Patient Medical History

Premier REHAB PHYSICAL THERAPY

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.

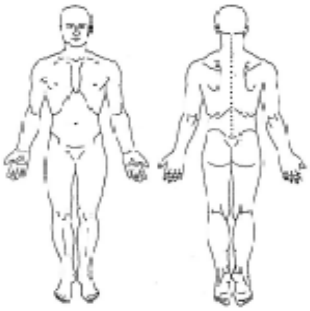
Medication	Dosage	frequency & route	Medication	Dosage	frequency & route
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

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.



Please Circle your pain level:

0 being no pain & 10 Extreme pain

0 1 2 3 4 5 6 7 8 9 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?

	Less than 30 min	1-2 hours	3-4 hours	No problems
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	__ Gallbalder Problems	__ Parkinsons
__ Autoimmune Disorder	__ Headaches	__ Rheamatoid Arthritis
__ Cancer	__ Hearing Impairment	__ Seizures
__ Cardiac Conditions	__ Hepatitis	__ Smoking
__ Cardiac Pacemaker	__ High Cholesterol	__ Speech Problems
__ Chemical Dependency	__ High/Low Blood Presure	__ 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 your allowed visits and or dollar amount limit.
- 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.

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_____

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 of 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 and 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 _____

Patient Summary Form

PSF-750 (Rev:2/18/2009)

Instructions
Please complete this form within the specified timeline and fax to the specified fax number as indicated on Plan Summary or plan information previously provided.

*Fax number may vary by plan.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° 2° 3° 4°

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

Neck Index | DASH | (other)

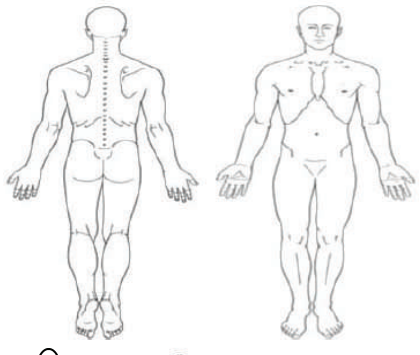
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1. Constantly (76%-100% of the time)
2. Frequently (51%-75% of the time)
3. Occasionally (26% - 50% of the time)
4. Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1. Not at all
2. A little bit
3. Moderately
4. Quite a bit
5. Extremely

6. How is your condition changing, since care began at *this* facility?

0. **N/A — This is the initial visit**
1. Much worse
2. Worse
3. A little worse
4. No change
5. A little better
6. Better
7. Much better

7. In general, would you say your overall health right now is...

1. Excellent
2. Very good
3. Good
4. Fair
5. Poor

Patient Signature: X _____ **Date:** _____

THE LOWER EXTREMITY FUNCTIONAL SCALE

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your lower limb Problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, do you or would you have any difficulty at all with:

	Activities	Extreme Difficulty or Unable to Perform Activity	Quite a Bit of Difficulty	Moderate Difficulty	A Little Bit of Difficulty	No Difficulty
1	Any of your usual work, housework, or school activities.	0	1	2	3	4
2	Your usual hobbies, re creational or sporting activities.	0	1	2	3	4
3	Getting into or out of the bath.	0	1	2	3	4
4	Walking between rooms.	0	1	2	3	4
5	Putting on your shoes or socks.	0	1	2	3	4
6	Squatting.	0	1	2	3	4
7	Lifting an object, like a bag of groceries from the floor.	0	1	2	3	4
8	Performing light activities around your home.	0	1	2	3	4
9	Performing heavy activities around your home.	0	1	2	3	4
10	Getting into or out of a car.	0	1	2	3	4
11	Walking 2 blocks.	0	1	2	3	4
12	Walking a mile.	0	1	2	3	4
13	Going up or down 10 stairs (about 1 flight of stairs).	0	1	2	3	4
14	Standing for 1 hour.	0	1	2	3	4
15	Sitting for 1 hour.	0	1	2	3	4
16	Running on even ground.	0	1	2	3	4
17	Running on uneven ground.	0	1	2	3	4
18	Making sharp turns while running fast.	0	1	2	3	4
19	Hopping.	0	1	2	3	4
20	Rolling over in bed.	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/ 80**

Please submit the sum of responses to ACN.

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