First Name: MI: Last Name:

Preferred Name: Date of Birth:

Address:                                                                                                   City, State:                                                           Zip Code:

Cell Phone: Home Phone: (This number will be used to receive text message reminders)

Emergency Contact: Relation: Phone:

Power of Attorney: Relation: Phone: (if applicable)

General Physician:

How were you referred to us? (Please fill out one)

* Physician (Name of referring physician: )
* Family/Friend (Name: )
* Other (Please list: )

Please describe the reason you are seeking physical therapy.

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

Do you have any allergies? Yes No

 -If yes, please all known allergies:

Date of onset of current symptoms/injury:

Have you had the same or 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 therapy, occupational therapy, chiropractic treatment, pain medication, etc.)

Have you received X-rays, MRI, CT scan, bone scan, etc for this problem? Yes No

 -If yes, please list the results:

Do you require this therapy to return to a prior level of function? Yes No

What are your goals for recovery?

Are you aware of any physical reason for why you should NOT receive treatment? Yes No

 -If yes, please explain:

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

Please list any previous relevant surgical procedures:

* 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 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:**