PHOENIX
REHABILITATION AND HEALTH SERVICES, INC.

Patient Registration Form

PATIENT INFORMATION

Patient Name: | **Account Number:**

Date of Birth: | **Age:** | **SS#:** | **Gender:**

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Home Phone: **Cell:** **Work:**

Email:

Address:

EMPLOYER INFORMATION:

Employer:

Employment Status: ☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Address:

Phone: | **Occupation:**

INSURANCE INFORMATION

Primary Insurance:	**Secondary Insurance:**
Policy #:	**Policy #:**
Group #:	**Group #:**
Subscriber's Name:	**Subscriber's Name:**
Subscribers DOB:	**Subscribers DOB:**
Relation to Patient:	**Relation to Patient:**

INJURY INFORMATION

My Injury is Related To: ___ Work ___ Auto ___ Sports ___ None **DOI:**

Injury Area: **Referring Doctor:**

WHY DID YOU CHOOSE PHOENIX REHABILITATION (Choose one)

☐ Accommodating Hours	☐ Attorney	☐ Billboard	☐ Convenient Location
☐ Email	☐ Employer	☐ Family	☐ Former Patient
☐ Friend	☐ Insurance Carrier	☐ Internet Search	☐ Medical Office Staff
☐ Medical Provider	☐ Online Reviews/Ratings	☐ Other	☐ PHOENIX Website
☐ Print Ad	☐ Self Referral/Direct Access	☐ Sign	☐ Social Media
☐ Specialty Program	☐ Therapist's Certification	☐ WC Panel of Providers	

RESPONSIBLE PARTY (Guarantor)

Name: | **Date of Birth:**

Phone: | **Relation:**

EMERGENCY CONTACT

Emergency Contact Name:

Emergency Contact Relation: **Emergency Contact Phone:**

Patient, Please sign here if the above information is complete and correct **Date**

PHOENIX
REHABILITATION AND HEALTH SERVICES, INC.

FINANCIAL POLICY AND CONSENT

Patient Name: _____ Account Number: _____

We would like to **THANK YOU** for choosing PHOENIX Rehabilitation and Health Services, Inc. PHOENIX Rehabilitation and Health Services, Inc. accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however, it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however, we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment.

CONSENT FOR CARE AND TREATMENT

I hereby give written consent for the provision of treatment. I authorize PHOENIX Rehabilitation and Health Services, Inc. to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition.

FINANCIAL RESPONSIBILITY

I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHOENIX Rehabilitation and Health Services, Inc. for any medically necessary therapeutic services that are deemed uncovered by my insurance policy.

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to PHOENIX Rehabilitation and Health Services, Inc. any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHOENIX Rehabilitation and Health Services, Inc. for treatment. By way of my signature below, I provide PHOENIX Rehabilitation and Health Services, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices.

CO-PAYMENTS, COINSURANCE AND DEDUCTIBLES

I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit according to my insurance benefits and the following PHOENIX Rehabilitation and Health Services policy: Co-pays are collected in full. $10 per visit is due for 10% coinsurance, $20 per visit for 20% coinsurance, etc. $50 per visit is due for a deductible until the deductible is met.

LITIGATION ACCOUNTS

I understand that PHOENIX Rehabilitation and Health Services, Inc. will directly bill my appropriate insurance; however, I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to PHOENIX Rehabilitation and Health Services, Inc.

PATIENT VALUABLES

I relieve PHOENIX Rehabilitation and Health Services, Inc. of any responsibility for loss of clothing, money, valuables, or other items that I decide to keep with me while I am a patient. I also understand that PHOENIX Rehabilitation and Health Services, Inc. will not be responsible and will not replace any property lost, broken, or stolen, which I decide to keep with me, or any property brought to me while I am a patient.

CONSENT TO RECEIVE EMAIL, TEXT MESSAGES, AND CALLS FOR APPOINTMENT REMINDERS AND OTHER HEALTHCARE COMMUNICATIONS

I consent to receive email, text messages, and calls from PHOENIX Rehabilitation and Health Services, Inc. for my protected health care and other services at the email address and phone number(s), including my wireless number, that have been provided during the intake process. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system. I understand that providing an email address and/or phone number is not a condition of receiving treatment. I am aware that e-mail communication can be intercepted in transmission or misdirected. I also understand that I may revoke my consent for contact at any time by directly contacting PHOENIX Rehabilitation and Health Services, Inc. or utilizing the opt-out method that will be identified in the applicable communication.

Patient Name: _____ Account Number: _____

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

FOR PHOENIX REHABILITATION AND HEALTH SERVICES INC. OFFICE USE ONLY

Verification of the identity of the above-named party was made by:

☐ Current Driver's License or other Photo ID

☐ Current Health Insurance Card

☐ Other:

_____ _____

Signature of PHOENIX Rehabilitation and Health Services Inc. Representative **Date**

I ACKNOWLEDGE THAT I READ AND UNDERSTAND ALL COMPONENTS OF THE PHOENIX REHABILITATION AND HEATLH SERVICES INC. POLICIES AS STATED ABOVE.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

PHOENIX
REHABILITATION AND HEALTH SERVICES, INC.

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or health care operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by PHOENIX Rehabilitation and Health Services, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any health care operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 430 Innovation Drive, Blairsville, PA 15717, Attention: Compliance Officer.

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or health care operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

_____

_____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and health care operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____

Signature of Patient or Representative **Date**

_____

Patient's Name

_____

DOB

_____ _____

Name of Personal Representative (if applicable) **Relationship to Patient**

To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patients health information set forth above are:

Accepted _____ Denied _____ Not Applicable _____

Other (explain) _____

Signature of Authorized Practice Representative: _____ **Da**te: _____

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REHABILITATION AND HEALTH SERVICES, INC.

Injury and Past Medical History Questionnaire

Patient Name: _____ DOB: _____ Date: _____

When did the condition for which you are seeking treatment begin? _____

Please describe the history and onset of the present condition: _____

_____

_____

Date of Surgery (if applicable): _____ Type of Surgery: _____

What are your chief complaints due to your condition? Please check all that apply.

- ☐ `Awakened by pain
- ☐ Burning
- ☐ Difficulty falling asleep
- ☐ Difficulty finding a comfortable sleeping position
- ☐ Difficulty walking
- ☐ Diminished motion
- ☐ Dizziness
- ☐ Fatigue
- ☐ `Headaches
- ☐ Irritability
- ☐ Loss of function
- ☐ Loss of motion - stiffness
- ☐ Nausea
- ☐ Numbness
- ☐ Pain
- ☐ Constant Pain
- ☐ `Pain worse in the AM
- ☐ Pain worse in the PM
- ☐ Pain worse with activity
- ☐ Spasm
- ☐ Swelling
- ☐ Tingling
- ☐ Weakness
- ☐ Other _____

If you have pain, please rate your pain today on a scale of 0 to 10? (0 is no pain, and 10 is worst possible pain or symptoms): /10

Where is your pain located and how would you describe it? _____

_____

Rate your syptom intensity in the past 5 days:

Symptoms at their worst: /10

Symptoms at their best: /10

Please list any contraindications to treatment or precautions that we should know: _____

_____

Occupation: _____

Work Status:

☐ Employed Full Time ☐ Employed Part Time ☐ Not employed
☐ Full time student ☐ Part time student ☐ Permanently Disabled
☐ Retired

Current Ability to work:

☐ Full Duty ☐ No formal restrictions ☐ Off work
☐ Restricted duties/schedule

Please outline restrictions: _____

_____

Normal work duties:

- ☐ Sitting for extended periods
- ☐ Standing for extended periods
- ☐ Typing/computer operation
- ☐ Repetitive Bending
- ☐ Repetitive Lifting
- ☐ Lifting moderate weights
- ☐ Lifting Heavy Weights
- ☐ Walking
- ☐ Operating Heavy Equipment
- ☐ Driving

Which of these duties are you not currently able to perform and why? _____

_____

_____

Patient Name: _____ DOB: _____ Date: _____

Please list any surgeries and procedures		
Type of Surgery	When	Results/Details

Please list any diagnostic tests and results related to your current condition		
Test	When	Results/Details

Please list other specialists seen for your current condition other than prescribing physician			
Name	Specialty	Reason	Date of Last Visit

Please mark beside all conditions that you have a history of:

- ☐ Allergies
- ☐ Anxiety
- ☐ Asthma
- ☐ Bowel Dysfunction
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Condition
- ☐ History of Smoking
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Malaise/Fatigue
- ☐ Mental/Cognitive Disorder
- ☐ Metal Implants
- ☐ Nausea/Vomiting
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy (current)
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Stroke/CVA
- ☐ Syncope/Fainting
- ☐ Recent Weight Change
- ☐ Other _____

Please mark beside all medications you are currently using

- ☐ Acetaminophen (Tylenol)
- ☐ Allergy Medication
- ☐ Antibiotics
- ☐ Anti-depressants
- ☐ Aspirin/Anti-Coagulants
- ☐ Cardiac (Heart) Medication
- ☐ Cholesterol Medication
- ☐ Diabetes Medication
- ☐ GI Medication
- ☐ Blood Pressure Medication
- ☐ Ibuprofen (Motrin/Advil)
- ☐ Muscle Relaxer
- ☐ Anti-inflammatories
- ☐ Osteoporosis Medication
- ☐ Pain Medication
- ☐ Steroids
- ☐ Other

_____

_____

_____

Have you recently been hospitalized? ☐ Yes ☐ No If so, when were you discharged? _____

Have you received therapy in the past 12 months? ☐ Yes ☐ No If yes, how many visits? _____

In what type of home do you live? ☐ Single Level Home ☐ 2 Level Home ☐ Ground Floor Apartment ☐ Upper Level Apartment ☐ Other: _____

Whom to you live with? ☐ Spouse ☐ Parent(s) ☐ Children ☐ Alone ☐ Other: _____

Are there stairs at home? ☐ Yes ☐ No If so, how many? _____

Is there a handrail? ☐ Yes ☐ No If yes, ☐ Right Side only ☐ Left Side only ☐ Both Sides

Where is the bathroom located? ☐ Lower Level ☐ Upper Level

Where is the bedroom located? ☐ Lower Level ☐ Upper Level

Do you currently smoke? ☐ Yes ☐ No If so, how many packs per day? _____

Did you smoke in the past? ☐ Yes ☐ No If so, how many packs_____years _____

What are your goals and what do you expect to achieve with treatment? _____

_____