ADVANCE REHABILITATION
MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____
REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____
PRIMARY CARE PHYSICIAN'S NAME: _____ **ARE YOU PRESENTLY WORKING? Y ES NO**
CAUSE OF INJURY OR ONSET: _____ **DATE OF NEXT MD APPT:** _____

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? ○ **YES** ○ **NO IF YES, WHERE:** _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) ○ **YES** ○ **NO IF YES, HOW MANY TIMES:** _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?
1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?
1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____ **WEAR GLASSES / CONTACTS?: YES NO**

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____
_____

ALLERGIES: Medication _____**Reaction**_____ **Other** _____**Reaction**_____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
□ PACEMAKER
□ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ RESPIRATORY PROBLEMS
□ ASTHMA □ controlled □ uncontrolled
□ COPD □ controlled □ uncontrolled
□ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS
□ BLOOD THINNERS (Anticoagulants)
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS

If checked any above, explain: _____

☐ **ANY OTHER MEDICAL PROBLEMS:** _____

SIGNATURE OF PATIENT: _____ **REVIEWED BY Therapist:** _____**Date**_____

Revised 4.16.15 KB

Advance Rehabilitation and Consulting, Inc
Conditions of Admission

Authorization for Treatment

I, the undersigned, hereby authorize and consent to rehabilitation services provided by Advance Rehabilitation and Consulting, including

any procedures which may be performed during this visit for: _____

Patient Name

Assignment of Insurance Benefits and Release of Information

I hereby assign and authorize direct payment to Advance Rehabilitation and Consulting, Inc. of all insurance benefits payable to me under the terms of any insurance policy for the services rendered, but not to exceed the regular charge for services received. I authorize any holder of medical information about me or any information needed to determine benefits payable for related services to be released to my insurance carrier, third party payor, and managed care organization or to any other insurance carrier, including worker's compensation claims. I authorize a copy of the authorization to be used in place of the original.

Medicare Patient Certification

I certify that the information given by me in applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of the authorization to be used in place of the original and request payment of authorized benefits to be made on my behalf.

Medicaid Authorization and Assignment

I request that payment of authorized Medicaid, Medigap or other Medical Assistance programs be made on my behalf to the above provider for services furnished to me by the provider/supplier. I authorize any holder of medical information about me or any information needed to determine benefits payable to be released to my insurance carrier. My signature certifies that I have received a service beginning with the date below. I understand that payment for this service will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of material may be prosecuted under applicable Federal and State Law.

Personal Valuables/Dependents/Visitors

It is understood and agreed that Advance Rehabilitation and Consulting, Inc. is not responsible for loss or damage to any personal valuables or properties. In order to maximize safety, small children will not be allowed in the treatment area of the clinic. If older children are present, please keep them off the exercise equipment in order to prevent injuries. There may be exceptions, please ask if you have any concerns or questions. We will do everything possible to accommodate your schedule if you are a caretaker of small children.

Financial Agreement, Guarantee of Account

I, the undersigned agree whether I sign as parent, guardian, spouse, agent, guarantor or as patient, that in consideration of the services to be rendered to the patient , I hereby individually obligate myself to pay the account of Advance Rehabilitation and Consulting in accordance with the regular rates and terms of the Facility. I understand that therapy services are rendered and charged to the patient and not to the insurance company, and the facility cannot accept total responsibility for collection of claims nor for negotiating a disputed settlement. I agree to be responsible for all deductibles, coinsurance and non-covered portions of services performed. I understand that Advance Rehabilitation and Consulting, Inc. is not a party to any lawsuit I may have due to litigation. I further understand that although information will be provided to my attorney, I am fully responsible to the provider for payment in full under the regular terms of the practice. Should the account be referred to an agency or attorney for collection, I shall pay actual attorney's fees and collection expense.

Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose medical information about you. As indicated in our notice, the terms of our notice may change. If we change our notice, you may request a revised copy. By signing below, you are stating that you have reviewed the Notice of Privacy Practices. Our Notice of Privacy Practices is posted in the waiting area, but you may request a written copy of the Notice at any time. You may also ask any questions about the Notice at any time.

THIS FORM HAS BEEN FULLY EXPLAINED TO ME AND I CERTIFY THAT I UNDERSTAND ITS CONTENTS AND ACCEPT ITS TERMS

Signature of Patient or Responsible Party	Relationship to Patient	Date

Witness	Date

Advance Rehabilitation and Consulting, Inc

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:	
Social Security Number:	Date of Birth:

I hereby authorize Advance Rehabilitation and Consulting, Inc. to use and/or obtain my health information without my consent for the purposes of treatment, payment or other healthcare operations.

I also hereby authorize Advance Rehabilitation and Consulting, Inc. to use and/or disclose any of my health information related to my current diagnosis, illness and/or injury to individuals and/or groups of individuals listed below (such as family, members of my household, close personal friends or anyone else) by my request so that all my rehabilitation needs can be met. The health information that I authorize to be used and/or disclosed is that information acquired during my care with Advance Rehabilitation and Consulting, Inc. and any health information that pertains to my care including past medical history and previous dates of service and those services received up to my discharge from Advance Rehabilitation and Consulting, Inc.

Names of Individuals and/or Groups of Individuals I authorize Advance Rehabilitation and Consulting, Inc. to disclose my health information to:

_____
_____
_____
_____
_____

By providing this Authorization, I understand as follows:

1. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and my treatment and/or payment obligations will not be affected.

2. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by the federal Privacy Rules.

3. I understand that I may revoke this Authorization at any time by notifying Advance Rehabilitation and Consulting, Inc. in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation.

4. I understand that I will receive a copy of this Authorization form after I sign it.

5. I understand that the Notice of Privacy Practices is posted in the clinic for my review. I also understand that a copy of the Notice is available to me, at my request.

6. I understand that this Authorization will expire on _____/____/_____(DD/MM/YR) or upon the following event (*if for research put "None" or "End of the research study"*): _____.

_____ _____
Signature of Patient or Patient's Representative Date

_____
Printed Name of Patient's Representative (*if applicable*)

_____
Representative's Relationship to Patient (*if applicable*)

ADVANCE REHABILITATION PATIENT INFORMATION

TODAY'S DATE	ARE YOU CURRENTLY RECEIVING HOME HEALTH?	YES	NO
_____/_____/_____	HAVE YOU RECEIVED HOME HEALTH WITHIN THE PAST 30DAYS?	YES	NO

PATIENT INFORMATION

NAME (LAST) **(FIRST)** **(MI)**

ADDRESS **CITY** **STATE** **ZIP**

TELEPHONE	DATE OF BIRTH	SS #	SEX	MARITAL STATUS
(_____)_____-_____	_____/_____/_____	_____-_____-_____	M F	Single Married Widowed

EMAIL ADDRESS (OPTIONAL)	CELL PHONE
THIS INFORMATION IS FOR ARCI ONLY – WILL NOT BE SHARED WITH OUTSIDE SOURCES	

PATIENT EMPLOYER	OCCUPATION	EMPLOYER TELEPHONE
		(_____)_____-_____

ADDRESS **CITY** **STATE** **ZIP**

SPOUSE INFORMATION

SPOUSE NAME (LAST) (FIRST) (MI)

SPOUSE EMPLOYER	OCCUPATION	SPOUSE DOB
		_____/_____/_____

CONTACT INFORMATION

EMERGENCY CONTACT (OTHER THAN HOME PHONE)	TELEPHONE	RELATIONSHIP
	(_____)_____-_____	

CONTACT PERSON (HIPAA)	TELEPHONE	RELATIONSHIP
	(_____)_____-_____	

ACCIDENT INFORMATION

DATE OF ACCIDENT/INJURY	AUTO OR WORK RELATED	SPORTS RELATED
_____/_____/_____	YES NO STATE WHERE ACCIDENT OCCURRED	YES NO SCHOOL _____

INSURANCE INFORMATION

1 PRIMARY INSURANCECARRIER

PATIENT RELATIONSHIP TO POLICY HOLDER SELF SPOUSE DEPENDENT OTHER

2. SECONDARY INSURANCE CARRIER

PATIENT RELATIONSHIP TO POLICY HOLDER SELF SPOUSE DEPENDENT OTHER _____

3. TERTERIARY INSURANCE CARRIER ☐ SELF ☐ SPOUSE ☐ DEPENDENT OTHER _____

GUARANTOR/ RESPONSIBLE PARTY (Required if patient is 18 years or under)

NAME RELATIONSHIP

ADDRESS CITY STATE ZIP

TELEPHONE HOME (_____)_____-_____OTHER (_____)_____-_____

EMAIL_____