TOTAL REHAB CENTER

Patient Information:

First Name: _____ Middle Name: _____ Last Name: _____
Age: _____ Sex: _____
Address: _____ City: _____ State: ____ Zip: _____
Social Security Number: _____ Date of Birth: ____/____/____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Employer:

Name: _____ Phone: _____
Employer Address: _____ City: _____ State: ____ Zip: _____
Retired _____ Disabled _____ Black Lung ____ Working Aged _____ Student ____

Spouse (or parent if minor):

Name: _____ ☐ **Check here if address and phone are the same**
Address: _____ City: _____ State: ____ Zip: _____

Insured Party:

☐ **Check here if patient is the Policy Holder**

If patient is not the Policy Holder, please complete the following:

Name: _____ Age: _____ Sex: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
Insured SS#: _____ Insured Date Of Birth: ____/____/____
Insurance Co. Name: _____ Employer: _____

Contact Person Outside Home:

Name: _____ Phone No.: _____
Address: _____ City: _____ State: _____ Zip: _____

Referring Physician: **Primary Care Physician:**

Name: _____ Name: _____

Have you had Chiropractic care or Physical Therapy anywhere else this year? _____

Total Rehab Center, PSC
175 MedPark Drive
Somerset, Kentucky 42503

To help us assess the cause of your problem, we ask you to complete this form before being seen by a physical therapist.

Personal Data:

Name:_____Height: _____ Weight: _____ Age: ___

1. Are you off work because of this condition? Yes___ No___
2. Please give your occupation and describe the physical demands (bending, lifting, reaching, etc.) _____
_____

Symptoms:

1. What is your primary reason for being seen by a Physical Therapist? (Circle)

Pain **L**imited Motion **W**eakness **A**ctivity Restrictions **U**nable to Work
Unable to Play Sports **U**nable to do Household Tasks **O**ther _____

2. When did your symptoms start? _____

3. What caused your symptoms to start? _____
_____

4. It is important that we have a measure of your pain. Please rate the intensity of your pain on the following scale by placing an "X" on the line at the point that represents your pain. **0 = No Pain** **10 = Excruciating Pain**

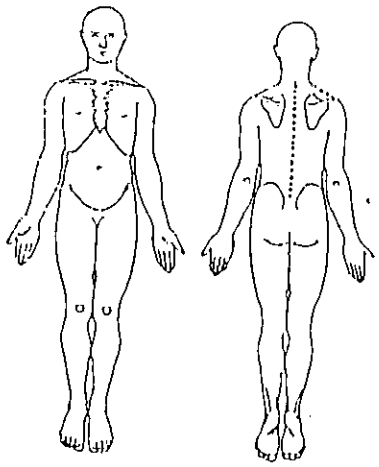
_____
0 1 2 3 4 5 6 7 8 9 10

5. Have you had any previous treatment for this problem? _____
_____

6. What eases your symptoms? _____
7. What aggravates your symptoms? _____

8. Please mark on the diagrams where you feel your pain or numbness.

////// = Numbness \ tingling
xxx = Pain



Have you had chiropractic care or physical therapy anywhere else this year. Yes_____ No_____

Medical History Questionnaire
Total Rehab Center

Have you ever been told you have:

Cancer	Yes	No
High blood pressure	Yes	No
Diabetes	Yes	No
Heart disease	Yes	No
Angina/chest pain	Yes	No
Stroke	Yes	No
Arthritis	Yes	No

Do you have any history of:

Shortness of breath	Yes	No
Allergies	Yes	No
Asthma	Yes	No
Bronchitis	Yes	No
Kidney disease/stones	Yes	No
Polio	Yes	No
Emphysema	Yes	No
Anemia	Yes	No
Rheumatic fever	Yes	No
Ulcers	Yes	No

Have you had or do you experience:

Nausea/vomiting	Yes	No
Fever/chills/sweats	Yes	No
Unexplained weight change	Yes	No
Numbness or tingling	Yes	No
Muscular weakness	Yes	No
Fainting spells	Yes	No
Dizziness	Yes	No
Night pain	Yes	No
Bowel or bladder changes	Yes	No
Headaches	Yes	No
Surgery	Yes	No

Comments/Notes

Have you had any recent illness, to include upper respiratory infections,(flu), or urinary tract infections (UTI)? ---------- Yes No

Do you smoke? ---------- Yes No
If yes, how many packs/day? _____ For how long? _____

Do you use alcohol? ---------- Yes No
If yes, how many drinks each day? _____ each week? _____

Are you taking medications? ---------- Yes No

How often do you feel stress is a significant factor in your life?

Never Seldom Occasionally Regularly Always

Date of last complete physical examination. Month_____ Year _____

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CONSENT TO THERAPY

1. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services and fully understand that I am financially responsible for any services not covered by this authorization.

2. I have presented myself to this facility for therapy treatments and consent to diagnostic procedures and care provided by my attending clinician.

3. I realize I have the right to refuse any drugs, treatment, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical records kept by this facility may be used for educational administrative, and/or facility approved purposed when my personal identity will not be revealed.

4. **NOTE TO WORKERS COMP PATIENTS** My Case Worker/Employer is entitled to receive my records related to my work injury. This is in compliance with the Kentucky State Law.

5. I understand if I need to cancel an appointment I will call within 24 hours or I may be subject to an office fee. If I miss 2 consecutive appointments without calling to cancel or reschedule, I may be asked to pay in advance for a portion of my rehab prior to my next appointment.

6. I have read the "Notice of Privacy Practices" or had it explained to me.

Collection Policy

It is the policy of Total Rehab Center to collect your co-pay at the time services are provided. Our quote to you is directly from your Insurance Company and we are not responsible if that amount changes once we receive an EOB from them.

We will gladly bill your insurance company for services that we render. If your insurance company assigns any portion of our fees to your financial responsibility as a patient, we will bill all remaining balances directly to you. It is the policy of Total Rehab to send out statements on a monthly basis.

If you are here for treatment as a result of a workers compensation claim, or an automobile accident, we will bill your insurance at the time services are rendered. If we receive a denial on your claim in either of these two situations the balance will IMMEDIATELY be transferred to you and will be your responsibility to pay.

If you have any questions or concerns, please feel free to inquire with the front office staff regarding your account. We will do our best to answer any questions or help you in any way possible.

ALL RETURNED CHECKS WILL BE SUBJECT TO A $25 SERVICE CHARGE.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACION.

_____ DATE: _____

Signature of Patient (if the patient is a minor under 18 years of age a Parent must sign)

Media Release Form

By signing this release form, I authorize Total Rehab Center to use the following personal information:

1) My picture, including photographic, motion picture, and electronic (video) images.
2) My voice, including sound and video recordings.

I hereby grant to Total Rehab Center and its subsidiaries the right to use, publish, and reproduce, for all purposes, my name, pictures of me in film or electronic (video) form, sound and video recordings of my voice and printed and electronic copy of the information described above in items 1 and 2. This information may be distributed to all media including, without limitation, cable and broadcast television and the internet, and for promotion, advertising, sale, meetings, educational conferences, brochures, and other print media. The permission extends to all media formats and markets now known or hereafter devised. This permission shall continue until I revoke the permission in writing. I hereby waive the right to any payment for signing this release and waive the right to receive payment for Total Rehab Center's use of any of the material described above.

I acknowledge that I have read the foregoing and I fully understand the contents.

Signature: _____

Print name: _____

Date: _____

For Minors Only

I hereby certify that I am the parent or guardian of _____, who is under the age of eighteen years, to whom this release applies and that I have the legal authority to execute this release. I approve and agree to the foregoing.

Signature: _____

Print name: _____

Date: _____

TOTAL REHAB CENTER

Release of Information

I, _____, give permission to Total Rehab Center to share information with the following health providers/facilities for the purpose of providing assistance to me. Also listed are names of people with whom you may discuss my physical therapy/health: _____ *(initial)*

List names of health providers/people below:

_____

_____

_____

_____

None of this information will be shared with other residents.

The only time staff would share information without my permission is when there is:

- Evidence of child or elder abuse or neglect
- A person presenting a danger to themselves or others
- A court order requires disclosing the information

I understand that my consent is valid while I am receiving treatment and during any related follow up.

I also understand that I can revoke this consent at any time,
I confirm that this form has been explained to me and I understand its content. My signature below indicates my consent.

Signature _____

Date _____