21ST CENTURY REHAB, PC

INDIANOLA

PATIENT INFORMATION FORM

Please print and complete ALL items. If an item does not apply, insert N/A.

PATIENT LEGAL NAME: ____ **SEX:** _______
LAST FIRST INITIAL

ADDRESS: ____
STREET CITY STATE ZIP

TELEPHONE: (H) ____________________ **(W)** ____________________ **(C)**________________

EMAIL ADDRESS:____

SOCIAL SECURITY #: __________________ **DATE OF BIRTH:** _________ **MARITAL STATUS:** _

EMPLOYER: ____ **FULL TIME STUDENT:** (Y) _ (N) _

SPOUSE NAME:________________________________ **SS#:**_______________ **DOB:** ________

PRIMARY CARE PHYSICIAN: ________________________________ **TELEPHONE:** ___________

PERSON TO NOTIFY IN CASE OF EMERGENCY *OUTSIDE* OF HOUSEHOLD:

NAME:____ **TELEPHONE:** ___________

ADDRESS: ____
STREET CITY STATE ZIP

INJURY HISTORY

ONSET DATE OF CURRENT SYMPTOMS/INJURY/ILNESS: ______________________________

PLACE OF INJURY: Home____ School_____Work ___ Auto ___ Other ________________________

HAVE YOU HAD PREVIOUS TREATMENT IN CURRENT CALENDER YEAR? (Y) _______(N) ______

ARE YOU CURRENTLY or HAVE RECENTLY RECEIVED ANY HOME HEALTH CARE? (Y) ___(N) __
Is anybody coming into your home to provide **ANY** services, including therapy?
(If yes, complete the following information)
AGENCY: ____ **TELEPHONE:**___________

RESPONSIBILITY INFORMATION

WHO WILL BE PRIMARILY RESPONSIBLE FOR THE BILL?______________________________

IS THIS A WORKER'S COMPENSATION CLAIM? (Y) _____(N) _____ (If yes, complete W/C form.)

IS THIS AN ACCIDENT CLAIM? (Y) ___ (N) ____ (If yes, complete Auto/Liability & Liability Financial forms.)

IS THERE AN ATTORNEY INVOLVED IN YOUR CASE? (Y) ____(N) __ (If yes, complete Letter of Protection.)

HOW DID YOU HEAR ABOUT 21ST CENTURY REHAB? DR.____ NEWSPAPER____ MAILER ____

FRIEND____ OTHER, PLEASE SPECIFY____

INSURANCE INFORMATION/VERIFICATION FORM
COMMERCIAL AND MEDICARE

PRIMARY INSURANCE COMPANY: ____

ADDRESS: ____ **TELEPHONE:** ______________

POLICY HOLDER'S FULL NAME: _________________________________**DOB:** ______________

ID #: ____________________________________ **GROUP #** ____________________________

RELATIONSHIP TO POLICY HOLDER: Self ____ Spouse ____Child ____ Step Child ____ Other ____

POLICY HOLDER'S ADDRESS: ____

POLICY HOLDER'S EMPLOYER: ____

SECONDARY INSURANCE COMPANY: ____

ADDRESS: ____ **TELEPHONE:** ______________

POLICY HOLDER'S FULL NAME:_________________________________**DOB:** ______________

ID #: __________________________________ **GROUP #** ______________________________

RELATIONSHIP TO POLICY HOLDER: Self ____ Spouse ____ Child ____ Step Child ____ Other ____

POLICY HOLDER'S ADDRESS: ____

POLICY HOLDER'S EMPLOYER: ____

VERIFICATION: (For office use only.)

Date: ______________ Patient Name: ________________________________ DOB: ___________

Insurance Company (1) ___________________________ (2) ______________________________

Effective Date: (1) _________________ (2) ____________________ In Network? (1) _____ (2) _____

Deductible: (1) ______ (2) ______ Co-Payment: (1)______ (2) _____ Co-Insurance (1) ______ (2) _____

Pre-certification Needed? (Y) ___ (N) ___ Referral Required? (Y) ____ (N) ____ (If yes, complete below.)

Authorization/Referral #: _______________ Authorization/Referral Date: ___________ to ___________

Limit on # visits? ________ $Limit on treatment? _________ Other limitations? ___________________

Documentation required/needed? ____
Claims Address: ____
Can claims be faxed? (Y) ____ (N) ____ Fax #: ____________________________
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Therapist: ___________________ Referral Date: ___________ DX/ICD: ________________________

Referring Physician (Full name): _________________________________ UPIN/NPI # _____________

21ST CENTURY REHAB, PC

CONSENT TO MEDICAL CARE

I consent to the therapy rendered to me (or the person for whom I am legally responsible) that is determined to be necessary by the therapist and/or physician.

FINANCIAL AGREEMENT

I agree to pay for the services rendered to me (or the person for whom I am legally responsible) either directly or through my insurance or third party payer(s). If through a third party, I hereby assign all the benefits payable for this care, to the provider. I also agree to pay directly for any services not covered by my third-party payer(s). For liability cases, where another party is responsible, I need to provide you with all the billing information. If I have an attorney I will provide this information during registration. It is the policy of 21st Century Rehab, PC that a letter of protection must be received from my attorney within the first two (2) weeks of my treatment. Without this letter, I will become responsible for the account in full.

Some durable medical equipment such as foot orthotics, braces and supplies, such as electrodes and various pieces of exercise equipment for the patient to use at home are generally not covered. If these items are needed, they will become my responsibility. I have read the insurance verification and I understand these benefits are not guaranteed. They are an estimate from my insurance company. My co-payments are due at the time of service and my percentage of financial responsibility is due at the end of each week in the week I am treated. If I owe more than the insurance company originally quoted, I will be responsible for that amount. If I over-pay the bill, I will be reimbursed the amount that I overpaid immediately.

RELEASE OF MEDICAL INFORMATION

I hereby authorize the provider to release to my insurance company(s) or third-party payer(s) all medical information needed to substantiate payment for the care to me (or the person for whom I am legally responsible) and permit representative to examine and make copies of record relating to such care and treatment.

ACKNOWLEDGMENT OF RECEIPT OF PROVIDER'S NOTICE OF PRIVACY PRACTICES

I,____, acknowledge that I have received a copy of 21st Century Rehab, PC's Notice of Privacy Practices which summarizes the ways my identifiable health information may be used and disclosed by the provider and states my rights with respect to my medical information. I understand the provider has the right to revise these information practices and to amend the Notice of Privacy Practices. I have been informed that in the event the provider revises the information, a revised Notice of Privacy Practices will be posted at the 21st Century Rehab, PC Clinic and that I may obtain a current Notice of Privacy Practices at any time from Jason Horras at 515-382-3366.

CONSENT TO COMMUNICATE VIA EMAIL

I understand that authorized personnel from 21st Century Rehab, PC may communicate with me regarding scheduling, the treatment being provided, educational information, including newsletters, as it relates to health-related products or services available at 21st Century Rehab, PC, or alternative treatments, locations, or providers. I agree to receive such communication via email at the following email address:

Email: ____

SIGNATURE:____DATE: __________

Signature for Minor (under 18 years of age):______________________________________

Welcome!

Thank you for choosing Indianola Physical Therapy for your physical therapy needs. If at anytime you have questions regarding your exercise program or insurance, please don't hesitate to ask me. If I can't answer your question, I will find an answer for you.

Because you are our #1 concern, we have developed a Discharge Survey that will be given to you at the end of your last visit. This lets us know where we need to improve our services. We want our physical therapy sessions to occur in a pleasant atmosphere and, most important, be beneficial to you, the patient.

We also keep a notebook labeled, Patient Perspectives, available for our patients to view. If during therapy, you would like to share your physical therapy experience and how it has helped you, please feel free to write down your story and we will add it to our book.

Success in therapy is largely dependent on your regular attendance. You will be scheduled for your full course of treatment. For example, if your doctor and/or therapist have determined that you should be seen 3 times per week for 3 weeks, you will be scheduled for 9 visits. If for whatever reason you are unable to keep one of your appointments, you are expected to make it up on another day. Missing one of your scheduled appointments makes it much more difficult to achieve the goals you have set for yourself and may actually lengthen the time you need therapy. We understand special circumstances may and will occur, but make every attempt to keep and make up your scheduled appointments.

Thank you for letting me welcome you to our clinic, and be assured that our top priority is helping you!

Patient Representative

21st Century Rehab Medical History

Name: ___________________________________ Date of Birth: ____/____/____ Age: ________

Ht:_____ Wt:_______ BP:_________ HR:________

Do you or have you ever been told that you have any of the following:

	(circle one)		Explanation
Balance Problems/difficulty walking	yes	no	______________________________
Any forms of Cancer	yes	no	______________________________
Diabetes	yes	no	______________________________
High Blood Pressure	yes	no	______________________________
Heart Disease/Heart Attack	yes	no	______________________________
Pacemaker	yes	no	______________________________
Angina/Chest Pain	yes	no	______________________________
Shortness of Breath	yes	no	______________________________
Allergies	yes	no	______________________________
Asthma	yes	no	______________________________
Polio	yes	no	______________________________
Headaches/Neck Pain	yes	no	______________________________
Jaw Pain or Popping	yes	no	______________________________
Back or Hip Pain	yes	no	______________________________
Shoulder, Arm or Hand Pain	yes	no	______________________________
Knee, Foot or Ankle Pain	yes	no	______________________________
Any Metal implants	yes	no	______________________________
Pregnant or possibly pregnant	yes	no	______________________________
Do you use tobacco	yes	no	______________________________
Any unexplained weight loss/gain	yes	no	______________________________
Incontinence/Bladder Control Problems	yes	no	______________________________

List any surgeries in the last 5-10 years:

____

____

Please list any current medications you are taking:

____

____

____

Do you have any other health concerns that you would like your therapist to be aware of?

____

____

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After your evaluation please initial that you understand your diagnosis, your prognosis, and your treatment plan.

Initials_______________ Date_______________