REGIONAL REHAB
Physical Therapy Consultants, Inc

INITIAL EVALUATION CHECKLIST

Please fill out the following forms as completely as possible and sign where indicated. We will need to make copies of your insurance ID cards and Drivers License or other form of photo ID. Thank you.

1. Insurance Auth and HIPPA Consent
2. Patient Information & Consent to Treat
3. Medical History
4. Pain Chart
5. Cancellation Policy

Note to therapist: Please be aware that in the case of Workman's Comp and Auto Accident Claims an additional "Notification of Initial Treatment" form must be completed on the first visit.

Regional Rehab
Physical Therapy
Laser Center
465 Mariner Blvd, Spring Hill, FL 34609
Tel: 352-688-8066 Fax: 352-688-8540

Patient Authorization to Release Information & Assignment of Benefits

I hereby authorize Regional Rehab to release any PROTECTED HEALTH INFORMATION in the course of my examination or treatment to any insurer or government agency providing benefits to me. I further authorize payment directly to Regional Rehab of all benefits payable under the terms of my insurance policy and agree to pay any co-pay or coinsurance determined my responsibility by my insurance policy.

All pre-determined CO-PAYMENTS must be paid upon signing in for your appointment.

Signature of Patient /Legal Guardian:X_____ Date: _____

Consent to the Use and Disclosure of Protected Health Information for HIPPA Compliant Healthcare Operations

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my therapist, another healthcare provider, a health plan, my employer or a health care clearinghouse. This protected health information related to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me. I understand I have a right to review Regional Rehab's Notice of Privacy Practices prior to signing this document and it is available upon request.

I consent to the use or disclosure of my protected health information by Regional Rehab for the purpose of evaluation or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Regional Rehab. I understand that diagnosis or treatment of me by the professional staff is conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. I have a right to revoke this consent, in writing, at any time, except to the extent that the staff of Regional Rehab may have taken action in reliance on this document.

Signature of Patient /Legal Guardian X_____ Date: _____

In conjunction with these privacy practices you will need to complete the following information:

1. Name of person(s) we may speak to regarding your health (i.e. spouse, child, etc. including phone number.)
   Name:_____Relation:_____Tel:_____
   Name:_____Relation:_____Tel:_____
2. May we leave a message regarding an upcoming appointment on your answering machine?
   Please check one: _____YES _____NO

Signature of Patient /Legal Guardian X_____ Date: _____

Witness: _____Date_____

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PATIENT INFORMATION & CONSENT

☐New Patient ☐Reactivation ☐ Name Change ☐ Address Change ☐ Insurance Change

Date:_____

How did you hear about us?_____

Name: _____Date of Birth: _____SS#_____
First M.I. Last Marital Status:_____

ADDRESS:

Mailing Address: _____
Street City State Zip

Secondary Address: _____
Street City State Zip

Home Phone: (____)_____Work Phone: (___)_____Cell: (___)_____

Email:_____ Occupation:_____

Next of Kin: _____ **Relationship**: _____**Tel:** _____

PARENT OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____Home Phone: (___)_____Cell: (___)_____

Address: _____
Street City State Zip

INSURANCE COVERAGE – PRIMARY **Type:** ☐**HMO** ☐**PPO** ☐**PRIVATE**

Insurance Company Name: _____Tel:_____

Policy or ID # _____Group Name or # _____

Name of Policy Holder (if different from patient)_____Relationship_____

INSURANCE COVERAGE – SECONDARY

Insurance Company Name: _____Tel:_____

Policy or ID # _____Group Name or # _____

PLEASE PRESENT ORIGINAL CARDS ~ WE NEED A COPY OF FRONT AND BACK

Are you here because of an Auto Accident or Personal Injury Case? ☐YES ☐NO

Do you have an active Workman's Comp Claim? ☐YES ☐NO

Do you have an Attorney representing you in this case? ☐YES ☐NO

If you answered **YES** to any of the above **we need the following additional information.**

Date of injury: _____ Case or Claim # _____

Name of Attorney: _____ Telephone: (___)_____

CONSENT TO TREAT

I hereby indicate my consent to receive physical therapy treatment at Regional Rehab. I understand that the purpose of these treatments is to reduce pain and/or inflammation, enhance my recovery from an injury or illness and to increase my functional activities. My participation is voluntary and I may withdraw at any time.

Signature of Patient/ Legal Guardian _____Date: _____

MEDICAL HISTORY
REGIONAL REHAB Physical Therapy / Laser Center

NAME:_____

DOB:_____**Age:**_____ **Wt:**_____ **Ht:**_____
Sex: M F (circle one)
Primary MD Name:_____
Tel:_____
Referring Person or MD:
Name:_____
Tel:_____
Diagnosis (if you know or have been told):
_____

Medical History: (please circle all that apply)

Heart problems	Diabetes
Pacemaker	Hypertension
Liver problems	Kidney disease
Circulatory	Cancer
Smoker	Tumor
Urinary problems	Loss of Spouse
Respiratory Problem	Stroke or seizures
Are you pregnant?	Depression

Allergies: _____
Other _____

List of Current Medications: (provide list we can copy)
_____
_____
_____
_____

Where is your problem? (please circle)
Shoulder Neck Knee Foot Elbow
Back Hip Ankle Other:_____

Which side(s): Right / Left / Both

Dominant Arm: Right / Left

Problem(s) (please check all that apply):

___Pain	___Balance Issues
___Weakness	___Falls
___Instability	___Stiffness
___Swelling	Other: _____

How did you injure yourself?
(_)No injury – just started hurting
(_)Sports (which sport)_____
(_)Motor vehicle accident
(_)Work / job
(_)Fall (_) Other_____
How long have you had symptoms?
Days____ Mos.____ Yrs._____
Date of onset/ injury/ surgery:_____
Please briefly describe the injury or condition:
_____
_____
_____

Previous treatments (other than surgery):
(Medications, physical therapy, injections, bracing, etc)
Other: _____

Have you had a steroid injection within the last 7days?___

How severe is the pain?
(0 = none, 10 = severe pain)

At rest?	0 1 2 3 4 5 6 7 8 9 10
At its worst?	0 1 2 3 4 5 6 7 8 9 10

Do you have pain at night? Yes / No
Does it wake you from sleep? Yes / No
Are you currently working? Yes / No

What makes your problem better?
_____

What makes your problem worse?
_____

Please describe your current limitations?
_____
_____

Have you had any imaging studies?

X-rays	No / Yes	date:_____
MRI	No / Yes	date:_____
CAT scans	No / Yes	date:_____

Interested in any of the following treatments? (circle)
Aquatic Therapy, Peripheral Neuropathy,
Wound Care, Swelling, Lymphedema or Weight Loss

IN THE PAST 90 DAYS HAVE YOU HAD ANY OF THE FOLLOWING? (Please check all that apply)

(_) Nursing Care at HOME?
(_) Physical Therapy at HOME?
(_) Occupational Therapy at HOME?
(_) Speech Therapy at HOME?
(_) Catheter Care, Trach Care or Wound Care at HOME?

<u>If you checked any of the above:</u>
NAME OF AGENCY providing care:_____

DISCHARGE DATE:_____

_____
Signature **Date**

Rev 4/12/10

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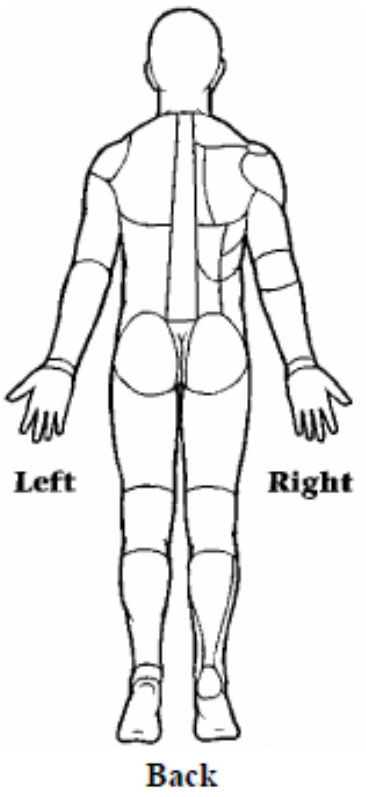
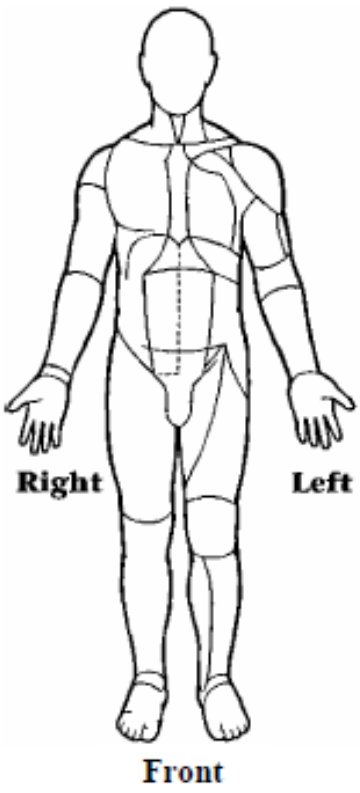
Pain Chart

DATE:_____

Patient's Name:_____

Circle the location of pain on the body outline and mark the degree of pain on the line below.

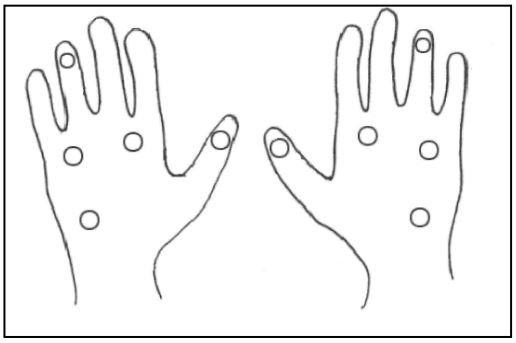


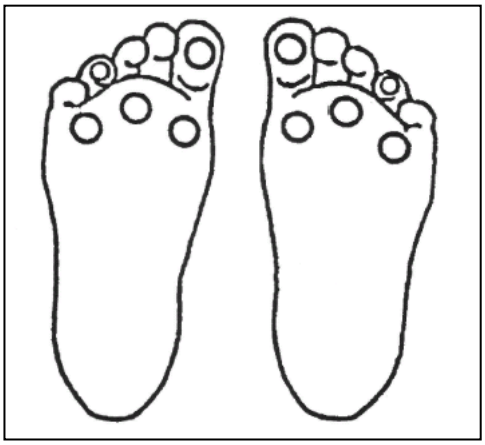


0 1 2 3 4 5 6 7 8 9 10

No pain Worst Pain Possible

FOR OFFICE USE ONLY





Right Left

Please rate you ability to perform the following activities:

0-Not Applicable 1-Not Limited 2-Can do with some difficulty 3-Can do with significant difficulty 4-Can't do at all

Sleeping___ Dressing___ Sitting___ Standing___ Walking___ Housework___
Driving___ Stairs___ Sports Activities___ Yard work___ **Manage Weight_____**

WHAT GOALS DO YOU WANT TO ACHIEVE WITH THERAPY?

_____

_____

_____

TO OUR PATIENTS REGARDING CANCELLATIONS AND NO SHOWS

Usually, your referring doctor and/or your therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that all you need to do is follow your therapist's instructions and we will be able to help you to achieve your goals in treatment.

We request **24 hours notice** in the event of a cancellation or in the case of an unexpected emergency, no later than 9:00AM on the morning of an appointment. It is your responsibility when you call in to have an alternative time in mind that will ensure you achieve the fully prescribed number of treatments that week whenever possible.

There is a $25.00 charge for a No Show or Cancellation without adequate prior notice. This charge will not be covered by insurance, but will have to be paid by you personally.

When you don't show, three people are hurt:

- You, the patient, because you don't get the treatment you need as prescribed by your doctor and/or therapist.
- The therapist, who now has a space in his/her schedule since the time was reserved for you personally, and
- Another patient, who could have been scheduled for treatment if there had been proper notice.

You may need to see a therapist other than the one who normally treats you if you do rearrange your appointment. All of our therapists are experienced professionals, and they will study your chart, so you will be in good hands. You will be returned to your original therapist in the next regularly scheduled visit.

PLEASE BE ON TIME If you are more than 15 minutes late for your appointment, we will try our best to work you in, however, your treatment time may be reduced or your appointment **cancelled** because other scheduled patients must still be seen for therapy that day. *If your appointment is cancelled because of tardiness you will be billed $25.00 in accordance with this policy.*

Please understand that your pain may increase and decrease as your course of treatment progresses and before it is finally minimized or eliminated. If you are in pain, come in and let us address it; once your pain is reduced, then we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself.

I have read and understand this policy. I agree to follow the recommendations listed.

_____ _____

Patient Signature Date

_____

Clinic Representative

(revised 10/27/10)