# New Patient Welcome Kit



## Thank you for choosing RehabAuthority.

### We look forward to helping you meet your rehabilitation needs.
### To help us serve you more efficiently, please fill-out, read, sign, and date in the designated areas.

| Patient's First Visit Date | Physical Therapist's Name | Patient's New Account Number |
|---|---|---|
| | | |

## Patient Information

| Patient Name *(Last, First Middle Initial)* | SSN *(Social Security Number)* | DOB *(Date Of Birth)* |
|---|---|---|
| | | |

| Sex ☐M*(Male)* ☐F*(Female)* | Marital Status ☐Married ☐Single ☐Divorced ☐Widow | Email | Home or Cell Phone |
|---|---|---|---|
| | | | |

| Street Address *(Mailing Address)* | City, State, Zip |
|---|---|
| | |

| When was your last physician visit? *(Date/Dates)* | Referring Physician's Name | Was this an auto accident? ☐Yes ☐No | Work related accident? ☐Yes ☐No | Date of the accident? |
|---|---|---|---|---|
| | | | | |

| Tell Us About Your Injury | Attorney's Name |
|---|---|
| | |

| Whom may we call in case of emergency? | Relation to you? | Phone |
|---|---|---|
| | | |

## Whom may we thank for referring you to our clinic?

☐ Attorney ☐ Billboard/Sign/Location ☐ Doctor ☐ Insurance Provider ☐ Newspaper ☐ Phone Book ☐ Radio

☐ Return Patient ☐ Television ☐ Website ☐ Family Or Friend ☐ Other: ____________________________

## Responsible Party

| Responsible Party Name or Business Name | Relationship to Patient | Phone |
|---|---|---|
| | | |

| Street Address *(Mailing Address)* | City, State, Zip |
|---|---|
| | |

| Insured Party's SSN *(Social Security Number)* | Insured Party's DOB *(Date Of Birth)* | Other Information |
|---|---|---|
| | | |

## Responsible Party Employer

| Employer's Name | Employer's Phone |
|---|---|
| | |

| Employer's Address | City, State, Zip |
|---|---|
| | |

## Patient Or Spouse Employer

| Employer's Name | Employer's Phone |
|---|---|
| | |

| Employer's Address | City, State, Zip |
|---|---|
| | |

## Consent For Care And Treatment

I, the undersigned, do hereby agree and give my consent for RehabAuthority to furnish medical care and treatment to ________________________________ *(Patient's Name)* as considered necessary and proper in diagnosing or treating his/her physical and condition.

| ____________________ | ____________________ | ____________ |
|---|---|---|
| Patient and/or Guardian Signature | Patient and/or Guardian Print Name | Today's Date |

## Benefit Assignment/Release Of Information

I, undersigned, do hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to RehabAuthority. A photocopy of the assignment is to be considered as valid as the original. I, the undersigned, do hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

| Patient and/or Guardian Signature | Patient and/or Guardian Print Name | Today's Date |
|---|---|---|

## Financial Policy Statement

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered unless prior arrangements have been made. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. Any unpaid balance after the first 30 calendar days of treatment accrues 1.5% interest each month thereafter. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes and internal usual and customary fee schedule, you will be responsible for the remaining difference.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to RehabAuthority.

The above does not apply for those patients that are treated under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

I understand and agree that my account if paid within 90 days of my discharge will be interest free, after 90 days my account will be subject to a 12% interest (APR). If I fail to make any payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

## Insurance Information

| Primary Insurance | | Mailing Address *(City, State, Zip)* | | | Phone |
|---|---|---|---|---|---|
| Group and/or Claim # | | Member Id # | | Adjuster/Case Manager | |
| Co-Pay or % | Deductible | Amount Met | Max Pt. $ /Visits | $/Visits Used | Effective Date |
| Secondary Insurance | | Mailing Address *(City, State, Zip)* | | | Phone |
| Group and/or Claim # | | Member Id # | | Adjuster/Case Manager | |
| Co-Pay or % | Deductible | Amount Met | Max Pt. $ /Visits | $/Visits Used | Effective Date |

## Patient's Responsibility

| Ded To Meet | Co-Pay/Coins | Arrangement |
|---|---|---|

***NOTE:*** *Estimated coverage information is provided as a courtesy to our patient, but is not intended to release them from total responsibility for their account balance.*

## The above information has been read and explained to me.
## I understand my full responsibility for the payment of my account.

| Patient and/or Guardian Signature | Patient and/or Guardian Print Name | Today's Date |
|---|---|---|

| Authorized RehabAuthority Representative's Signature | Authorized RehabAuthority Representative's Print Name | Today's Date |
|---|---|---|

# Medical Screening Intake Questionnaire

| Patient's Name | | Chief Complaints or Concern | |
|---|---|---|---|
| Date of Birth | | Date of Injury or Symptoms | |
| Reason for Therapy | | Date of Last Doctor Visit | |

| Please indicate if you have received any of the following for current injury. | | | | | | | |
|---|---|---|---|---|---|---|---|
| Orthopedic Surgeon | ☐Yes ☐No | Physiatrist (Pain Doctor) | ☐Yes ☐No | MRI | ☐Yes ☐No | Physical Therapy | ☐Yes ☐No |
| Neuro Surgeon | ☐Yes ☐No | Chiropractor | ☐Yes ☐No | CT-Scan | ☐Yes ☐No | Occupational Therapy | ☐Yes ☐No |
| Neurologist | ☐Yes ☐No | ER Care | ☐Yes ☐No | X-Ray | ☐Yes ☐No | Massage Therapy | ☐Yes ☐No |

Did you have surgery for this injury? If yes, please describe and provide the procedure date(s). If no, please write none.

| General/Constitutional | | Cardiovascular | | Musculoskeletal | |
|---|---|---|---|---|---|
| Fatigue | ☐Yes ☐No | High Blood Pressure | ☐Yes ☐No | Muscle Pain/Cramps | ☐Yes ☐No |
| Recent Weight Change | ☐Yes ☐No | Chest Pain | ☐Yes ☐No | Stiffness | ☐Yes ☐No |
| Night Sweats/Fevers | ☐Yes ☐No | Coronary Artery Disease | ☐Yes ☐No | Joint Pain or Swelling | ☐Yes ☐No |
| Other: | ☐Yes ☐No | Heart Surgery/Pacemaker | ☐Yes ☐No | Osteoporosis | ☐Yes ☐No |
| **Respiratory** | | **Neurological** | | **Gastrointestinal/Urinary** | |
| Shortness of Breath | ☐Yes ☐No | Frequent Headaches | ☐Yes ☐No | Nausea/Vomiting | ☐Yes ☐No |
| Excessive Cough/Sputum | ☐Yes ☐No | Seizures/Epilepsy | ☐Yes ☐No | Abdominal Pain | ☐Yes ☐No |
| Asthma | ☐Yes ☐No | Numbness/Tingling | ☐Yes ☐No | Rectal Bleeding | ☐Yes ☐No |
| Bronchitis | ☐Yes ☐No | Fainting/Dizziness | ☐Yes ☐No | Blood in Urine | ☐Yes ☐No |
| Emphysema | ☐Yes ☐No | Weakness | ☐Yes ☐No | Kidney Stones | ☐Yes ☐No |
| Other: | ☐Yes ☐No | Stroke/TIA | ☐Yes ☐No | Other: | ☐Yes ☐No |
| **Endocrine** | | **Hematological/Lymphatic** | | **Ophthalmological** | |
| Excessive Thirst/Urination | ☐Yes ☐No | Bruise Easily | ☐Yes ☐No | Glasses/Contacts | ☐Yes ☐No |
| Thyroid Disease | ☐Yes ☐No | Slow to Heal | ☐Yes ☐No | Blurred/Double Vision | ☐Yes ☐No |
| Hormone Problem(s) | ☐Yes ☐No | Enlarged Glands | ☐Yes ☐No | Eye Disease/Injury | ☐Yes ☐No |
| Diabetes | ☐Yes ☐No | Other: | ☐Yes ☐No | Glaucoma | ☐Yes ☐No |
| **Ear-Nose-Throat** | | **Other** | | **Other** | |
| Hearing Loss or Ringing | ☐Yes ☐No | Are you pregnant? | ☐Yes ☐No | HIV/AIDS | ☐Yes ☐No |
| Sinus Problems | ☐Yes ☐No | Breast Pain/Discharge | ☐Yes ☐No | Tuberculosis | ☐Yes ☐No |
| Difficulty Swallowing | ☐Yes ☐No | Menstrual Changes | ☐Yes ☐No | Cancer | ☐Yes ☐No |
| Voice Change | ☐Yes ☐No | Blood Clot | ☐Yes ☐No | Depression | ☐Yes ☐No |
| Face Pain | ☐Yes ☐No | Confusion/Memory Loss | ☐Yes ☐No | Unexplained Weight Loss | ☐Yes ☐No |
| Ear Ache | ☐Yes ☐No | Do you use tobacco? | ☐Yes ☐No | Other: | ☐Yes ☐No |
| **Allergies** | | | | | |
| Food or Drink | ☐Yes ☐No | Medical | ☐Yes ☐No | Environmental | ☐Yes ☐No |

## Please Check the Following Yes or No Boxes

During the past month have you been feeling down, depressed or hopeless? ☐Yes ☐No

During the past month have you been bothered by having little interest or pleasure in doing things? ☐Yes ☐No

Is this something with which you would like help? ☐Yes ☐No ☐Yes, But Not Today

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐Yes ☐No

## Please list any medications you are currently taking.

| 1. | 2. | 3. |
|---|---|---|
| 4. | 5. | 6. |

Have you ever taken a steroid medication? ☐Yes ☐No

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? ☐Yes ☐No

## Please list any surgeries or other conditions for which you have been hospitalized.

1.

2.

3.

## Using the 0-10 scale, with 0 being "no pain" and 10 being "the worst pain imaginable" please describe:

You current level of pain ______/10

The best your pain has been during the past 24 hours ______/10

The worst your pain has been during the past 24 hours ______/10

## Please Sign and Date

| Patient and/or Guardian Print name | Patient and/or Guardian Signature | Date |
|---|---|---|

## For Physical Therapist Use Only

| Height | Weight | Blood Pressure | Heart Rate | Temperature | Respiratory Rate |
|---|---|---|---|---|---|
| | | | | | |

Patient's Account Code ______

Therapist's Initials ______