RPM Rehab, Inc. Patient Facesheet

Patient Account #:_____

PATIENT INFORMATION

First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ SS#: _____ (If minor, use SS# for responsible party) □ Male □ Female

Responsible Party Name, if a minor _____ Responsible Party Date of Birth: _____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Which type of Appointment Reminder Notifications would you prefer? □ Phone □ Text Message Preferred phone # _____

Email _____ □ I would like to opt in to receive emails for tips from the providers, feedback, future events, updates or regarding my account.

Referring Physician: _____ Primary Care Physician (*if different*): _____

Nickname: _____ Marital Status: Married / Single / Widowed (circle) Spouse's Name: _____

Employer: _____ Occupation: _____ Full-time / Part-time / Retired / Not Working

Emergency Contact/Permission to release information to:

1) Name _____ Phone: _____ Relation: _____

2) Name _____ Phone: _____ Relation: _____

Please select one of the following: *(Therapies: Physical, Massage , Occupational, Chiropractic, Respiratory, Lymphedema, Pelvic Floor, and Pain Class)*

□ This is my first time this calendar year to receive any type of rehabilitation therapy.

□ I have received rehabilitation this calendar year. □Treatment was at this facility □Treatment was at _____

MEDICAL INSURANCE INFORMATION

Are your injuries due to a **Motor Vehicle Accident**: NO / YES….Claim # _____ Date of Injury: _____ Insurance: _____

Are your injuries due to a **Work Related Accident**: NO / YES….Claim # _____ Date of Injury: _____ Insurance: _____

If you marked yes to your injuries being related to a Motor Vehicle Accident or Work Related Injury, we may not be able to provide treatment until your claim information has been reviewed, verified, and authorized. Your health insurance may deny coverage is your treatment is related to an injury.

PRIMARY INSURANCE: _____

If you are not the subscriber: Subscriber's Name _____ DOB _____

SECONDARY INSURANCE: _____

If you are not the subscriber: Subscriber's Name _____ DOB _____

TERTIARY INSURANCE: _____

If you are not the subscriber: Subscriber's Name _____ DOB _____

RPM Rehab, Inc. will bill your insurance company for your rehab services, however, we are not contracted with every insurance company. The responsible party listed below is fully responsible for payment of all charges incurred. By signing below, you understand that you are financially responsible for any deductibles, co-pays, co-insurances and any non-covered services or supplies. You also authorize us to release any information requested by the insurance company with regards to payment of benefits. Co-pays and co-insurance payments are expected at the time of service, unless prior arrangements have been made. If you have to cancel or change an appointment, please give us a 24 hour notice if possible.

We do charge a $50 No-Show fee for any no-show appointments or same-day cancellations.

Patient/Responsible Party Signature: _____ Date: _____

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Patient Health History

Patient Name: _____ **Date of Birth:** _____

CURRENT INJURY/CONDITION

Date of Injury or Date of onset of symptoms:_____ Injury: _____

Check All That Apply:

____Work Related Injury ____Motor Vehicle Accident ____Injury Recurrence ____Aggravation of Pre-existing Injury

____Sports Related Injury ____Lifting Injury ____Fall ____Causes Unknown

Current Symptoms: _____

Have you had these symptoms before? NO / YES If yes, when? _____

Have you had any care for the current injury or condition: NO / YES (physical therapy/occupational/massage/_____)

What tests have you had related to your current injury: X-ray MRI CT Scan EMG NCV Bone Scan Other: _____

Are your symptoms any different now since the initial injury? Worse / Better / Same

Check any activities you have difficulty with due to your current condition or injury:

___ Getting Dressed ___ Sit to Stand ___ Driving ___ Climbing Stairs ___ Reaching ___ Bending

___ Sleeping ___ Exercising ___ Daily Activities ___ Walking ___ Running ___ Other _____

PAIN MANAGEMENT:

What are you doing to reduce your pain: _____

_____

_____

SURGERY HISTORY:

Did you have surgery for your current injury/ condition? NO / YES

Date of Surgery: _____ Surgical Procedure: _____ Date of re-check with DR: _____

List any other surgeries you have had that we should be aware of: _____

_____

Medical History:

What medications are you currently taking? _____

Are you allergic or sensitive to: (circle) medications, latex, adhesives or hot/cold?

Do you currently have or ever had any of the following:

___ AIDS/HIV ___ Artificial Joint ___ Diabetes ___ Hepatitis ___ Metal Implants ___ Skin Allergies

___ Allergies ___ Arthritis RA/OA ___ Heart Disease ___ High Blood Pressure ___ Pacemaker ___ Stroke

___ Asthma ___ Cancer ___ Heart Murmur ___ Hypoglycemia ___ Seizures ___ Other _____

Patient Signature: _____ **Date** _____

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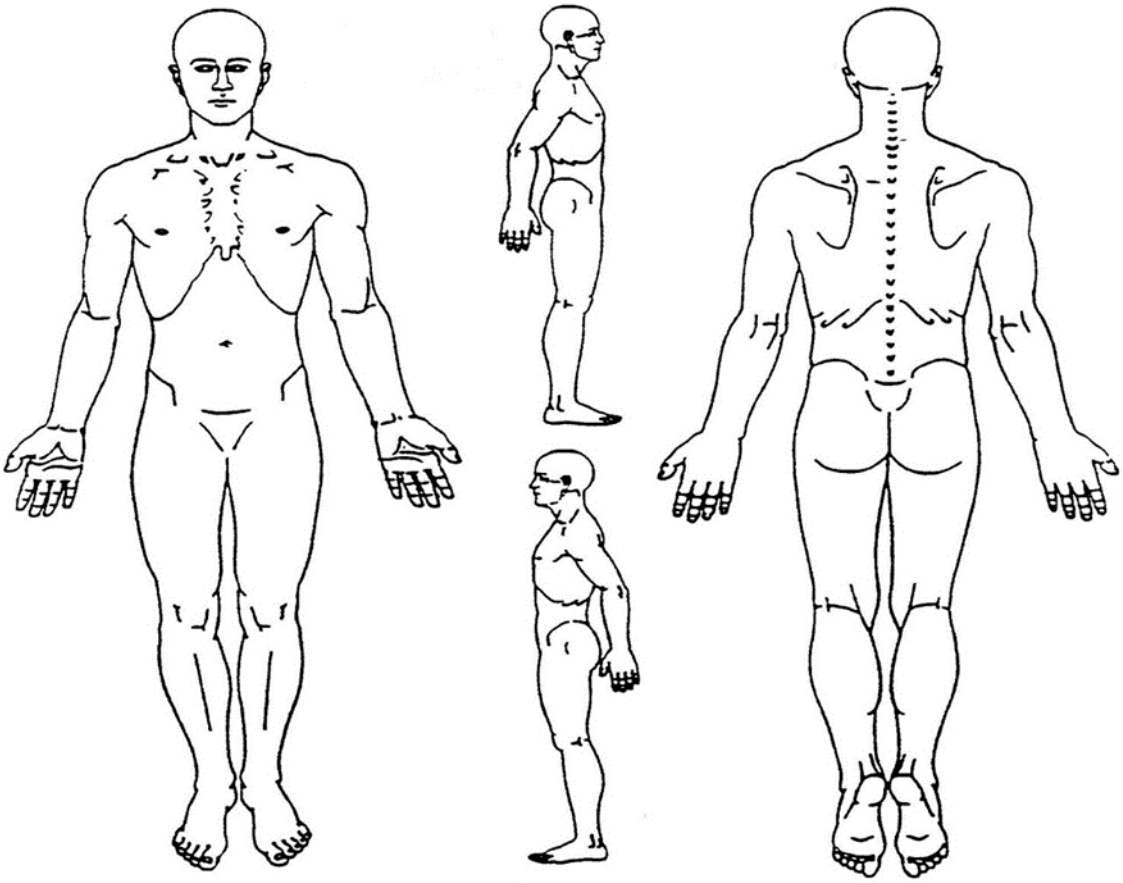
Pain Diagram

Patient Name: _____ DOB: _____ Date: _____

Please mark these drawings according to where you hurt.

Please indicate which sensations you feel by referring to the key (symbols) below.

	Stabbing	Burning	Pins & Needles	Numbness	Aching
KEY:	///////	xxxxxx	000000	=======	+++++++



Please rate your pain over the last week on the following 10 point scale with 0 representing no pain at all and 10 representing a need for emergency care and a trip to the hospital. You will give three scores, one for least amount of pain in the past week, one for your greatest pain in the past week, and one for your typical pain daily.

												What % of the time do you experience this pain?
Least	0	1	2	3	4	5	6	7	8	9	10	_____
Worst	0	1	2	3	4	5	6	7	8	9	10	_____
Usual	0	1	2	3	4	5	6	7	8	9	10	_____

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Patient Name: _____ **DOB:** _____

PATIENT CONSIDERATIONS

- If you are unable to attend your scheduled appointment(s) please call 24 hours in advance to reschedule. If you do not show up for your scheduled appointment, a "no show", do not cancel 24 hours before your scheduled appointment time, and/or repeatedly arrive late without prior notification to your scheduled appointment, a $**50 fee** may be charged directly to you. This charge is not payable by your insurance.
- In order for you to reach your rehabilitation goals, it is imperative that you keep your scheduled appointments. Please arrive on time. If you are more than 10 minutes late, you may be asked to wait or reschedule. If you are late, your treatment time may be shortened, so as not to impose on other patients' treatment time.
- **Medicare / Railroad Medicare patient** – please **DO NOT** schedule your Physical Therapy appointments on the same day as other Doctor appointments, where you are being treated for the same condition. Medicare will only pay for one (1) visit per day.
- Appointments are made for your convenience, however there may be times when your appointment may be rescheduled or cancelled due to our clinicians covering other locations. We will try to contact you as soon as possible; however there may be occasions where advance notice is not permissible. We apologize in advance for any inconvenience this may cause.

NOTICE OF PRIVACY PRACTICES

You are entitled to full confidentiality of your records as maintained by RPM Rehab Inc. under Federal and State guidelines (42 CFR 2.22). In most cases this means that your records cannot be released unless you specifically authorize that release in writing. Please be aware that RPM Rehab, Inc. personnel may exchange information freely within the clinic, but that neither RPM Rehab, Inc. nor its employees may disclose to an outside individual or agency that you are a patient receiving services, the nature of those services or the condition for which you are seeking treatment.

Your confidential information may only be released if:

a) You consent in writing on an approved Release of Information form, or
b) The disclosure is forced by legitimate court, or
c) The minimal information necessary is disclosed to medical personnel in a medical emergency.

You have a right to inspect and obtain a copy of your records, with the understanding that portions of the record may be withheld if they are determined to be detrimental to your physical and/or emotional health. If you would like a copy of your records, there will be a copy fee. Copy fees vary depending on current state law.

ACKNOWLDEGEMENT AND CONSENT TO TREAT

I understand there are certain risks inherent to any physical endeavor. Every effort will be made to minimize these risks by providing me adequate instruction and supervision. I understand clear and direct communication between my therapist and me is necessary to ensure my safety and well-being. Nonetheless, in rare instances, injury may occur.

I have read, understand and agree to the above rights and responsibilities for patients of RPM Rehab, Inc. In signing, I consent to be treated by the therapists and staff of RPM Rehab Inc.

Patient Signature: _____ **Date:** _____

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INFORMED CONSENT FOR IN-CLINIC SERVICES DURING

COVID-19 PUBLIC HEALTH EMERGENCY

This document contains important information about your decision to receive in-clinic therapy services in light of the COVID-19 public health emergency. Please read this carefully and let us know if you have any questions.

Decision to Receive In-Clinic Therapy Services

You have agreed to receive some or all of your Physical Therapy, Occupational Therapy or Massage Therapy services in the Cascade Summit Physical Therapy clinic ("In-clinic"). If there is a resurgence of the Covid pandemic or if other health concerns arise, however, your primary treating therapist may require that your therapy services be provided via telehealth. If you have concerns about meeting through telehealth, your therapist will discuss that with you first to address and resolve any issues. You understand that, if your therapist believes it is necessary, your therapist may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, we will respect that decision, as long as it is feasible and clinically appropriate. *Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.*

Risks of Opting for In-clinic Services

You understand that the novel coronavirus that causes COVID-19, has been declared a worldwide pandemic by the World Health Organization and that COVID-19 is extremely contagious and is believed to spread by person-to-person contact; and, as a result, federal and state health agencies recommend social distancing. You also recognize that all the staff at Cascade Summit Physical Therapy are closely monitoring this situation and have put in place reasonable preventative measures aimed to reduce the spread of COVID-19. However, given the nature of the virus, you understand there is an inherent risk of becoming infected with coronavirus by virtue of proceeding with physical therapy. You hereby acknowledge and assume the risk of becoming infected with coronavirus through participating in therapy. This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure

To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, [my other staff] and other patients) safer from exposure, sickness and possible death. If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement. Initial each to indicate that you understand and agree to these actions:

· You will only keep your in-clinic appointment if you are symptom free and everyone you live with and everyone you are in close contact with on a regular basis are symptom free. _____

· You will take your temperature before coming to each appointment. If it is elevated (100 Fahrenheit or more), or if you have other symptoms of the coronavirus, you agree to cancel the appointment or proceed using telehealth. If you wish to cancel for this reason, you will not be charged the normal cancellation fee. _____

· You will wait in your car or outside [or in a designated safer waiting area] until no earlier than 5 minutes before our appointment time. _____

· You will wash your hands before beginning treatment. _____

· You will adhere to the safe distancing precautions we have set up in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. _____

· You will wear a mask in all areas of the office (your therapist and our staff will too). _____

· You will keep a distance of 6 feet and there will be limited physical contact (e.g. no shaking hands) with your therapist and our staff]. _____

· You will try not to touch your face or eyes with your hands. If you do, you will immediately wash or sanitize your hands. _____

· If you are bringing your child, you will make sure that your child follows all of these sanitation and distancing protocols. _____

Rehab Practice Management

INFORMED CONSENT FOR IN-CLINIC SERVICES DURING

COVID-19 PUBLIC HEALTH EMERGENCY

· You will take steps between appointments to minimize your exposure to COVID-19. _____
· If you have a job that exposes you to other people who are infected, you will immediately let your therapist know. _____
· If your commute or other responsibilities or activities put you in close contact with others (beyond your family), you will let your therapist know. _____
· If a resident of your home tests positive for the infection, or if you are exposed to someone who is suspected of having symptoms or is awaiting results from testing for COVID-19, you will immediately let your therapist know and we will then begin or resume treatment via telehealth. _____

The above precautions may be changed at any time if additional local, state or federal orders or guidelines are published. If that happens, we will review and discuss with you any necessary changes.

Our Commitment to Minimize Exposure
Cascade Summit Physical Therapy has taken steps to reduce the risk of spreading the novel coronavirus within the clinic and we have posted our efforts in the clinic. Please let me know if you have questions about these efforts.

If You or Your Therapist Are Sick
You understand that all of our staff at Cascade Summit Physical Therapist are committed to keeping you, our staff and all of our families safe from the spread of this virus. If you show up for an appointment and your therapist or Office Manager believe that you have a fever or other symptoms, or believe you have been exposed, we will require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If your therapist or any of our staff with whom you come into close contact test positive for the coronavirus, we will notify you of the occurrence of a possible exposure so that you can take appropriate precautions.

Your Confidentiality in case of Infection
If you were to test positive for the coronavirus, we may be required to notify local health authorities that you have been in the office. If we do have to report this, we will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for your care at Cascade Summit Physical Therapy. By signing this form, you are agreeing that we may do so without an additional signed release.

Informed Consent
This agreement supplements the general informed consent that we agreed to at the start of our work together.

Your signature below shows that you agree to these terms and conditions.

_____ _____
Patient Name (printed) Account #

_____ _____
Patient Signature Date

_____ _____
Witness Date

Schedule Preferences

Name: _____ DOB: _____

Days you are available for scheduling (please circle):

Any Day of the Week	Any Time of the Day	Mornings from _____
	Specific Time _____	Afternoons from _____

COMPLETE ABOVE OR BELOW ONLY

Monday	Any Time of the Day	Mornings from _____
	Specific Time _____	Afternoons from _____
Tuesday	Any Time of the Day	Mornings from _____
	Specific Time _____	Afternoons from _____
Wednesday	Any Time of the Day	Mornings from _____
	Specific Time _____	Afternoons from _____
Thursday	Any Time of the Day	Mornings from _____
	Specific Time _____	Afternoons from _____
Friday	Any Time of the Day	Mornings from _____
	Specific Time _____	Afternoons from _____

Other: _____

_____

Office Use Only:

Fx_____ Duration_____

□ PT/PTA	□ Gym only	□ Next w/ PT	□ DB okay	□ Gym/Pool
□ PT only	□ Pool only	□ Sch. Int.	□ DND	□ _____

Comments: _____

_____