Spine&Rehab Specialists

# SPINE & REHAB SPECIALISTS
# PATIENT INFORMATION

**Patient Information: Please review information and make any corrections needed**

| | | | |
|---|---|---|---|
| LAST NAME | FIRST NAME | | MIDDLE INITIAL |
| HOME ADDRESS | CITY | STATE | ZIP CODE |
| HOME PHONE ( ) - | WORK PHONE ( ) - | CELL PHONE ( ) - | |
| E-MAIL ADDRESS | | DATE OF BIRTH / / | |
| SOCIAL SECURITY# - - | SEX: ☐ M ☐ F Marital status: ☐ S ☐ M ☐ D ☐ W | | |
| EMPLOYER | OCCUPATION | | |
| EMPLOYER ADDRESS | CITY | STATE | ZIP CODE |
| EMERGENCY CONTACT | RELATIONSHIP | PHONE# ( ) - | |
| HOW WOULD YOU LIKE TO RECEIVE YOUR APPOINTMENT REMINDERS? ☐ PHONE CALL ☐ TEXT ☐ EMAIL | | | |
| WHICH PHONE NUMBER/EMAIL SHOULD WE SEND IT TO? _____ | | | |
| WHO RECOMMENDED US TO YOU | MAY WE THANK THEM FOR REFFERING YOU TO US ☐ Y ☐ N | | |
| REFERRING PHYSICIAN | | | |
| DIAGNOSIS/CHIEF COMPLAINT | | | |
| NEXT DR.'S APPOINTMENT: | PRIOR PHYSICAL THERAPY FOR THIS INJURY ☐ YES ☐ NO | | |
| IS INJURY RELATED TO ☐ WORK ☐ AUTO ACCIDENT ☐ N/A IF YES: DATE / / WHERE | | | |
| ACCIDENT DETAILS | | | |

**Insurance Information: Please verify that everything listed below is correct**

| | | | |
|---|---|---|---|
| PRIMARY INSURANCE | PHONE # ( ) - | INSURANCE GROUP # | |
| CLAIM / ID # | NAME OF INSURED | RELATIONSHIP TO PATIENT | |
| INSURED DATE OF BIRTH / / | INSURED SS# - - | INSURED EMPLOYER | |
| ADJUSTOR (IF THROUGH WORKERS COMPENSATION: | | | |
| SECONDARY INSURANCE | PHONE # ( ) - | INSURANCE GROUP # | |
| CLAIM / ID # | NAME OF INSURED | RELATIONSHIP TO PATIENT | |
| INSURED DATE OF BIRTH / / | INSURED SS# - - | INSURED EMPLOYER | |

## MVA / AUTOMOBILE ACCIDENT

| | | |
|---|---|---|
| ☐ USE MY HEALTH INSURANCE ☐ YES ☐ NO (If yes, see health insurance above) | | |
| ☐ USE PIP (own car insurance) ☐ YES ☐ NO | USE AUTOMOBILE INSURANCE ☐ YES | ☐ NO |
| ☐ USE AUTOMOBILE INSURANCE: COMPANY NAME | | |
| POLICY # | NAME ON POLICY | |
| NAME OF ADJUSTOR | TELEPHONE ( ) - | |
| ☐ VIA ATTORNEY NAME | TELEPHONE ( ) - | (Need Letter of Protection from Attorney) |

## MEDICARE PATIENTS ONLY:

| | | |
|---|---|---|
| **Are you currently receiving home health care for any reason, (or have in the last 3 months)?** ☐ **Yes** ☐ **No** | | |
| **If yes, provide the name of agency** | **Dates of treatment:** | **Discharge date: / /** |

I hereby give consent to Spine & Rehab Specialists to provide physical therapy care and treatment that is reasoned to be necessary in evaluating and/or treating my physical condition.

| | |
|---|---|
| **Authorized Signature:** | **Date:** |

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# SPINE & REHAB SPECIALISTS
# FINANCIAL POLICIES

**FINANCIAL RESPONSIBILITY:** As a courtesy, Spine & Rehab Specialists will fill your medical insurance claims to your medical insurance. Spine & Rehab Specialists is not responsible for issues between the patient and insurance carrier, nor can Spine & Rehab Specialists intervene or negotiate for either party on disputed claims. It is the patient's responsibility to inform Spine & Rehab Specialists of any insurance changes. Payment for service and supplies is due in full at the time of service, unless arrangements have been made.

_____
Initials

**MISSED APPOINTMENTS:** In fairness to other patients and Spine & Rehab Specialists, a 24 hour notice to cancel appointments is required. **If 3 appointments are missed without any form of cancellation, patient will be automatically discharged from physical therapy and the physician will be notified of noncompliance.**

_____
Initials

**MEDICAL RECORDS:** If you need your medical records, please ask for our Medical Records Request Form, and understand we have 15 days to fulfill this request and there will be a $ 25.00 Medical Records Fee.

_____
Initials

**PATIENT INFORMATION CONSENT:** I have read and fully understand Spine & Rehab Specialists' Notice of Privacy Practices. I understand that Spine & Rehab Specialists may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provide and any administrative operations related to treatment or payment.
I hereby consent to the use and disclosure of my personal health information for purposes as noted in Spine & Rehab Specialists Notice of Privacy Practices.

_____
Initials

**CONSENT TO CONFIDENTIAL MEDICAL INFORMATION:**
I hereby authorize Spine & Rehab Specialists to share any and all of my medical/billing information with the following person/people:

Full Name: _____ Relationship: _____
Full Name: _____ Relationship: _____

**PATIENT AUTHORIZATION:**

- By my initials and signature I understand these policies and my financial obligations for services rendered.
- I hereby assign payment of benefits by my insurance company to Spine & Rehab Specialists, and I accept responsibility to ensure my insurance carrier makes payment on my account within 90 days. Lack of payment by my insurance carrier will result in all charges being transferred to my personal balance on my statement.
- I hereby agree to pay any office visits/co-payment charges at time of visit.
- I hereby agree to promptly pay my personal account balance, including unmet deductibles, co-insurance, or copays upon receipt of my statement. I understand and agree that responsibility for payment for services rendered is mine, due and payable unless other financial arrangements have been made. In the event of default, I agree to pay such collection costs and reasonable attorney fees as may be require to effectively collect the debt.

**Patient/Guardian Signature**: _____ **Date**: _____

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# MEDICAL HISTORY FORM

**To ensure you receive a complete and thorough evaluation, please provide us with important background information. If you do not understand a question leave it blank and your therapist will assist you.**

| **Name:** | **Date of Birth:** |
|---|---|
| **Height:** **Weight:** | |

| **Occupational/Leisure Activities:** |
|---|
| **Restrictions:** |

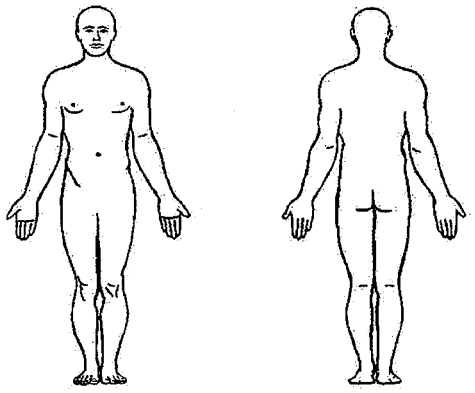
| **ARE YOU CURRENTLY UNDER THE CARE OF:** | **YES** | **NO** | **IF SEEN IN LAST 3 MONTHS, PLEASE EXPLAIN** |
|---|---|---|---|
| Medical Doctor/Osteopath | | | |
| Dentist | | | |
| Chiropractor | | | |
| Psychiatrist/Psychologist | | | |
| Physical Therapist | | | |
| Other (explain) | | | |

| **HAVE YOU HAD ANY RECENT DIAGNOSTIC TESTS?** | **YES** | **NO** | **DATE** | **RESULTS** |
|---|---|---|---|---|
| X-rays | | | | |
| MRI | | | | |
| CT Scan | | | | |
| EMG | | | | |
| Other (explain) | | | | |

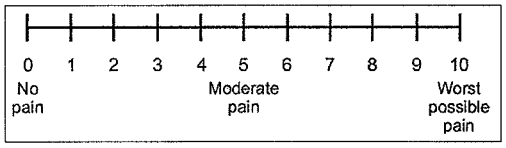
| **PLEASE ANSWER THE FOLLOWING:** | **YES** | **NO** | |
|---|---|---|---|
| **Have you had any therapy in the last 12 months?** | | | **Where?** |
| **Are you pregnant?** | | | **Due date:** |
| **Do you smoke?** | | | **How often?** |
| **In the past month, have you noticed a change in bowel & bladder activities?** | | | |
| **During the past month, have you often been bothered by feeling down, depressed, or hopeless?** | | | |
| **During the past month, have you often had little interest or pleasure in doing things?** | | | |
| **Do you want help with that?** | | | **Yes, but not now** |

| **Condition/Disease** | **Never** | **Now** | **Past** |
|---|---|---|---|
| Heart Disease | | | |
| Lung Disease | | | |
| Seizures / Epilepsy | | | |
| Pacemaker | | | |
| High / Low Blood Pressure | | | |
| Diabetes | | | |
| Stroke / T.I.A. | | | |
| Cancer | | | |
| Asthma | | | |
| Osteoporosis | | | |
| Back Injury | | | |
| Fracture | | | |
| Rheumatoid Arthritis | | | |
| Osteoarthritis | | | |
| Headaches | | | |
| Dizzy Spells | | | |
| Fainting Spells | | | |
| Unexplained Weight Loss | | | |
| Falls / Loss of Balance | | | |
| Latex Allergy | | | |
| Infections | | | |
| HIV/AIDS | | | |
| Blood Clots | | | |

**Please indicate on the body chart where you are having pain?**



**Please rate your current pain level:**




**List any medications you are taking:**

| **Please list any surgeries you have had and when:** |
|---|
| |
| **Please list any other conditions/diseases we should know about:** |
| |

**Signature of patient or legal guardian:** **Date:**