RPM REHAB

Patient Demographics

Patient Account #: _____

PATIENT INFORMATION

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

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

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 _____ (For use with our online portal and communication)

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 review the following therapist and advise below: *(Physical, Massage, Occupational, Chiropractic, Respiratory, Cardiac, or Pain Class)*

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

□ I have received one or more rehabs this calendar year. □ Treatment was with RPM □ Treatment was at _____

MEDICAL INSURANCE INFORMATION

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

Adjuster: _____ Phone: _____ Attorney: _____ Phone: _____

Please Note: *You are covered while the claim is open and there is remaining personal injury protection (PIP) coverage. You are responsible for keeping track of your PIP coverage remaining. Remaining balances after PIP exhausts will be forwarded to you/the patient for payment.*

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

Employer of Injury: _____ Please Note: For your treatment to be covered by your injury claim, you must notify us of any changes to your attending physician, claim status, or if an IME is scheduled.

If you marked yes to your injuries being related to a Motor Vehicle Accident or Work-Related Injury, and we were not previously notified by you or your physician, 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 _____

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 must cancel or change an appointment, please give us a 24-hour notice if possible.

We do charge a $67.50 No-Show fee for any no-show appointments or same-day cancellations.

**** Patient/Responsible Party Signature: _____ Date: _____**

RPM REHAB

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 $**67.50 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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Medical History

Patient Name: _____ Date of Birth _____ Age _____

Account # _____ Date Completed _____

Medical History was supplied by Caregiver/Patient and reviewed by Clinician

☐ Yes ☐ No

Reason for Therapy

Date Condition Began: _____

Any previous episodes of this condition? ☐ Yes How many in the last year? _____ No ☐

Is this a Work Related Injury? ☐ Yes ☐ No

Date of next doctor appointment for this condition: _____

In a few words, describe the onset of the current condition(s):

_____

Current Symptoms

Rate your symptom intensity in the past 5 days:

(0 is no pain or symtpoms and 10 is worst possible pain or symptoms)

Symptoms at worst ____ out of 10

Symptoms at best ____ out of 10

Surgery

Did you have surgery for this condition? ☐ Yes ☐ No

Date of surgery (if applicable): _____

Type of surgery: _____

How do activities change the symptoms?

Please list activities that make your symptoms worse? _____

_____

Please list activities that make your symptoms better? _____

_____

What activites can you no longer do because of this condition? _____

_____

Diagnostic Tests

List any diagnostic tests you have received for this condition: _____

_____

_____

Previous Therapy

Have you received therapy (Physical, Occupational, Speech, or Massage) in the past 12 months?

☐ Yes ☐ No

If yes, where and for what reason?

_____

_____

List of Medical Conditions

Please check any medical conditions that you have a history of:

☐ Abnormal Bleeding	☐ Chronic Back Pain	☐ Diabetes Type 2	☐ High Cholesterol	☐ Osteoarthritis
☐ Angina	☐ Chronic Neck Pain	☐ DVT-Blood Clots	☐ HIV/AIDS	☐ Osteoporosis
☐ Anxiety	☐ Closed head Injury	☐ Fibromyalgia	☐ Hypertension	☐ Psoriatic Arthritis
☐ Arrhythmia	☐ Colitis	☐ Frequent UTI	☐ Hypothyroidism	☐ PVD - Numbess
☐ Asthma	☐ Congestive Heart Failure	☐ GERD	☐ Irritable Bowel Synd.	☐ Rheumatoid Arthritis
☐ Bipolar Disorder	☐ COPD	☐ Glaucoma	☐ Joint Pain	☐ Scoliosis
☐ Blood Clotting Disorder	☐ Crohn's Disease	☐ Gout	☐ Lymphedema	☐ Seizure Disorder
☐ Bowel Incontinence	☐ CVA (Stroke)	☐ Heart Disease	☐ Migraine Headaches	☐ Shortness of Breath
☐ Cancer	☐ Degenerative Disc Disease	☐ Hepatitis B	☐ MRSA	☐ Sleeping Disorder
☐ Carpal Tunnel Syndrome	☐ Depression	☐ Hepatitis C	☐ Multiple Sclerosis	☐ TB
☐ Cellulitis	☐ Diabetes Type 1	☐ Hiatal Hernia	☐ MI/Heart Attack	☐ Urinary Incontinence
☐ Feeding Difficulties	☐ Memory Difficulties	☐ Speech Dificulties	☐ Mental Disorders	

☐ Other: _____

Please provide some detail if you marked any of these concerns (Memory, Speech, Feeding difficulties)

_____

_____

_____

Other Conditions

Do you have a pacemaker? ☐ Yes ☐ No

Is there a posibility of Pregnancy? ☐ Yes ☐ No

List any conditions not already included:

_____

Surgeries

Have you had any previous surgeries *(not related to this injury)?* ☐ Yes ☐ No

List Surgeries you have had including date if known:

Surgeries and Procedures

Type	Date	Results/Details

Medications

Do you take any prescribed or over the counter medications? ☐ Yes ☐ No

Have there been any recent changes to your medications? ☐ Yes ☐ No

Please list current medications ***(or provide a list to the receptionist to make a copy)*** Please include dose and frequency if possible

Name	Dose	Frequency	Method (oral, injection, sublingual, etc)

Allergies

Do you have any allergies to medications, food, or other substances that we need to be aware of?

☐ Yes ☐ No

Please provide details: _____

Smoking

Do you currently smoke cigarettes?	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Do you drink alcohol?	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never
Do you use illicit drugs?	☐ Frequently	☐ Occasionally	☐ Rarely	☐ Never

Employment

What is your current work status? ☐ Full Time ☐ Part Time ☐ Full time student ☐ Part time student ☐ Retired ☐ Disabled ☐ Not Employed

Occupation: _____

Current ability to work: ☐ Able to perform all duties/ no restrictions ☐ Off work ☐ Restricted duties or schedule ☐ Temp Disability

Equipment

Do you use any equipment to assist with mobility, work, or daily activities?

☐ Yes ☐ No

If Yes, what equipment do you use? _____

Please mark these drawings according to where you hurt and

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

Type of sensation	Aching		Stabbing		Burning		Pins & Needles		Numbness
Symbol Indicator	+++++++++		///////		xxxxxx		OOOOOOO		==========