

NEW PATIENT INFORMATION SHEET

Name (Last) _____ (First) _____ (Middle) _____

Mailing Address _____

Date of Birth _____ Age _____ Sex: Male Female Social Security # _____

Phone: Home _____ Work _____ Cell _____

Marital Status: Married Divorced Single Other Unknown Widowed Separated

Employment Status: Full Time Part Time Not Employed Self-Employed Retired Active Military
 Unknown Full Time Student

In case of emergency, please notify _____ Phone _____

Attorney involvement? Yes No Attorney name _____ Phone _____

Name of Employer, Parent or Guarantor _____

Street Address of Employer or Parent _____

City, State and ZIP of Employer or Parent _____

Name of Spouse _____ Spouse Date of Birth _____

Spouse's Employer _____ Phone _____

Have you received any therapy this year? Yes No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to requesting services through our organization? Yes No If yes, please complete the following 3 questions:

1. Name of Home Health Agency _____

Phone number of Home Health Agency _____

Date of discharge from Home Health Agency _____

2. Would you authorize/release the Home Health Agency to provide a copy of your discharge summary? Yes No

3. In the event of a denial due to duplication of services, will you be willing to obtain a copy of your discharge information from the Home Health Agency **or** sign a release so we may obtain it on your behalf? Yes No

For Office Use Only

Facility _____ Account # _____

Admit Date (soc) _____ D/C Date from Old VARD # _____

VARD # _____ Description (Injury Area) _____

Discipline: PT OT ST WH Wellness

Accident: Auto? Yes No If yes, state _____ Work Comp? Yes No Other? Yes No

Onset Date _____ Therapist _____

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient _____

Medicare # _____ Admit/Eval Date _____

Facility _____ Provider # _____

1. Is the patient covered by Veterans Administration or Black Lung? Yes No
2. Was illness due to an injury? Yes No If yes,
 - a. Date of accident _____
 - b. What type of accident cause your illness/injury? _____
 - c. Is the patient filing or intending to file a liability suite? _____
If yes, please give name and address of attorney _____
3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan? Yes No
 - a. Date of retirement _____
 - b. Is the patient married? _____
 - c. Is the spouse currently employed? _____
 - d. Does the spouse have group coverage? _____
 - e. Does the patient have coverage through a spouse, parent or guardian's employer group health plan? _____
4. Is the patient entitled to benefits solely on the basis of end stage renal disease? Yes No Has the patient been undergoing kidney dialysis for more than 12 months? Yes No

If you answered yes to any of the above questions, you will need to fill out the information requested below.

Insurance company _____

Address _____

Policy/certificate number _____

Group name _____

Group number _____

PATIENT SIGNATURE _____ DATE _____

RESPONSIBLE PARTY SIGNATURE _____ DATE _____

Relationship to patient _____

Signature of person completing this form _____ Date _____
(If other than the patient)

**AUTHORIZATION
FOR
TREATMENT, ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY
AND DISCLOSURE OF ALF RESIDENT INFORMATION**

1. I hereby authorize the Facility to release/disclose any information contained in Patient's resident record to Lake Centre for Rehabilitation/Rehab Therapy Works ("LCR/RTW") in order to complete any patient registration forms. A copy of this authorization shall be considered as effective and valid as the original.
2. I hereby consent to treatment by Lake LCR/RTW as outlined in the treatment Plan of Care developed in collaboration with my attending physician. I agree to cooperate with all reasonable requests by Provider in connection with Provider's rendition of therapy services.
3. **MEDICARE:** Patients who are covered by Medicare are responsible for their annual deductible and the 20% portion of the Medicare allowed benefit amount for covered services. I understand Medicare does not pay for all of my therapy costs. Medicare only pays for 80% of the covered benefit. My covered outpatient therapy benefit this year is \$ 1,840.00, unless I qualify for an exception to the benefit limit. If I receive therapy service that is not a Medicare covered benefit, I am responsible for payment, personally or through any other insurance I may have. The purpose of this notification is to help me make an informed choice about whether or not I want to receive therapy services, knowing I may have to pay for the services myself. I understand that LCR/RTW will bill my secondary insurance carrier. I authorize LCR/RTW to furnish my insurance company any information needed to process the claim. I assign to LCR/RTW all money paid for the rehabilitation services furnished. I agree to pay all deductibles, co-insurance and non-covered items not paid for by my secondary insurance carrier. I certify that I am ___ am not ___ eligible for coverage with Tricare for Life Health Care System. I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of any medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to LCR/RTW.
4. **PRIVATE:** I understand that every effort will be made by LCR/RTW to bill my insurance carrier for services rendered. I authorize LCR/RTW to furnish my insurance company any information needed to process the claim. I assign to LCR/RTW all money paid for the rehabilitation services furnished. LCR/RTW DOES NOT accept assignment on non-contracted claims. Any amount not paid by my insurance company is my direct responsibility. I also understand that it is my responsibility to see that all claims are paid within 30 days of receipt. If claims are not paid by 60 days, I will be responsible for payment of the claim (IN FULL) at that time. Any balance due after 60 days may be subject to a delinquency fee of 1% per month. I understand that health and accident insurance policies are an arrangement between my insurance company and myself, that all services rendered me are charged directly to me, and that I am personally responsible for payment.
5. **WORKERS' COMPENSATION:** Patients who are covered under Workers' Compensation are not financially responsible for services rendered unless their claim is controverted/denied. If this occurs, I understand that I am immediately responsible for all controverted/denied charges regardless of pending litigation.
6. **MANAGED CARE PLANS:** Patients who are covered under a participating Managed Care Plan are responsible for any applicable deductibles and/or co-payments required under their plan. I understand that I am responsible for payment of any applicable deductibles and/or co-payments under my plan at the time services are rendered. **I certify that I am ___ am not ___ eligible for coverage with Tricare/Champus.**
7. I, and Patient if applicable, agree to execute any documents and perform any acts that Provider may reasonably request. The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable Powers of Attorney, Health Care Surrogate forms or Court Orders appointing the undersigned as the legal guardian of the Patient.
8. I agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provisions of Paragraphs 2, 3, 4, 5, 6, 7 and 8 shall survive any such termination.

WITNESSES:

PRINTED NAME _____

X _____
Patient Signature/Legal Representative

Date _____

X _____
Financially Responsible Party If Not Patient

Date _____

ALF RESIDENTS: FACILITY _____

Date _____

Signature of Patient or Legal Guardian and Relation to Patient

**Acknowledgement of Receipt of Privacy Notice
in Combination with Voluntary Consent**

Acknowledgement:

As a patient of Lake Centre for Rehabilitation the **Notice of Privacy Practices** has been made available to me which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the Notice of Privacy Practices and understand how medical information about me may be used, the duties of Lake Centre for Rehabilitation and my rights to privacy protection and access to my medical information. I understand that the Office Manager is available to answer any questions that I may have regarding issues of privacy.

Consent:

I give consent for medical information about me to be used and disclosed for purposes of treatment, payment or health care operations. I understand that the privacy regulations allow Lake Centre for Rehabilitation to use or disclose my medical information for these purposes and that my consent is not required. Lake Centre for Rehabilitation is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Lake Centre for Rehabilitation may choose not to agree to the request for a restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent I must complete and sign a “Request to Restrict Uses and Disclosures of Protected Health Information” form and return it to the office manager. I may obtain a copy of the form from the office manager at:

Lake Centre for Rehabilitation Leesburg
600 North Blvd. West, Suite D
Leesburg, FL 34748

Signature of Patient or Personal Representative

Date

Written name of Patient or Personal Representative

Description of Personal Representative’s authority to act on Patient’s behalf

PATIENT HISTORY

Today's Date _____
Patient ID# _____

NAME Last _____
First _____ MI _____ Jr/Sr _____

1 SOCIAL HISTORY & LIVING ENVIRONMENT

With whom do you live?

- | | |
|--|---|
| <input type="checkbox"/> Alone | <input type="checkbox"/> Other relative(s) (not spouse or children) |
| <input type="checkbox"/> Spouse only | <input type="checkbox"/> Group setting |
| <input type="checkbox"/> Spouse and other(s) | <input type="checkbox"/> Personal care attendant |
| <input type="checkbox"/> Child (not spouse) | |
| <input type="checkbox"/> Other _____ | |

Does your home have:

- | | |
|--|--|
| <input type="checkbox"/> Stairs, no railing | <input type="checkbox"/> Cane |
| <input type="checkbox"/> Stairs, railing | <input type="checkbox"/> Walker or rollator |
| <input type="checkbox"/> Ramps | <input type="checkbox"/> Manual wheelchair |
| <input type="checkbox"/> Elevator | <input type="checkbox"/> Motorized wheelchair |
| <input type="checkbox"/> Uneven terrain | <input type="checkbox"/> Glasses, hearing aids |
| <input type="checkbox"/> Assistive devices _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Any obstacles _____ | |

Where do you live?

- | | |
|--|--|
| <input type="checkbox"/> Private home | <input type="checkbox"/> Rented room |
| <input type="checkbox"/> Private apartment | <input type="checkbox"/> Board and care/assisted living/
group home |
| <input type="checkbox"/> Other _____ | |

Employment/Work

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Working full-time outside of home | <input type="checkbox"/> Homemaker |
| <input type="checkbox"/> Working part-time outside of home | <input type="checkbox"/> Student |
| <input type="checkbox"/> Working full-time from home | <input type="checkbox"/> Retired |
| <input type="checkbox"/> Working part-time from home | <input type="checkbox"/> Unemployed |

2 GENERAL HEALTH STATUS

Please rate your health:

- Excellent Good Fair Poor

Have you had any major life changes during the past year? (eg, new baby, job change, death of a family member) Yes No

3 MEDICAL/SURGICAL HISTORY

Please check if you have ever had:

- | | |
|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Seizures/Epilepsy |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Developmental or growth problems |
| <input type="checkbox"/> Blood disorders | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Circulation/vascular problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Infectious disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Diabetes/high blood sugar | <input type="checkbox"/> Ulcers/stomach problems |
| <input type="checkbox"/> Low blood sugar/hypoglycemia | <input type="checkbox"/> Skin diseases |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Muscular Dystrophy | |
| <input type="checkbox"/> Parkinson's Disease | |

Within the past year, have you had any of the following symptoms? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Difficulty sleeping |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Loss of appetite |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Bowel problems |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Weight loss/gain |

Medical/Surgical History (continued)

- | | |
|---|--|
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Urinary problems |
| <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Joint pain or swelling | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Pain at night | <input type="checkbox"/> Other _____ |

Have you ever had surgery? Yes No If yes, please describe, and include dates.

	Month	Year
_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
_____	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

For men only: Have you been diagnosed with prostate disease? Yes No

For women only: Have you ever been diagnosed with any of the following? (Check all that apply)

- | |
|--|
| <input type="checkbox"/> Pelvic inflammatory disease |
| <input type="checkbox"/> Endometriosis |
| <input type="checkbox"/> Trouble with your period |
| <input type="checkbox"/> Complicated pregnancies or deliveries |
| <input type="checkbox"/> Pregnant, or think you might be pregnant |
| <input type="checkbox"/> Other gynecological or obstetrical difficulties If yes, please describe _____ |

4 CURRENT CONDITION(S)/CHIEF COMPLAINT(S)

Describe the problem(s) for which you seek physical therapy:

	Month	Year
When did the problem(s) begin (date)?	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
What happened? _____		

Have you ever had the problem(s) before? Yes No

What did you do for the problem(s)? _____

Did the problem(s) get better? Yes No

About how long did the problem(s) last? _____

How are you taking care of the problem(s) now? _____

What makes the problem(s) better? _____

What makes the problem(s) worse? _____

What are your goals for physical therapy? _____

Are you seeing anyone else for the problem(s)?

- | | |
|--|---|
| <input type="checkbox"/> Acupuncturist | <input type="checkbox"/> Occupational therapist |
| <input type="checkbox"/> Cardiologist | <input type="checkbox"/> Orthopedist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Dentist | <input type="checkbox"/> Pediatrician |
| <input type="checkbox"/> Family practitioner | <input type="checkbox"/> Podiatrist |
| <input type="checkbox"/> Internist | <input type="checkbox"/> Primary care physician |
| <input type="checkbox"/> Massage therapist | <input type="checkbox"/> Rheumatologist |
| <input type="checkbox"/> Neurologist | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Obstetrician/gynecologist | |

5 FUNCTIONAL STATUS/ACTIVITY LEVEL (Check all that apply)

- Difficulty with locomotion/movement:
 - Bed mobility
 - Transfers (such as moving from bed to chair, from bed to commode)
 - Gait (walking):
 - On level
 - On stairs
 - On ramps
 - On uneven terrain
- Difficulty with self-care (eg, bathing, dressing, eating, toileting)
- Difficulty with home management (eg, household chores, shopping, driving/transportation, care of dependents)
- Difficulty with community and work activities/integration:
 - Work/school
 - Recreation or play activity

6 MEDICATIONS

Do you take any prescription medicine? Yes No
If yes, please list _____

Do you take any non-prescription medicines? (Check all that apply)

- Advil/Aleve
- Antacids
- Ibuprofen/Naproxen
- Antihistamines
- Other _____
- Decongestants
- Herbal supplements
- Tylenol
- Aspirin

Medications (continued)

Other (cont) _____
Have you taken any medications previously for the condition you are seeing the physical therapist for? Yes No If yes, please list _____

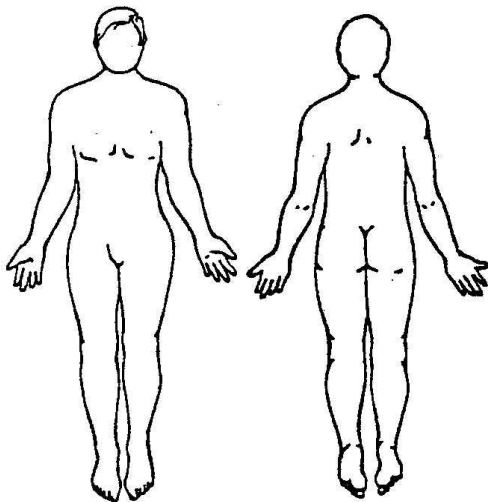
7 OTHER CLINICAL TESTS

With the past year, have you had any of the following tests? (Check all that apply)

- Angiogram
- Arthroscopy
- Biopsy
- Blood tests
- Bone scan
- Bronchoscopy
- CT scan
- Doppler ultrasound
- Echocardiogram
- EEG (electroencephalogram)
- EKG (electrocardiogram)
- EMG (electromyogram)
- Mammogram
- MRI
- Myelogram
- NCV (nerve conduction velocity)
- Pap smear
- Pulmonary function test
- Spinal tap
- Stool tests
- Stress test (treadmill, bike)
- Urine tests
- X-rays
- Other _____

QUALIFIED PAIN DRAWING

ADMINISTRATION: The patient completes the pain drawing by using four modalities: numbness, pins and needles, burning or stabbing.



KEY: oooo = Pins & Needles //// = Stabbing
xxxx = Burning ---- = Numbness

VISUAL ANALOGUE SCALE

ADMINISTRATION: The patient makes a mark on the line to designate how intense the pain is at the present time.

Pain As Bad As It Could Be



PATIENT SIGNATURE _____