WELCOME TO REHAB ASSOCIATES
30 Years of Quality Physical Therapy Services

We are looking forward to meeting you on _______________ at __________________.
Our goal in therapy is to maximize your abilities, and to improve your quality of life. On your first visit a complete evaluation and plan of care will be designed to meet your specific goals.

Please complete this initial paperwork and bring it to your appointment. If you would like for us to bill your insurance company, please bring your insurance card(s) and the physician's prescription with you to your first appointment. **We are located at 105 W Dave Longaberger Ave. Dresden, Ohio**.

Your first appointment will take approximately 1 hour. If you become aware that you will not be able to keep this appointment please give us a call as soon as possible and we will gladly reschedule your appointment. **Our phone number is (740) 345-2837**. You will be scheduled for your follow-up therapy sessions based upon the physician's prescription and the evaluation findings from your first therapy visit. Established therapy goals will help us monitor your progress and modify your exercises as your condition improves. Active participation in your therapy program is very important. We are partners in the goal of improving your health. Your input in developing goals that are meaningful to you is a big part in the success of your therapy program.

We have found the following information helpful to new patients:

1. Wear loose fitting clothing and tennis shoes.
2. Plan on completing the full number of treatments prescribed by your physician and therapist.
3. Your home program is an essential part of your treatment and should be followed as prescribed by your physician and therapist.
4. If you have any questions or concerns about your program please talk with your therapist.
5. You must be supervised on all equipment in the gym area. Please wait for an employee to assist you with all equipment.

I have fully read and agree to the above therapy patient guidelines.

Signature ____________________________________ Date ___________________

Call Central Scheduling at 740-345-2837 for all scheduling needs.

WELCOME TO REHAB ASSOCIATES
30 Years of Quality Physical Therapy Services

We would like to take this opportunity to ask you two questions.

1. How did you FIRST find out about Rehab Associates?

____ I have been here before
____ My Physician
____ My Employer
____ My Insurance Company
____ Friends/Family Members Name ______________________
____ Yellow Pages/Phone Book
____ Brochure/Advertisements
____ Internet
____ Other ______________________________________

2. Why did you choose to come here for therapy services? (Please choose no more than two)

____ I have been here before
____ No waiting period to start
____ Friend/Family Recommendation
____ Convenient location for work/home
____ Physician Recommendation
____ Insurance coverage accepted
____ Convenient hours in AM/PM (circle one)
____ Other ______________________________________

Patient __________________________________ Date ____________________________

Physician ____________________________

YOUR E-MAIL ADDRESS ____

ADMISSION AGREEMENT

CONSENT TO CARE AND TREATMENT: I consent to be admitted to the Rehab Associates (RA) and understand that any care examinations will be provided by RA which may include therapists, therapist assistants, or technicians. I consent to the administration by RA of all services and treatments necessary for me.

ACKNOWLEDGEMENT OF INFORMED CONSENT: I acknowledge it is my responsibility to comply with instructions and home treatment programs after my initial evaluation, and to inform my therapist of any change in my condition or contraindications to the plan of care. If I refuse treatment that is suggested to me, I will not hold RA or any individual responsible for any of the consequences.

RELEASE OF INFORMATION: I consent to the release of information to my physician, referring agency, and/or members of the multidisciplinary team of RA, including any medical information necessary to bill my account to my insurance company, their authorized representatives, Medicare, a Welfare agency, or Workers Compensation. I also consent to any physician, hospital, medical care facility to release all information on my medical history and treatment to RA.

ASSIGNMENT OF INSURANCE BENEFITS: I assign and authorize payment of any insurance benefits directly to RA except that payment will not exceed the balance due on my account. I understand my signature requests that this payment be made directly to RA. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.**

CANCELLATION/NO-SHOW POLICY: I understand I am responsible for the following cancellation/no-show charges regarding scheduled therapy appointments. 1) I must cancel my scheduled appointments **AT LEAST** the day previous. 2) A $20.00 fee may be charged for the same day cancellations that cannot be rescheduled for another time that same day. 3) A $20.00 fee may also be charged if I fail to show for a scheduled appointment without a cancellation call. This policy may vary for therapy services provided at satellite clinics. Please refer to specific satellite clinic policies for variations.

POLICY OF FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE: We are committed to provide you with the best possible care. If you have medical insurance, we will help you receive your maximum benefit allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. **FULL PAYMENT OR PERCENTAGE OF PAYMENT IS DUE WEEKLY UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF.** Any such request must be accompanied by a completed Patient Information Sheet and your insurance cards. We will make a copy of your card(s) to keep on file. We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however: 1) **YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY.** 2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. 3) Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. **THE FINAL BILL WILL THEN BE THE PATIENT'S RESPONSIBILITY.** We must emphasize that as a medical provider, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of services rendered. Services are payable within 30 days from the date of the RA billing statement. A 2% per month finance charge shall be applied to any past due balances. There shall be a $20.00 fee charged for each/every returned check. We realize that temporary financial problems may affect timely payment of your account. Please notify us of any such financial problems.

I have fully read and agree to the above Admission Agreement and consent to any professional services provided by Rehab Associates - Newark, I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information given is true and correct to the best of my knowledge. I will notify you of any changes in the information provided on the Patient Information Sheet.

I hereby authorize photocopies of this form to be valid as the original.

________________________________ Date:________________
(Patient Signature)

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

I, ____________________________ being parent/legal guardian (circle one) of ____________________________ hereby do give RA
(print your name) (print patient's name)
permission to evaluate and treat him/her in accordance with his/her physician's prescription.

Date: ________________ Signed: ________________________________ Witness: ____________________________

10/14/14

REHAB ASSOCIATES PATIENT INFORMATION SHEET

ARE YOU RECEIVING ANY IN HOME SERVICES? YES OR NO

IN THE LAST 3 MONTHS HAVE YOU RECEIVED IN HOME SERVICES? YES OR NO

PATIENT INFORMATION: **DATE OF INJURY:** ____________

LAST NAME	FIRST NAME		MI
SOCIAL SECURITY NUMBER		BIRTH DATE	
STREET ADDRESS			
CITY	STATE	ZIP	
HOME PHONE#	CELL #		
SEX MALE ___ FEMALE ___	MARITAL STATUS M__ S__ W__ D		
SPOUSE OR NEAREST RELATIVE		**PHONE**	
SOCIAL SECURITY NUMBER		**BIRTH DATE**	
STREET ADDRESS	CITY	STATE	ZIP
YOUR EMPLOYER	JOB TITLE	WORK PHONE	
STREET ADDRESS	CITY	STATE	ZIP
SPOUSES EMPLOYER	**JOB TITLE**	**WORK PHONE**	
STREET ADDRESS	**CITY**	**STATE**	**ZIP**

YOUR E-MAIL ADDRESS ____________________________

PHYSICIAN INFORMATION: **NPI** ____________

REFERRING PHYSICIAN		PHONE	
STREET ADDRESS	CITY	STATE	ZIP
FAMILY PHYSICIAN	PHONE		SEND REPORT Y or N
STREET ADDRESS	CITY	STATE	ZIP
OB/GYN	PHONE		SEND REPORT Y or N
STREET ADDRESS	CITY	STATE	ZIP

INSURANCE INFORMATION: **SEE COPY OF CARD** ____________

PRIMARY PAYER HEALTH INSURANCE ____ AUTO INSURANCE ____ WORKER'S COMP ____ SELF ____ ATTORNEY ____ MEDICAID ____ MEDICARE ____ OTHER ____			
INSURANCE NAME			
SUBSCRIBER NAME AND RELATION			
SUBSCRIBER NUMBER	GROUP NUMBER		
SECONDARY PAYER			
SUBSCRIBER NAME AND RELATION			
SUBSCRIBER NUMBER	GROUP NUMBER		
WORKERS COMP NUMBER	SELF INSURED COMPANY? Y___ N ___,	CLAIM FILED?	
EMPLOYER AT TIME OF INJURY	DATE OF INJURY	PHONE	
STREET ADDRESS	CITY	STATE	ZIP

Revised 12-19-14

Physical Therapy
608 Main Street
Dresden, OH 43821

Patient Questionnaire

*Patient Name*________________________ *Date* ________________________

1. *Describe your symptoms* ________________________

Please circle and rate (1, 2, 3 etc.) ___Pain ___Stiffness ___Effusion ___Weakness ___Abnormal Gait ___Lack of Coordination

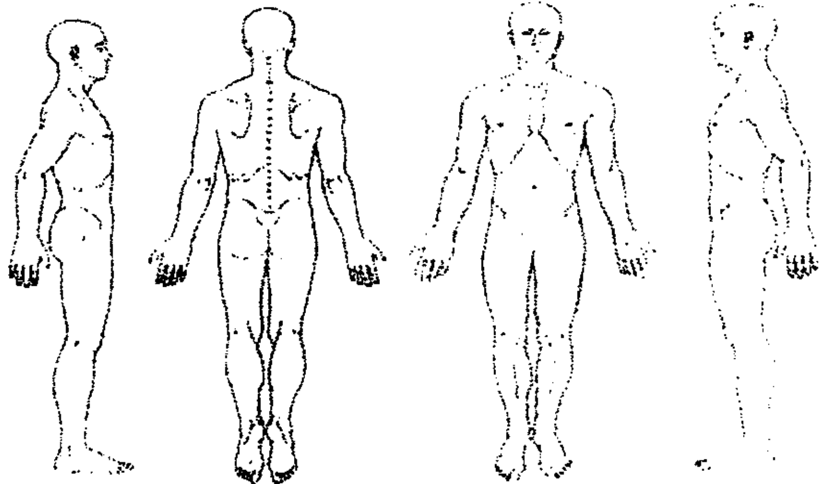
a. When did your symptoms start? ________________________

b. How did your symptoms begin? ________________________

2. *How often do you experience your symptoms?*

① Constantly (76-100% of the day)
② Frequently (51-75% of the day)
③ Occasionally (26-50% of the day)
④ Intermittently (0-25% of the day)

Indicate where you have pain or other symptoms



3. *What describes the nature of your symptoms?*

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. *How are your symptoms changing?*

① Getting Better
② Not Changing
③ Getting Worse

5. *During the past 4 weeks:*

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. *During the past 4 weeks how much of the time has your condition interfered with your social activities?*
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. *In general would you say your overall health right now is...*

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. *Who have you seen for your symptoms?*

① No One ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

a. What treatment did you receive and when? ________________________

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* ____________ ③ CT Scan *date:* ____________
② MRI *date:* ____________ ④ Other *date:* ____________

9. *Have you had similar symptoms in the past?*

① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office ② Chiropractor ③ Medical Doctor ④ Physical Therapist ⑤ Other

10. *What is your occupation?*

____

① Professional/Executive ② White Collar/Secretarial ③ Tradesperson ④ Laborer ⑤ Homemaker ⑥ FT Student ⑦ Retired ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time ② Part-time ③ Self-employed ④ Unemployed ⑤ Off work ⑥ Other

11. Medical/Surgical History:

a. Please check if you have ever had:

- ☐ arthritis
- ☐ broken bones/fracture
- ☐ osteoporosis
- ☐ blood disorders
- ☐ circulation/vascular problems
- ☐ heart problems
- ☐ high blood pressure
- ☐ lung problems
- ☐ stroke
- ☐ thyroid problem
- ☐ diabetes/high blood sugar
- ☐ low blood sugar/hypoglycemia
- ☐ head injury
- ☐ multiple sclerosis
- ☐ muscular dystrophy
- ☐ Parkinson disease
- ☐ seizures/epilepsy
- ☐ allergies ________________
- ☐ developmental or growth problems
- ☐ cancer
- ☐ infectious disease
- ☐ kidney problems
- ☐ incontinence
- ☐ pelvic pain
- ☐ repeated infections
- ☐ ulcers/ stomach problems
- ☐ skin diseases
- ☐ depression
- ☐ orthopedic surgeries ____
- ☐ joint pain ____
- ☐ other ____

For men only: Have you been diagnosed with prostate disease? ☐ yes ☐ no

For women only: Pregnant or think you might be pregnant? ☐ yes ☐ no

12. Medications

Do you take any medications? ☐ yes ☐ no If yes, please list: ____________________

____

____

13. Social/Health Habits

Currently smoke tobacco? ☐ yes ____________________ ☐ no

Alcohol use? ☐ yes ____________________ ☐ no

Prior exercise/activity level? ____

____

14. Height and Weight

Height ______ Feet ________ Inches Weight ____________________

15. Have you fallen in the last year? ☐ yes ☐ no How often? ________________

____________________ ____________________

Patient Signature **Date**

____

Therapist Signature **License #** **Date**

ACKNOWLEDGMENT OF RECEIPT

I, ________________________________ acknowledge that I have received the Notice of Privacy Practices issued by Rehab Associates.

I, ________________________________, authorize Rehab Associates to discuss my health information with the following persons:

Spouse ________________________________

Children ________________________________

____

Parent ________________________________

____

Other ________________________________

____

____
Date

____
Signature of Patient