



Patient Medical History and Intake Questionnaire

Patient Name: _____ Age: _____ Sex: F _____ M _____

Why did you choose this location: _____

What is your main complaint and in what area is it located? _____

Occupation: _____

Are you presently working? Yes _____ No _____ If no—Last day worked: _____

Have you ever had these symptoms before? Yes _____ No _____ If so, when? _____

Have you had physical therapy, occupational therapy or chiropractic care for this injury before? Yes _____ No _____

Which one and when? _____

Check all of those which apply to your current condition:

____ Work Related Injury ____ Sports Injury ____ Fall ____ Motor Vehicle Accident ____ Aggravation of Pre-Existing Injury ____ Causes Unknown ____ Injury Recurrence
____ Lifting Injury ____ Other: _____

What have you been doing to decrease your pain? _____

On a scale from 0 (no pain) to 10 (very severe pain), what is your pain level? _____

Are your symptoms getting worse/ better/ the same/ since your injury? _____

Are you currently taking any medications? (Please list) _____

Are you allergic to any medications? (If yes, please list) _____

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

	Yes	No		Yes	No		Yes	No
Diabetes	_____	_____	Cancer	_____	_____	Metal Implants	_____	_____
Chest Pain	_____	_____	Asthma	_____	_____	Dizziness	_____	_____
Heart Disease	_____	_____	Arthritis	_____	_____	Fractures	_____	_____
Pacemaker	_____	_____	Aids/HIV	_____	_____	Skin Allergies	_____	_____
Headaches	_____	_____	Allergies to Heat	_____	_____	Nausea/Vomiting	_____	_____
Kidney Problems	_____	_____	Allergies to Cold	_____	_____	Ear Ringing	_____	_____
Are You Pregnant	_____	_____	Seizures	_____	_____	Hypoglycemia	_____	_____
Bladder Problems	_____	_____	Respiratory Problems	_____	_____	High Blood Pressure	_____	_____

If you answered yes to any of the above, please explain and give an approximate date of occurrence: _____

Please circle tests you have had performed:

None X Rays MRI CT Scan Bone Scan Other (Explain) _____

Check any of the following activities which you have difficulty with due to your injury:

____ Housekeeping ____ Lifting ____ Driving ____ Shopping ____ Reaching ____ Dressing ____ Cooking ____ Climbing Stairs ____ Child Care ____ Bending ____ Yard Work ____ Sit to Stand

List all of your surgeries: _____

Is there any other information about your present health that we should know about? _____

Date Patient or Guardian Signature PT/OT Initials

PATIENT INFORMATION				<i>Today's Date:</i>	
<i>How did you choose this clinic?</i>			<i>Facility:</i>		
Patient Name					
Last:		First:		M.I.	Male Female
E-mail:					
Address:		Apt#	City:		State: Zip:
Home #:		Cell Phone #:		SS#	
Age:	DOB:	Marital Status:		S M D W	Student Other
Emergency Contact: Name			Phone		
EMPLOYMENT INFORMATION					
Employer:			Address:		
Full Time / Part Time			Work #:		
MEDICAL INFORMATION					
<i>Have you had any therapy provided to you within the last year? Yes No Where:</i>					
Injured Body Part:				Date of Injury/Onset of Symptoms:	
Work Related: yes no		Accident: yes no		Auto: yes no	If Auto, what state:
Referring Physician Name:					
Last:		First:		Phone:	
Primary Care Physician:				Phone:	
Date of Next Physicians Visit:			Date of Prescription:		
WORK RELATED					
<i>Date Verified:</i>		<i>Verified With:</i>		<i>Verified By:</i>	
Current Occupation:					
Insurance Company:			Network:		
Address:			Phone:		
ID/Claim #:		Adjuster Name:		Phone:	
Employer:					
Address:					
Employer Phone:					
Rehabilitation Nurse/ Case Manager:			Company name:		
Preferred Form of Delivery of Information:		Fax	Email		
Phone:		Fax:		Email:	
<i>Is your work comp injury disputed by your employer? Yes No</i>					
If Yes, Attorney Name & Phone:					
MEDICARE PATIENTS					
<i>Have you had any therapy or nursing services in your home? Yes No Name of Agency:</i>					
Medicare ID#:					
AUTO / COMMERCIAL / MEDICARE (secondary)					
Circle one: PPO HMO POS AUTO OTHER					
Insurance Company:			Phone:		
Subscriber Name:		DOB:		Rel.to Patient:	
Subscriber Employer:					
ID/Claim #:		Group #			
Claim Mailing Address:					
Adjuster/Attorney Name & Phone:					
PLEASE SIGN ON BACK					

CONSENT FOR TREATMENT

I hereby authorize and give my consent to Accelerated Rehabilitation Centers and its affiliates to provide me with therapy services including but not limited to Physical, Occupational and Speech Therapy.

FINANCIAL POLICY

Thank you for choosing Accelerated Rehabilitation Centers, LTD.(Accelerated) as your physical therapy provider. We will work closely with you and your physician to provide you with treatment. Please understand that timely payment for your treatment is important. Your clear understanding of our financial policy is important to our professional relationship.

Cancellation/No show policy: A 24 hour notice must be received or a fee will be assessed.

1. All co-pays and deductibles are due at the time of service.
2. Payment of patient balance is due in full at the time of service unless other arrangements have been made. If you cannot make full payment at the time of service, please discuss this with our Patient Care Advocate.
3. If any portion of your account balance exceeds 60 days you will be responsible for this amount, plus interest herein at 1 1/2 % per month, regardless of your insurance.

We accept cash, checks, Visa, MasterCard, Discover and American Express.

INSURANCE

We accept Medicare, all major insurance and numerous PPO and managed care contracts. Please be aware that some, and perhaps all, of the services provided may be considered not medically necessary by your insurance provider. You will be responsible for these charges.

Your medical insurance is a contract between you and your insurance company. We are not a party to this contract. Accelerated will submit all claims for charges to your insurance provider as a service to you. Co-pays must be paid at the time of service in order to abide by your insurance contract. If your policy requires a referral, be sure to have it with you when you come to our office. Failure to obtain and present this at the time of service may result in a loss of your insurance benefits. If you need assistance in obtaining a referral, please ask our Patient Care Advocate.

To guarantee payment for services rendered, we request documentation of a major credit card. Please provide the following information:

Credit Card Type: Master Card / Visa / Discover / American Express

Name on Card _____

Card #: _____ Exp Date: _____

For your convenience, if you would like your credit card debited weekly for co-pay portion or total charges, please initial here: _____

Date: _____. Select One Co-pay portion Total charge

Please be advised that if you are paying by check, Accelerated charges a \$20 fee for returned checks.

Thank you for understanding our financial policies. If you have any questions or concerns, our Patient Care Advocate will be happy to discuss them with you.

I authorize payment of benefits directly to Accelerated for services provided.

Signature of Patient (Parent / Guardian, if necessary)

Therapist Signature

Date: _____

INSURANCE VERIFICATION (office use only) Verified By: _____ Date: _____ Verified With: _____

Insurance Effective Date:	IN NETWORK	OUT OF NETWORK
Deductible:	\$ Amt Met:	\$ Amt Met:
Patient Co-Pay Amount:		
% Insurance Amount:		
Patient Co-Insurance Amount:		
Out of Pocket Maximum:		
Authorization Number:		
Pre Existing Condition? Yes No	Precert Required: Yes No	
Annual Limit for Therapy: VISITS: #	DOLLAR AMOUNT: \$	
Per Visit Limit: MODALITY: #	DOLLAR AMOUNT: \$	
Documentation Required: Script Notes Eval Referral		
Name of Network Used by Insurance Company:	Confirmed Plan Type:	
Claims Mailing Address:		
Street/PO Box:		
City:	State:	Zip:
Phone:		Fax:

* QUOTATION OF BENEFITS IN NOT A GUARANTEE OF PAYMENT.

Although these benefits were quoted based on your individual contract with your insurance company, the information obtained does not guarantee payment. In addition to co-pay/co-insurance and deductibles, you are responsible for any amount not covered by your insurance company.

Patient / Responsible Party

Patient Care Advocate / Facility Manager

Date: _____



Patient Information

Welcome to Accelerated Rehabilitation Centers!

Personal Items & Clothing:

Patients are encouraged to wear comfortable clothing when receiving therapy treatments. Appropriate attire typically includes shorts, t-shirts, and gym shoes. Tank tops or halter tops are better for neck and shoulder injuries. Please make sure that the involved body part and surrounding areas are easily exposed. A wash-room is available for clothing changes. Please secure all personal items. Accelerated Rehabilitation Centers is not responsible for any lost or stolen items. If items need to be secured, please see the facility manager prior to treatment.

Workers' Compensation Patients:

We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your workers' compensation adjuster and/or rehabilitation case manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

Billing/Payments:

All patients co-pays are to be paid on the same day of treatment session unless other arrangements are made with the front office coordinator. All billing questions should be addressed to our front office coordinator. Please inform us immediately if you have made any changes in your address, phone number or insurance carrier. The patient is ultimately responsible for all outstanding balances.

Cancellations/No Show Appointments:

In order to treat your injury in a timely and efficient manner, you are expected to attend all scheduled therapy visits. All cancellations are to be at least 24 hours in advance, and rescheduled within the same business week whenever possible. There will be a \$25.00 charge to all patients who cancel their appointments with less than 24 hours notice, unless that appointment is rescheduled. There will be a \$25.00 charge to all patients who do not show up for their scheduled appointments. Three consecutive no shows appointments may result in a discharge.

Patient or Guardian Signature

Date

As a courtesy to other patients, please do not bring children and spouses in to the treatment area.

Thank you for choosing Accelerated Rehabilitation Centers as your physical therapy provider. Our highly skilled staff is looking forward to helping you accomplish your rehabilitation goals in a safe and timely manner.



Notice of Privacy Practices

Date: _____

Patient Name (Print): _____

Location: _____

I received a copy of the NOTICE OF PRIVACY PRACTICES.

(PATIENT or GUARDIAN Signature)

I authorize the release of appointment information left on the voicemail or message center at:

Home Phone Number: _____

Cell Phone Number: _____

Work Phone Number: _____