VALLEY REHABILITATION 43 S Main St., Montgomery, Pa 17752 (570) 547-0480

PATIENT INTAKE FORM

Date: ________

Patient's Name: ____

Date of Birth: ___________ Age:_______ __ Single __Married __Divorced __ Widowed

Address:____

Home Phone #: ________________________________ Other contact # ________________________________

Emergency contact & number ____

Referring physician ______________________ Primary Care Physician ______________________________

If not referred by primary care physician, do you want records to be forwarded to primary? Yes No

How did you hear about Valley Rehabilitation? ____

What do you hope to accomplish through P.T. at Valley Rehab? ____

____

EMPLOYMENT INFO: Employer's Name: ______________________________ Full-time OR Part-time?

Occupation ________________________________ Employer Phone #: ________________________

STUDENT: N/A Full-time Part-time

INSURANCE:

My *Primary* insurance is secured through: ***(Circle One)*** My employer My spouse's employer Other

If other than yourself, list their: Name _________________________ Date of birth ______________

My *Secondary* insurance is secured through: ***(Circle One)*** My employer My spouse's employer Other

If other than yourself, list their: Name ___________________________ Date of birth ______________

HEALTH HISTORY

Diagnosis or Briefly describe your *current* problem: ____

Onset date of ***current*** problem: ________________ Is this a recurrent problem? YES NO

Is your ***current*** problem related to: ___ Fall ___ Auto accident ___ Work Injury Other _________________

For your ***current*** problem, have you had:

___ x-rays ___ CT scan ___ MRI ___ Bone scan ___ Previous P.T. or O.T. ___ Surgery

Please list dates & locations of performed tests/therapy/surgeries: _______________________________________

____

____

Please list all medications that you currently take, including non-prescription**:** ____________________________

____

Please check all conditions that you ***currently have or have had*** in the past:

___ Seasonal Allergies ___ Other Allergies (please list) ______________________________________

___ Arthritis ___ Osteoporosis ___ Seizure Disorder

___ Depression/ Anxiety ___ High Blood Pressure ___ Headaches

___ Heart Attack ___ Kidney Disorder ___ Diagnosed Cardiac Disease

___ Stroke ___ Parkinson's Disease ___ Diabetes (Circle) Stable Unstable

___ Emphysema ___ Asthma ___ Unexplained Weight Change

___ Prolonged steroid use? (legal or illegal) ___ Past or present Cancer

___ Smoker? How many packs/day?_______ ___ Are you currently pregnant???

Please list any other MAJOR medical problems or surgeries not listed above**:** _____________________________

____

____

ATTORNEY INFORMATION (only if it pertains to the condition that you are seeking treatment for!!!)

Name:____ Phone #: __________________

Address:____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please list the name/names of persons whom we can release protected health/medical information to:

Name	Relationship	Phone#

CONSENT TO TREATMENT & RELEASE OF MEDICAL RECORDS

1) I authorize Valley Rehabilitation to perform physical therapy treatment on me.

2) I authorize Valley Rehabilitation the access to any medical records which may be needed for or aid in my continued care and treatment. Records may also be released as necessary to my insurance company for the purpose of compensation to Valley Rehabilitation.

CANCELLATION/ NO SHOW POLICY

Consistent attendance of all therapy sessions is very important, because it can make the difference between whether you succeed in your treatment or not. **If you cannot attend an upcoming appointment, you must notify us.** Please give us as much prior notice as possible. A twenty-four hour notice is appreciated, however is not required.

1) I understand that on the second occasion I do not show up for an appointment (no prior notice), I will be charged $25. For each no show thereafter I will be charged $35. I understand that these fees will not be paid by my insurance, and will be my financial responsibility. I understand that there is no fee for cancelling an appointment.

2) I further understand that **I will be discharged from Valley Rehab's care** after three 'no shows' within a two-week period. I will need to obtain a new order from my referring physician before any further appointments can be scheduled.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have read/received the Notice of Privacy Practices from Valley Rehabilitation. I have had the opportunity to ask any questions that I may have and understand that further information can be obtained, as necessary, from the Valley Rehabilitation staff.

By signing below, I certify that I have read and understand all of the above information, and certify that, that to the best of my knowledge and/or ability, all information provided by myself if correct and truthful.

____

Patient printed name

____ ______________________

Patient's Signature **Date**

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FINANCIAL AGREEMENT

Financial Responsibility
I understand that Valley Rehabilitation will verify the specifics of my insurance coverage within 72 hours of my initial appointment, and advise me of any applicable co-payments, co-insurance or deductibles that will apply to my treatment. I agree that I am directly, completely and fully responsible to Valley Rehabilitation for bills submitted for rehabilitation services rendered to me, including co-payments, co-insurance, deductibles and/or any claims submitted to and denied by my insurance carrier. I understand that applicable co-payments assigned by my insurance carrier must be paid at the time of service. I further understand that applicable co-insurance totals are likely to be billed to me after the completion of my treatment, once Valley Rehabilitation has received payment from my primary insurance carrier. I understand that all outstanding balances are due in full within 30 days of invoicing by Valley Rehabilitation. If I cannot pay the outstanding balance in full, I must establish a written payment agreement with Valley Rehabilitation within 30 days of the original invoicing. A finance charge of 1% per month, 12% annum, will be applied to unpaid balances that are 31 or more days past due. These finance charges will be included in my payment-in-full. Interest will not be applied to any balance for which a payment agreement has been established, provided that payment on my account is received by Valley Rehabilitation a minimum of every 30 days. If payment is late or not received every 30 days, interest will begin to accrue at the above noted rate until my account is paid in full.

Assignment of Proceeds
I hereby agree to an assignment of proceeds of any monies received by me or on my behalf with respect of the injury or illness that has caused me to seek Valley Rehabilitation's services. This includes, but is not limited to, any settlement, claim, judgment, verdict or partial settlement which occurs with respect to this injury or illness. I further authorize and direct my insurance carrier, third party insurance carriers and my attorney to pay directly to Valley Rehabilitation any sums that may be due and owed to them for services rendered to me, and to withhold such sums from any settlement (full or partial), claim, judgment, or verdict as may be necessary to protect them adequately.

Auto Accident
Payment arrangements must be made before I receive treatment. I understand that Valley Rehabilitation does not extend credit for services rendered, even in the event of injuries sustained in an automobile accident or third party liability situation involved in litigation. If financial coverage cannot be established in terms of private payment, medical insurance, workers' compensation insurance, auto insurance, homeowners insurance or other liability insurance, or if coverage by any of these entities is terminated, I will not be able to receive further treatment from Valley Rehabilitation. I agree that I will instruct all applicable representatives or attorneys to fully pay the amount due to Valley Rehabilitation for services rendered to me.

Collection Proceedings
Should my account become delinquent beyond 120 days with no established payment agreement, I will be responsible for additional expenses incurred by Valley Rehabilitation in the process of collecting the monies owed on my account, including reasonable legal fees, collection costs and other expenses reasonably incurred.

Notification of Changes
I will notify Valley Rehabilitation of any changes in address, employment or attorney representation within 10 days of the change. I will notify Valley Rehabilitation *immediately* of any changes in insurance coverage relevant to my treatment. If I do not notify Valley Rehabilitation of changes or termination of insurance coverage, I will be responsible for any and all charges accrued during my treatment.

I agree that this agreement is primarily for Valley Rehabilitation's protection beyond any lien being filed and financial responsibility being served in consideration of their awaiting payment. This agreement is effective on the first day that I receive rehabilitation services and applies to any services received until the time of my discharge from rehabilitation services.

Printed Name ____

Signature ____ Date _______________