we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- You the patient are responsible for payment of services rendered if your insurance denies payment due to exceeding you allowed visits and or dollar amount limit. ***Exceeding your therapy cap may occur if you attend several facilities within the same year or if you attend therapy to many times within the same year.***
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage
- If any payment is made directly to the patient for services billed by PREMIER REHAB, the patient recognizes an obligation to promptly submit the same payment to PREMIER REHAB.

Have you had any Physical Therapy or Speech Therapy in the current c/year? Yes No
 If yes, how many visits? _____ Staff initial _____

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

By signing below you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.

Patient Name (Printed) **Signature** of Patient or Legal Guardian **Date**

PREMIER REHAB representative/witness _____ Date _____

Please answer:

Are you currently employed? YES NO If YES FT or PT ?

Is your spouse or other family member currently employed? YES NO If YES FT or PT ?

How many employees work for the employer providing coverage? _____

Are you on disability? YES NO Did you sustain an injury while at work? YES NO

Are your injuries related to an accident (i.e. is the pt being treated for an injury for which another party could be liable)? YES NO

Home Health Care Services/Hospice

These types of services are subject to the home health/Hospice consolidated billing provision

- Skilled nursing care
- Hospice
- Home health aide services
- Physical Therapy
- Speech-language pathology
- Medical social services
- Routine and non-routine medical supplies
- Medical services provided by an intern or resident-in-training of a hospital under an approved teaching program of the hospital in the case of an HHA that is affiliated under the common control with that hospital.
- Care for homebound patients involving equipment too cumbersome to take to the home.

Per Medicare: Since Medicare payment for services subject to home health consolidated billing is made to the primary Home Health Agency, Part B providers or suppliers of these services must be aware that separate Medicare payment will not be made to them.

Are you currently receiving any medical treatment by a Home Health Care Agency or any other medical staff at home including Hospice ? Yes No Staff Initial

If your answer above is YES:

Please contact your Home Health Care/Hospice provider to arrange Physical Therapy treatment.

If you choose not to have Physical Therapy services provided by your primary Home Health Care Agency and you currently have a Home Health Care/Hospice Episode on file, you the beneficiary will be liable for payment for our services.

Patient Name (Printed)

Signature

Date

PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

THE PATIENT HAS THE RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility, provisions for after hours and emergency care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative or other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.
- Have an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. Surgery centers and diagnostic imaging centers may be exceptions to this statement and will have a facility-specific policy.
- Be fully informed before any transfer to another facility or organization.
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

THE PATIENT IS RESPONSIBLE FOR:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

Signature _____

Date _____

Back Index

ACN Group, Inc. Form BI-100

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ **Date** _____

This questionnaire will give your provider information about how your back condition affects your everyday life. Please answer every section by marking the one statement that applies to you. If two or more statements in one section apply, please mark the one statement that most closely describes your problem.

Pain Intensity

- ① The pain comes and goes and is very mild.
- ② The pain is mild and does not vary much.
- ③ The pain comes and goes and is moderate.
- ④ The pain is moderate and does not vary much.
- ⑤ The pain comes and goes and is very severe.
- ⑥ The pain is very severe and does not vary much.

Sleeping

- ① I get no pain in bed.
- ② I get pain in bed but it does not prevent me from sleeping well.
- ③ Because of pain my normal sleep is reduced by less than 25%.
- ④ Because of pain my normal sleep is reduced by less than 50%.
- ⑤ Because of pain my normal sleep is reduced by less than 75%.
- ⑥ Pain prevents me from sleeping at all.

Sitting

- ① I can sit in any chair as long as I like.
- ② I can only sit in my favorite chair as long as I like.
- ③ Pain prevents me from sitting more than 1 hour.
- ④ Pain prevents me from sitting more than 1/2 hour.
- ⑤ Pain prevents me from sitting more than 10 minutes.
- ⑥ I avoid sitting because it increases pain immediately.

Standing

- ① I can stand as long as I want without pain.
- ② I have some pain while standing but it does not increase with time.
- ③ I cannot stand for longer than 1 hour without increasing pain.
- ④ I cannot stand for longer than 1/2 hour without increasing pain.
- ⑤ I cannot stand for longer than 10 minutes without increasing pain.
- ⑥ I avoid standing because it increases pain immediately.

Walking

- ① I have no pain while walking.
- ② I have some pain while walking but it doesn't increase with distance.
- ③ I cannot walk more than 1 mile without increasing pain.
- ④ I cannot walk more than 1/2 mile without increasing pain.
- ⑤ I cannot walk more than 1/4 mile without increasing pain.
- ⑥ I cannot walk at all without increasing pain.

Personal Care

- ① I do not have to change my way of washing or dressing in order to avoid pain.
- ② I do not normally change my way of washing or dressing even though it causes some pain.
- ③ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ④ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ⑤ Because of the pain I am unable to do some washing and dressing without help.
- ⑥ Because of the pain I am unable to do any washing and dressing without help.

Lifting

- ① I can lift heavy weights without extra pain.
- ② I can lift heavy weights but it causes extra pain.
- ③ Pain prevents me from lifting heavy weights off the floor.
- ④ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (e.g., on a table).
- ⑤ Pain prevents me from lifting heavy weights off the floor, but I can manage light to medium weights if they are conveniently positioned.
- ⑥ I can only lift very light weights.

Traveling

- ① I get no pain while traveling.
- ② I get some pain while traveling but none of my usual forms of travel make it worse.
- ③ I get extra pain while traveling but it does not cause me to seek alternate forms of travel.
- ④ I get extra pain while traveling which causes me to seek alternate forms of travel.
- ⑤ Pain restricts all forms of travel except that done while lying down.
- ⑥ Pain restricts all forms of travel.

Social Life

- ① My social life is normal and gives me no extra pain.
- ② My social life is normal but increases the degree of pain.
- ③ Pain has no significant affect on my social life apart from limiting my more energetic interests (e.g., dancing, etc).
- ④ Pain has restricted my social life and I do not go out very often.
- ⑤ Pain has restricted my social life to my home.
- ⑥ I have hardly any social life because of the pain.

Changing degree of pain

- ① My pain is rapidly getting better.
- ② My pain fluctuates but overall is definitely getting better.
- ③ My pain seems to be getting better but improvement is slow.
- ④ My pain is neither getting better or worse.
- ⑤ My pain is gradually worsening.
- ⑥ My pain is rapidly worsening.

Index Score = [Sum of all statements selected / (# of sections with a statement selected x 5)] x 100

Back
Index
Score