PHYSIO MED

Outpatient Rehabilitation Center

Welcome to Physio Med

APPOINTMENTS-

Patients are scheduled 2-3 times a week depending on your doctor's order, authorization, and/or financial situation. It is very important you keep your appointments as scheduled. Medicare and Work-Comp are extremely strict if you are not compliant with the therapist's Plan of Care. A gap in treatment greater than a week is unacceptable and could result of non-payment from your insurance company.

INSURANCE-

We participate in many insurance plans. We will bill your insurance accordingly. Please be sure to give our office the correct information. If you have a change of insurance, please notify us ASAP to avoid any confusion.

RECORDS-

Your medical records are confidential. If you wish to have copies of your office reports released to another physician or to an attorney, we must have written consent. Please inform our office of any changes to your address, and telephone number.

OFFICE FEES-

We believe that our professional fees are within the range of usual and customary charges for this region. Any patient's co-pay, co-insurance and/or deductible will be collected upon checking in. We will send you a statement for any additional charges deemed patient responsibility by the insurance

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Print Name Date

Signature

PATIENT INFORMATION FORM

Today's Date: _____/_____/_____

NAME: ________________________________ ________________________________ __________________

First **Last** **M. Initial**

LOCAL ADDRESS**:** ____

City***:*** ____________________________ **State:** _______________ **Zip Code:** ____________________

OUT OF STATE ADDRESS**:** ____

City: ____________________________ **State*****:*** _______________ **Zip Code*****:*** ____________________

E-Mail Address: ____

Home Phone: _______________________________ **Work/cell phone:** __________________________________

Date of Birth: _____/_____/_____ Age: _______ SS#: ___ ___ ___ - ___ ___ - ___ ___ ___ ___

□ **MALE** □ **FEMALE** **Martial Status** □ **married** □ **single** □ **widowed** □ **divorced**

DIAGNOSIS/REASON FOR THERAPY**:**____

____

Is Primary Diagnosis related to an Auto Accident? YES NO

REFERRING PHYSICIAN**:** ____

Physician's Phone Number***:*** ____

Physician Address: ____

For Self-Referred* – *PRIMARY CARE PHYSICIAN**:** ____

Physician's Phone Number***:*** ____

Physician Address: ____

EMERGENCY CONTACT INFORMATION

Notify: ___________________________________ **Relationship:** _____________________________

Home Phone Number: _____________________________ **Work Phone:** ________________________

HOW DID YOU HEAR ABOUT US?

- □ **Physician's office:** ____
- □ **Are you a returning Patient:** ____
- □ **Were you referred by a patient:** ____
- □ **Social Media:** ____

(Website, Google, Yelp, Instagram, Facebook, etc.)

- □ **Other:** ____

PATIENT SIGNATURE: ____ **DATE:** ________________

NAME: ____ DATE: ____/____/______

R____/L____HANDED HEIGHT_________________ WEIGHT_______________

DO YOU USE TOBACCO PRODUCTS? YES / NO PACKS PER DAY______________

HAVE YOU HAD RECOMMENDATIONS TO QUIT? YES / NO

HAVE YOU BEEN GIVEN ADVICE/SUPPORT FOR SMOKING CESSATION? YES / NO

MEDICATIONS

NAME	DOSAGE	FREQUENCY
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
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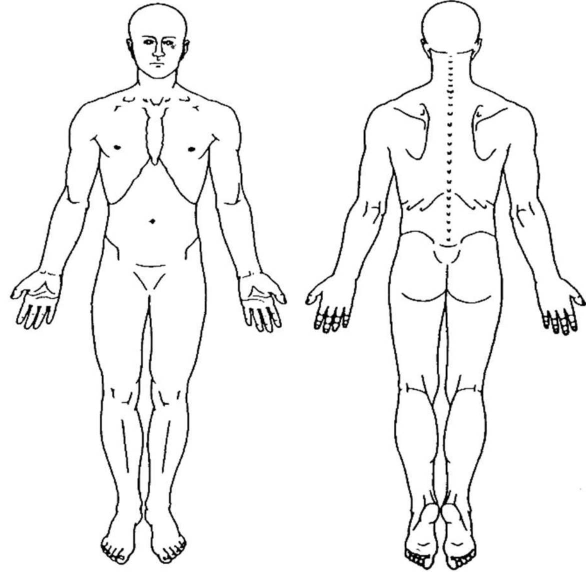
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________
________________________	____________	_________________

PAIN SCALE: NOW: ___/10+
WORST: ___/10+
BEST: ___/10+

KEY
10 VERY, VERY STRONG PAIN
9
8
7 VERY STRONG PAIN
6
5 STRONG PAIN
4 SOMEWHAT STRONG PAIN
3 MODERATE PAIN
2 WEAK PAIN
1 VERY WEAK PAIN
0 NO PAIN AT ALL

Please locate on body chart:
O: NUMBNESS
X: PAIN
///: RADIATING



PAST MEDICAL HISTORY

PLEASE SPECIFY

☐ HYPERTENSION ____

☐ DIABETES ____

☐ VISUAL DEFICITS ____

☐ HEARING DEFICITS ____

☐ PACEMAKER ____

☐ CARDIAC PROBLEMS ____

☐ CIRCULATORY PROBLEMS____

☐ RESPIRATORY PROBLEMS (ASTHMA, SHORTNESS OF BREATH) ________________

☐ SURGERIES ____

☐ METAL IMPLANTS ____

☐ NEUROLOGICAL DEFICITS (MS, PARKINSONS, CVA, etc)______________________

☐ CANCER ____

☐ ALLERGIES____

☐ OTHER____

AUTHORIZATION FOR RELEASE OF INFORMATION, INSURANCE ASSIGNMENTS, VALUABLES, AND CONSENT FOR TREATMENT

Authorization to release medical information: Physio Med, Inc. is hereby authorized to disclose all or any part of my medical records/or the patient named in this registration, to insurance companies, organizations, or agencies that may be concerned with the payment of the rehabilitation cost of me and/or other named on this registration.

This authorization is given with full knowledge that such disclosure may contain information, which may result in denial of insurance benefits or which may be otherwise harmful or inimical to me and/or the registered patient.

I also agree that if all or any part of insurance benefits is denied, I and/or undersigned will be liable for all rehabilitation charges.

Assignment of benefits: This assignment will remain in effect until revoked by me in writing.

Authorization: I certify that the information given in applying for payments under Title XVIII 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 request that payment of authorized benefits be made on my behalf. I hereby authorize Physio Med, Inc. to treat and, I understand that I am responsible for any health insurance deductibles, co-pays and co-insurance.

The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient, as the patient's legal representative, to execute the above and accepts its terms.

______________________________	______________________________
Name of Patient (PRINT)	**Date**
______________________________	______________________________
Signature	**Admitting Staff**

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Physio-Med, Inc. Notice of Privacy Practices as required by Federal Law.

________ ______________________________ _______________________________

Date **Signature** **Name of Personal Representative (If applicable)**

Reason Patient / Personal Representative failed to sign:

____

____

____

Staff Signature

Patient Infectious or Commmunicable Disease Survey

Date:_______________________________

Please check any of the following if you have been diagnosed or had close contact with someone diagnosed with the following infectious diseases within the last 14 days. If none, please check "NONE" at the bottom.

SARS-COV-2	☐	Poliovirus (contact)	☐
Diptheria (contact/airborne)	☐	Conjunctivitis (contact/droplet)	☐
Ebola Virus (contact)	☐	Rotavirus (contact)	☐
Haemophilius Influenzae (droplet)	☐	Herpes Zoster/Varicella Zoster/Shingles (contact)	☐
MRSA (contact)	☐	Strep Throat (contact/airborne)	☐
Hepatitis A (contact)	☐	Pneumonia (airborne)	☐
Hepatitis B (contact)	☐	Meningitis (airborne)	☐
Hepatitis C (blood contact)	☐	Respiratory Syncytial Virus (RSV) - (contact/droplets)	☐
Influenza (contact/droplet)	☐	Rubella (German Measles)(Airborne)	☐
Leprosy, Hansen's Disease (droplets)	☐	Salmonellosis (contact)	☐
Measles (contact/droplets/airborne)	☐	Shigellosis (contact)	☐
Meningococcal (contact/droplets)	☐	Herpes (contact)	☐
Mumps (contact/airborne)	☐	Staphylococcus Aureus (contact/droplet)	☐
Pertussis - Whooping Cough (droplets)	☐	HIV (blood contact)	☐
Varicella (contact/airborne)	☐	Rhinovirus (airborne/contact)	☐
Tuberculosis (droplets)	☐	Tetanus (contact)	☐
Smallpox (contact/airborne)	☐	Toxic Shock Syndrome (contact)	☐
Mononucleosis (contact)	☐	NONE	☐
Syphilis (contact)	☐	Other	☐

Description of other: ____

____

If you encounter or contract any of the above infectious or communicable diseases, please notify Physio Med, Inc. Staff to initiate our Infection Control Protocols.

Patient Signature ____

(Medicare Patients Only)

DISCLAIMER

I have, with the approval of my physician, chosen this facility as the provider of my rehabilitation services, beginning this date _______________ and until such time as I no longer meet the payor source criteria, or am discharged by my physician or therapist.

I am not receiving therapy services in another location or Facility. There are also no medical practitioners/nurses, home health aides or home health therapy coming to my home to provide medical or therapy services.

I understand that if I am receiving home health care Medicare will deny outpatient therapy services and therefore, I will be financially responsible for services rendered by Physio Med Outpatient Rehab.

____________________________ ____________________
Signature Date

____
Print Name