Rehab Access Information Form

Thank you for choosing Rehab Access, Inc. In order to serve you properly, we will need the following information. All the information will be strictly confidential. Please Print Clearly.

How did you hear about us? Friend_______ Phone Book ___________ Physician ________ Other ___________

Reason for Visit: ____Accident ____ Work Injury ____Sports Injury ____ Recurring Illness ____ Post-Surgery ____Other

PATIENT

Last Name:_________________________________First:_______________________M.I._______

Street Address: _____________________________________ City:________________ State:_____

Zip :__________Date Of Birth:___/____/___Sex:(M/F)_________S.S.#:________-________- _______

Home Phone:________________Work Phone:________________Cell/Other:____________ _____

Email:____

DRIVERS LICENSE AND INSURANCE CARD (GIVE TO RECEPTIONIST TO COPY)

1. Are you Employed ? YES NO Are you a student? YES NO If yes___ full time ____part time
2. Marital Status: _______Single _____Married ______ Other
3. Today's Date ____/___/___
4. Doctor who referred you to this Clinic:____
5. Primary Dr.:____ _____

EMPLOYER (or parents if under 18 years of age)

Name of Company:____ Work Number:______________

Address:____City:______________State:______

EMERGENCY CONTACT (Friend or Relative not living with you)

Name of Contact: ________________________Phone/Cell/Beeper: (___)__________Relationship:__________

INSURANCE INFORMATION (give insurance card to receptionist)

Primary Insurance: ____________________________________ID# or Policy#_______________________

Mailing Address: ________________________________City: ______________State ______Zip__________

Name of Insured: __________________________Group name: _________________Group #____________

SECONDARY INSURANCE INFORMATION (give insurance card to receptionist)

Secondary Insurance: ____________________________________ID or Policy# _____________________

Mailing Address:_________________________________City__________________State_______Zip__________

Name of insured: __________________________Group Name or #________________________________

WORKER'S COMPENSATION

Comp.Carrier:____Phone: ______________

Address:__________________________________City___________________State_______ Zip____________

Adjuster:___________________________________ Verified By:______________________________________

Date of Accident:________________ Claim Number:__________________________

ATTORNEY INFORMATION

Attorney Name:_________________________________Phone____________________

Address:_____________________________________City_____________________State_________Zip__________

HAVE YOU RECEIVED PHYSICAL THERAPY THIS YEAR? YES or NO

How long was your treatment? ____

ARE YOU CURRENTLY RECEIVING ANY TYPE OF HOME HEALTH SERVICES? YES or NO

FOR OFFICE USE ONLY:

DIAGNOSIS:____

AUTHORIZARION #:____

LAST DATE MD SEEN (M/C):____

MD ADDRESS/PHONE NUMBER:____

OTHER:____

Rehab Access, Inc.
Patient Medical History

PLEASE MARK IF YOU HAVE HAD ANY OF THE FOLLOWING CONDITIONS:

___ Heart Attacks	___ Allergies	___ Asthma
___ Angina	___ Osteoporosis	___ Fracture
___ Stroke	___ Emotional Problems	___ Whiplash
___ Tumors	___ Nervous Problems	___ Lung Disease
___ Cancer	___ Kidney/Bladder Disease	___ Hernia
___ Diabetes	___ Back Injury	___ Gout
___ Epilepsy/Convulsions	___ Neck Injury	___ Dislocations
___ Arthritis	___ Hepatitis	___ Thyroid Disease
___ Circulatory Problems	___ Tuberculosis	___ Joint Strain
___Respiratory Problems(COPD)	___ Pneumonia/Emphysema	___ Muscle Strain
___Gastrointestinal Disease	___ High Blood Pressure	___TMJ
___Alcohol Problem	___ Congestive Heart Failure	___ Pacemaker
___ Valvular Disease	___ Atherosclerotic Diesase	___ Pregnant Now
___ Surgical Implants	___ Congenital Disorders	___Dementia/Alzheimers

MARK THE FOLLOWING IF YOU HAVE RECENTLY EXPERIENCED:

___ Headaches	____ Shortness of Breath	___ Hoarseness
___ Muscular Pain w/exertion	____ Weight Loss	___ Falls
___ Dizziness	___ Tingling, Numbness	___ Tremors
___ Balance Problems	___ Muscle Pain at Rest	___ Fatigue
___ Pain Coughing Sneezing	___ Difficulty Sleeping	___ Weakness
___ Blurred Vision	___ Skin Discoloration	

___ Constant Pain Unrelieved By Rest Movement

PLEASE LIST ANY MAJOR SURGERIES OR HOSPITALIZATIONS:

____

____

PLEASE LIST IF YOU ARE ALLERGIC TO ANY MEDICATIONS

____

____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING

____

____

PLEASE MARK THE FOLLOWING DIAGNOSTIC TEST YOU HAVE TAKEN

___X-RAY OF ________________________DATE_____RESULTS____________________

___MRI OF __________________________DATE_____RESULTS____________________

___EMG/NCV OF ______________________DATE_____RESULTS____________________

PLEASE MARK THE FOLLOWING WHICH BEST DESCRIBE YOUR PAIN

___CONSTANT	___INCREASING	____NIGHT PAIN	___STIFFNESS
___DULL/ACHY	___INTERMITTENT	___ DECREASING	___SHARP PAIN
___OCCASSIONAL	___ STATIC	___ PAIN UPON WAKING	

HAVE YOU EVER BEEN TREATED BY A PHYSICAL THERAPIST OR CHIROPRACTOR? ____ WHAT WERE YOU TREATED FOR?____________________

PATIENT NAME:_______________________________________DATE _______________

Rehab Access, Inc.

CONSENT FOR TREATMENT: I as a patient consent to physical therapy treatment at Rehab Access, Inc. as prescribed by my physician**.** I consent to maintain the confidentiality of the other patients of the facility and not to disclose to anyone anything discussed at the facility by anyone other than me.

Patient
Signature: ____Date: __________________

AUTHORIZED RELEASE OF INFORMATION: I hereby authorize Rehab Access, Inc. to release medical records pertaining to my treatment to any entity that is responsible for payment of physical therapy charges. I understand that this authorizes my insurance company to pay any benefits directly to Rehab Access, Inc. In addition, I further understand that I am ultimately responsible for any remaining co-insurance or co-payment.

Patient
Signature:____Date:__________________

HIPPA Patient Information Consent: I have read and fully understand Rehab Access Inc.'s Notice of Information Practices. I understand that Rehab Access, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Rehab Access, Inc. will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal information for purposes as noted in Rehab Access, Inc. Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient
Signature: ____Date__________________