Rehab for Life Patient Registration Packet

6215 E. Florida St.
Evansville, IN 47715
Phone: 812-401-5210

First Name:_____ M.I.:_____ Last Name:_____ D.O.B.:_____/_____/_____

Address:_____ City:_____ State:_____ Zip:_____

Home #:_(_____)_____ Cell #:_(_____)_____ Work #:_(_____)_____

Email:_____ Employer:_____ Gen. Physician:_____

Emergency Contact:_____ Relation:_____ Phone #:_(_____)_____

Primary Medical Insurance:_____ Insurance ID:_____

Policy Holder:_____ Policy Holder D.O.B.: _____/_____/_____ Policy Holder SSN:_____

Secondary Medical Insurance:_____ Insurance ID:_____

Policy Holder:_____ Policy Holder D.O.B.: _____/_____/_____ Policy Holder SSN:_____

Referral Source: ___Physician Referral (Name of referring physician:_____)

___Family/Friend (Name of family/friend:_____) ___Other (Please list:_____)

Is this a work-related injury? ___Yes ___No

***If yes:**

Injury Date: _____/_____/_____ Employer:_____ Employer Phone #:_(_____)_____

Is this injury related to a motor vehicle accident? ___Yes ___No

***If yes:**

Motor Vehicle Accident Date: ____/____/____ State in which Motor Vehicle Accident Occurred: _____

Who was deemed legally responsible? _____

Do you use tobacco? ___Yes ___No

***If yes, are you actively participating in a smoking cessation program to stop usage? ___Yes ___No**

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Current Medications (Prescribed AND over-the-counter): ___Aspirin/Advil ___Blood Thinners ___Insulin

___Medication for Osteoporosis ___Muscle Relaxers ___Nerve Pills ___Prescription Pain Killers

___Stimulants ___Tranquilizers ___Other:_____

_____

Surgical History: _____

_____

Approximately how many falls have you experienced in the past year?_____falls

Please indicate whether or not you have EVER been diagnosed with any of the following conditions:

Y	N	Heart Surg./Pacemaker	Y	N	Kidney Problems	Y	N	Shingles	Y	N	X-ray/Cobalt Treatment
Y	N	Heart Murmur	Y	N	Liver Problems	Y	N	Hepatitis	Y	N	Chemotherapy
Y	N	Rheumatic Fever	Y	N	Respiratory Problems	Y	N	HIV+/AIDS/ARC	Y	N	Asthma
Y	N	Mitral Valve Prolapse	Y	N	Sinus Problems	Y	N	Arthritis/Rheumatism	Y	N	Difficulty Breathing
Y	N	Artificial Valves	Y	N	Stomach Problems/Ulcers	Y	N	Artificial Bones/Joints	Y	N	Diabetes/Hypoglycemia
Y	N	Heart Disease	Y	N	Psychiatric Problems	Y	N	Emphysema	Y	N	Leukemia
Y	N	Congenital Heart Defect	Y	N	Venereal Disease	Y	N	Fainting/Seizures/Epilepsy	Y	N	Anemia
Y	N	Chest Pains	Y	N	Alcohol/Drug Abuse	Y	N	Frequent Headaches	Y	N	High/Low Blood Pressure
Y	N	Scarlet Fever	Y	N	Tuberculosis	Y	N	Frequent Neck Pain	Y	N	Bleeding Problems
Y	N	Nervousness	Y	N	Jaw Problems (TMJ/TMD)	Y	N	Back Problems	Y	N	Glaucoma

Please indicate whether or not you have RECENTLY noticed any of the following symptoms/conditions:

Y	N	Weight Loss/Gain	Y	N	Nausea/Vomiting
Y	N	Dizziness/Lightheadedness	Y	N	Unusual Weakness
Y	N	Fever/Chills/Sweats	Y	N	Visual Problems
Y	N	Incontinence	Y	N	Hearing Problems
Y	N	Bleeding	Y	N	Pregnant or Think You Might Be Pregnant

How would you rate your current pain level on a scale from 1 to 10, with 1 being very little pain and

10 being maximum pain tolerance? (Please circle the number that corresponds with your current pain level.)

1 2 3 4 5 6 7 8 9 10

No Pain<----------->Max Pain

Date of onset of current symptoms/injury: _____/_____/_____

Have you had the same or a similar problem in the past? ___Yes ___No

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***If yes, please explain:_____**

Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.:_____

_____

Have you received x-rays, a MRI, a CT scan, a bone scan, etc. for this problem? ___Yes ___No

Has your doctor discussed your medical findings or given you a diagnosis? ___Yes ___No

***If yes, what were the findings? _____**

_____

Do you require this therapy to return to prior level of function? ___Yes ___No

What are your goals for recovery? _____

Are you aware of any physical reason why you should not receive treatment? ___Yes ___No

***If yes, please explain:_____**

Do you have any allergies? ___Yes ___No

***If yes, please list all known allergies:_____**

- **I authorize and consent that the therapists of Rehab for Life, LLC treat my needs as laid out in my plan of care and/or as authorized by my physician.**
- **I authorize the release of all my demographic information and/or medical records to insurance companies, workers' compensation carriers, and other treating physicians when necessary for filing claims, proving medical necessity, and obtaining payment.**
- **I authorize Rehab for Life, LLC to act as my agent in helping to obtain payment from my insurance companies.**
- **I authorize payment from insurance companies or workers' compensation carriers be made directly to Rehab for Life, LLC.**
- **I understand that it is my responsibility to inform Rehab for Life, LLC of any changes in my insurance companies, coverage, or if my insurance is ever terminated.**
- **Rehab for Life, LLC will verify your eligibility/benefits and obtain any required prior authorizations. HOWEVER, insurance companies never guarantee benefits stated. If benefits are misquoted to Rehab for Life, LLC and/or services are deemed to be medically unnecessary, I acknowledge that I will not hold Rehab for Life, LLC responsible. I understand that I am, ultimately, the one responsible for all charges incurred, regardless of what my insurance states.**
- **I acknowledge that I am responsible for all charges incurred once my insurance has made all of their adjustments and/or payments.**
- **I understand that Rehab for Life, LLC may assign any unpaid balance to a third party collection agency or with an attorney to assist in the collection process. If this occurs, I acknowledge that a collection fee of 33% will be added to my balance and that I will also be responsible for any attorney fees or court costs in conjunction with the collection process.**
- **By providing my contact information, I agree to receive information, such as appointment reminders, patient surveys, and other information relating to my therapy via the communication channels provided above.**
- **Rehab for Life, LLC will provide a copy of the Privacy Statement and/or Patient's Rights and Responsibility upon request.**

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- **I have been notified that Rehab for Life, LLC, has a 24 hour cancellation/rescheduling policy. If I miss my appointment or cancel an appointment with less than 24 hours notice, I will be charged a $50.00 cancellation fee per missed treatment. I understand that Rehab for Life, LLC reserves the right to discharge any patient for chronically missing and/or cancelling scheduled appointments. The cancellation and no show fees are the sole responsibility of the patient.**
- **I am aware that Rehab for Life, LLC enforces a dress code policy. Patients are expected to wear clothing that is not too revealing or offensive to other people. This also includes undergarments for patients who are receiving myofascial release. All clothing should be comfortable and allow for adequate movement. Shoes need to be non-slip, non-skid and provide adequate support. Additional guidelines will be provided for patients seeking aqua therapy.**

To the best of my knowledge, the above information is accurate and complete.

Patient/Guarantor Signature:_____ Date:____/____/____

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FOR COMPLETION BY THERAPIST

Patient's Height:_____ft._____in. **Patient's Weight:_____lbs.**