Patient Medical History

Patient Name:______________________________
Referring Physician:__________________________
Patient Occupation_____________________________
Emergency Contact Name:______________________________ **Phone: (**______**)** ________**-**_________

Date of first MD visit for this problem or injury_________________ Follow-up MD visit for this problem___________
Is this a work injury? Yes No Is an Attorney involved: Yes No
Date of Injury or onset of symptoms _________________________
How did your symptoms begin (gradually, suddenly, injury specifics)?____

____

Have you had surgery for this problem/Injury: Yes No Type of Surgery______________________________
Date of Surgery______________________________

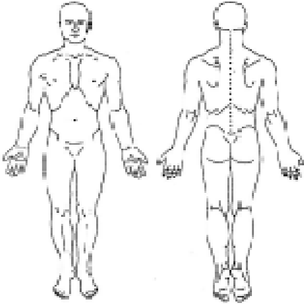
List your current medications. Include prescriptions, over-the-counter, herbs, and vitamins.

Medication	Dosage	frequency & route	Medication	Dosage	frequency & route
______________	_______	_______________	______________	_______	_______________
______________	_______	_______________	______________	_______	_______________
______________	_______	_______________	______________	_______	_______________
______________	_______	_______________	______________	_______	_______________

Are you allergic to any medications or latex? If yes please specify____
Please list symptoms you are currently having (pain, swelling, weakness, etc)___________________________________

____

Body Chart: Please mark the areas on the chart where you feel pain.



Please Circle your pain level:
0 being no pain & 10 Extreme pain
0 1 2 3 4 5 6 7 8 9 10

What is your main complaint?____

Check all the activities that you have trouble performing as a result of your present condition.

___Bathing ___Child Care ___Dressing ___Eating
___Homemaking ___Yard work ___Sitting ___Sleeping
___Standing ___Walking ___Working

How Long can you tolerate the following?

	Less than 30 min	1-2 hours	3-4 hours	No problems
Walking	____	____	____	____
Sitting	____	____	____	____
Standing	____	____	____	____

What treatment have you previously received for this injury/episode?
__ Physical Therapy __ Occupational Therapy __ Chiropractic Care
__ Surgery __ Medications: ____________________________
__ Other ____

Please circle if you have had any of these test done for this injury/episode: Bone Scan X-Ray MRI
CAT Scan EMG- NCV Myelogram Other______________________________

Do you have or have you had any of the following?

__ Allergies
__ Anemia
__ Anxiety
__ Arthritis
__ Asthma
__ Autoimmune Disorder
__ Cancer
__ Cardiac Conditions
__ Cardiac Pacemaker
__ Chemical Dependency
__ Circulation Problems
__ Currently Pregnant
__ Depression
__ Diabetes
__ Dizzy Spells
__ Emphysema/Bronchitis
__ Fibromyalgia
__ Fractures
__ Gallbalder Problems
__ Headaches
__ Hearing Impairment
__ Hepatitis
__ High Cholesterol
__ High/Low Blood Presure
__ HIV/AIDS
__ Incontinence
__ Kidney Problems
__ Metal Implants
__ MRSA
__ Multiple Sclerosis
__ Muscular Disease
__ Osteoporosis
__ Parkinsons
__ Rheamatoid Arthritis
__ Seizures
__ Smoking
__ Speech Problems
__ Strokes
__ Thyroid Disease
__ Tuberculosis
__ Vision Problems

What are your expectations/goals during your Physical Therapy program?________________________________

____

Patient/Guardian Signature ______________________________ Date ______________

Premier REHAB PHYSICAL THERAPY

PATIENT NAME_____________________________ **Patient Date of Birth**____________

Home Address____

City_________________________ State ___________ Zip Code _____________

Phone Number (______) _______-__________

Consent for Care and Treatment

I give my consent for treatment by the staff at PREMIER REHAB for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at PREMIER REHAB.

Signature ____Date________________

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to **PREMIER REHAB** for medical benefits to which I am entitled, including Medicare, private insurance, and third party payers for services performed during the course of my treatment at Premier Rehab.

I authorize Premier Rehab to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Rehab staff.

PREMIER REHAB will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other healthcare operations. *Healthcare operations generally include those activities we perform to improve quality of care.*

Signature ____Date________________

Appointment/Cancellation Policy

Premier Rehab requires that all appointments be cancelled and/or rescheduled within 24 hours of your scheduled appointment time. If you cancel with less than 24 hours notice or fail to keep an appointment, you will be charged a $25 no-show/late cancellation fee which is due prior to your next scheduled appointment.

RELEASE OF INFORMATION

I hereby authorize Premier Rehab to release and disclose all Medical History to:

Name: _____________________________________ Relationship to patient:_______________________

Name: _____________________________________ Relationship to patient:_______________________

I authorize Premier Rehab staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (_____) ________-________and (_____) ________-________

TEXT MESSAGING CONSENT: I consent to receiving text messages from Premier Rehab to wireless number (______) _______-_________. *Text messages to the wireless number provided will include appointment reminders.*

EMAIL CONSENT: I consent to receiving email messages from Premier Rehab to the following email address _________________________@______________.______ *Email messages will include appointment reminders.*

I also understand that I have the right to terminate this authorization at any time in writing or verbally.

___________________________ ___________________________ ____________

Patient Name (Printed) Signature Date

How did you hear about Premier Rehab?____

Premier REHAB PHYSICAL THERAPY

<u>Notification of Patient Responsibility for co-payments/Co-percentages and Deductibles</u>

- We bill insurance carriers solely as a courtesy to the patient.
- Payment is due at each visit as determined by your benefits.
- The amount collected at each visit is only an estimate.
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company.

Please list your health insurance plan(s):

Primary Insurance Name: ______________________ **ID Number:** ____________________________

Insured Name: _____________________________ **Insured DOB:** _________________________

Secondary Insurance Name: ____________________ **ID Number:** ____________________________

Insured Name: _____________________________ **Insured DOB:** _________________________

It is the patients' responsibility to inform our staff if there is a change in insurance coverage and or contact information to include address and contact phone numbers.

<u>If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of $40.00 per check plus the original amount of each check</u>.

<u>Please read:</u>

- If you have a secondary or tertiary insurance we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- You the patient are responsible for payment of services rendered if your insurance denies payment due to exceeding your allowed visits and or dollar amount limit.
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage
- If any payment is made directly to the patient for services billed by PREMIER REHAB, the patient recognizes an obligation to promptly submit the same payment to PREMIER REHAB.

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

<u>By signing below you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.</u>

___________________________________ ___________________________________ ________________

Patient Name (Printed) Signature of Patient or Legal Guardian Date

PREMIER REHAB representative/witness_____________________________ Date__________________

Premier REHAB PHYSICAL THERAPY

PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

THE PATIENT HAS THE RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility, provisions for after hours and emergency care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative of other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.
- Have and advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. Surgery centers and diagnostic imaging centers may be exceptions to this statement and will have a facility-specific policy.
- Be fully informed before any transfer to another facility or organization.
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

THE PATIENT IS RESPONSIBLE FOR:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

Signature ____ Date ________________

Patient Name ______________________ Date ____________

THE UPPER EXTREMITY FUNCTIONAL INDEX (UEFI)

We are interested in knowing whether you are having any difficulty at all with the activities listed below because of your upper limb problem for which you are currently seeking attention. Please provide an answer for **each** activity.

Today, *do you* or *would you* have any difficulty at all with:

(Circle one number on each line)

	Activities	**Extreme Difficulty or Unable to Perform Activity**	**Quite a Bit of Difficulty**	**Moderate Difficulty**	**A Little Bit of Difficulty**	**No Difficulty**
1	Any of your usual work, housework, or school activities	0	1	2	3	4
2	Your usual hobbies, recreational or sporting activities	0	1	2	3	4
3	Lifting a bag of groceries to waist level	0	1	2	3	4
4	Lifting a bag of groceries above your head	0	1	2	3	4
5	Grooming your hair	0	1	2	3	4
6	Pushing up on your hands (e.g., from bathtub or chair)	0	1	2	3	4
7	Preparing food (e.g., peeling, cutting)	0	1	2	3	4
8	Driving	0	1	2	3	4
9	Vacuuming, sweeping or raking	0	1	2	3	4
10	Dressing	0	1	2	3	4
11	Doing up buttons	0	1	2	3	4
12	Using tools or appliances	0	1	2	3	4
13	Opening doors	0	1	2	3	4
14	Cleaning	0	1	2	3	4
15	Tying or lacing shoes	0	1	2	3	4
16	Sleeping	0	1	2	3	4
17	Laundering clothes (e.g., washing, ironing, folding)	0	1	2	3	4
18	Opening a jar	0	1	2	3	4
19	Throwing a ball	0	1	2	3	4
20	Carrying a small suitcase with your affected limb	0	1	2	3	4
	Column Totals:					

Minimum Level of Detectable Change (90% Confidence): 9 points **SCORE: _____/80**

Source: Stratford et al (2001): Development and initial validation of the upper extremity functional index. Physiotherapy Canada. 53(4):259-267.
Minimum detectable change (90% confidence): 6 points.