

# Rehab for Life Patient Registration Packet

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



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First Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ M.I.: \_\_\_\_\_ Last Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

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

Email: \_\_\_\_\_ Employer: \_\_\_\_\_ Gen. Physician: \_\_\_\_\_

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

Power of Attorney: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_  
(If applicable)

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? \_\_\_\_\_

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Do you use tobacco?  Yes  No

\*If yes, are you actively participating in a smoking cessation program to stop usage?  Yes  No

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:

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

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

<input type="checkbox"/> Y	<input type="checkbox"/> N	Weight Loss/Gain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Nausea/Vomiting
<input type="checkbox"/> Y	<input type="checkbox"/> N	Dizziness/Lightheadedness	<input type="checkbox"/> Y	<input type="checkbox"/> N	Unusual Weakness
<input type="checkbox"/> Y	<input type="checkbox"/> N	Fever/Chills/Sweats	<input type="checkbox"/> Y	<input type="checkbox"/> N	Visual Problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Incontinence	<input type="checkbox"/> Y	<input type="checkbox"/> N	Hearing Problems
<input type="checkbox"/> Y	<input type="checkbox"/> N	Bleeding	<input type="checkbox"/> Y	<input type="checkbox"/> 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

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Date of onset of current symptoms/injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you had the same or a similar problem in the past? \_\_\_Yes \_\_\_No

\*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.

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- 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.
- 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: \_\_\_/\_\_\_/\_\_\_

\*\*\*\*\*

## FOR COMPLETION BY THERAPIST

Patient's Height: \_\_\_\_\_ ft. \_\_\_\_\_ in.

Patient's Weight: \_\_\_\_\_ lbs.