ST. MARY'S PHYSICAL THERAPY

PLEASE COMPLETE ALL THE QUESTIONS

NEW PATIENT REGISTRATION

Patient Name: _____ Date of Birth: _____

Address: _____ City/Zip: _____

Primary Phone: _____ Secondary Phone: _____

SSN: _____-____-_____ Primary Care Physician: _____ for how long?_____

Marital Status: *(Check one):* ☐ Single ☐ Married ☐ Divorced ☐ Widowed Email address: _____

Check one: ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired Date of Retirement: _____

Employer: _____ Phone: _____

Employer Address: _____

MISCELLANEOUS INFORMATION

Emergency Contact Name: _____ Relation: _____

Emergency Contact DOB: _____ Emergency Contact's Phone: _____

Religion preference: _____ Medical Allergies: _____

Allergy to Latex: ☐ Yes ☐ No Living Will: ☐ Yes ☐ No Medical Power of Attorney: ☐ Yes ☐ No

If anyone would visit or call, do you want us to let them know you are here? ☐ Yes ☐ No

The following is ONLY if we do not have a current copy of your insurance cards.

INSURANCE INFORMATION

Primary Insurance Name: _____ ID#: _____ Group#: _____

Cardholder/Guarantor Name: _____ SSN: _____ DOB: _____

Guarantor Employment: _____

Relationship of cardholder to the patient? *(Check one)* ☐ Self ☐ Spouse ☐ Child

Secondary Insurance Name: _____

Cardholder/Guarantor Name: _____ SSN: _____ DOB: _____

Guarantor Employment: _____

Relationship of cardholder to the patient? *(Check one)* ☐ Self ☐ Spouse ☐ Child

ST. MARY'S REHABILITATION SERVICES

Intake Form

Name: _____ Date: _____

Birth Date: _____ **Primary Phone Number:** _____

Cultural/Religious: Any customs or religious beliefs or wishes that might affect care? _____

Advanced directive? (Living will, medical power of attorney, or Do Not Resuscitate) ☐ No ☐ Yes

LATEX ALLERGY: ☐ No ☐ Yes **OTHER ALLERGIES:** _____

GENERAL HEALTH STATUS: Please rate your health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Have you had any recent major life changes (e.g., new baby, job change, death of a family member)? ☐ No ☐ Yes

Are you under any distress (physical or psychological that may affect your treatment or compliance)? ☐ No ☐ Yes

Do you currently smoke? ☐ No ☐ Yes If so, how many packs per day? _____

How many caffeinated beverages do you drink per day? _____

Do you currently drink alcohol? ☐ No ☐ Yes If yes, approximately how many beverages per week? _____

Do you feel unsafe at home or has anyone hit or tried to injure you in any way? ☐ No ☐ Yes

If female, is there any possibility of pregnancy at this time? ☐ No ☐ Yes

MEDICATIONS: Prescription/Non-prescription/Herbal (List): _____

_____

_____

LIST ANY SURGERIES and DATES: _____

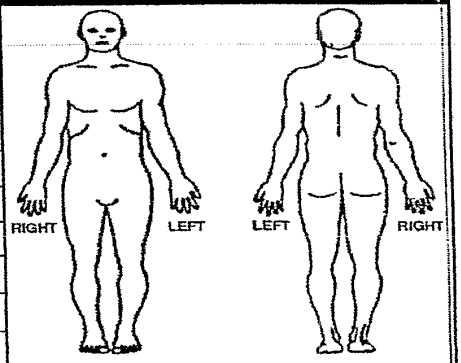
_____

_____

MEDICAL HISTORY: Please check if you have ever had any of the following:

	NO	YES		NO	YES
Allergies			Lung Problems/Pneumonia		
Arthritis			Hypoglycemia		
Blood Disorders			Multiple Sclerosis		
Broken bones/Fractures			Osteoporosis		
Cancer			Pacemaker		
Circulation Problems			Parkinson's Disease		
Deep Brain Stimulator			Prostate Disease		
Defibrillator			Repeated Infections		
Depression			Seizures/Epilepsy		
Diabetes			Skin Disease		
Gynecological Problems			Stroke		
Head Injury			Swallowing Difficulty		
Heart Problems			Thyroid Problems		
High Blood Pressure			Ulcers		
Infectious Disease			OTHER:		
Kidney Problems			OTHER:		

PAIN LOCATION & LEVEL



Mark the areas on the diagram where you feel the pain sensation in your body using the key below.

Burning: X X X X	**Pain Level:**
Numbness: = = = =	Now: _____ / 10
Pins & Needles: 0 0 0 0	Best: _____ / 10
Stabbing: //////	Worst: _____ / 10

Patient Sticker

ST. MARY'S
REHABILITATION SERVICES

Intake Form

Within the last year have you had any of the following:

SYMPTOMS, CLINICAL TESTS, PROCEDURES	NO	YES	SYMPTOMS, CLINICAL TESTS, PROCEDURES	NO	YES
Balance Problems			Joint Pain or Swelling		
Blood Work			Loss of Appetite		
Bowel or Bladder Problems			MRI		
Chest Pain			Nausea/Vomiting		
Coordination Problems			Pain at Night		
CT Scan			Persistent Cough		
Difficulty Sleeping			Shortness of Breath		
Difficulty Walking			Stress Test		
Dizziness or Blackouts			Unexplained weight loss or gain		
EEG/EKG/EMG			Vision Problems		
Falls			Weakness in Arms/Legs		
Fever/Chills/Sweats			X-Ray		
Headaches			OTHER:		
Hearing Problems			OTHER:		
Hoarseness			OTHER:		

Please comment on any items marked "YES" above: _____

_____

_____

_____

Have you received therapy services in the past year? If "YES", please list. _____

_____

_____

What is your goal for therapy? _____

Please list any additional information that you feel will be helpful during your therapy:

_____

_____

_____

_____

This intake form has been reviewed and verified as accurate with the patient and/or surrogate by the evaluating therapist(s).

_____ _____

Patient/Surrogate signature and date **Therapist signature and date**

Patient Sticker

ST. MARY'S PHYSICAL THERAPY

TREATMENT CONTRACT

Thank you for selecting St. Mary's Medical Center for your therapy. We are committed to providing you with effective and quality therapy.

Patient responsibilities:

1. You should be prepared to make a commitment to the treatment program as explained to you by your therapist. This may include performing exercises on a daily basis.

2. You should be prepared to consistently attend your treatment sessions as scheduled. Please notify the clinic at least 24 hours in advance if you need to change the date or time of your appointments. If you cancel 3 times or do not show for 2 of your scheduled appointments, we will reserve the right to administratively discharge you. You will need a new prescription from your physician to continue therapy. We also reserve the right to reschedule your appointment if you are more than 10 minutes late so that you can receive appropriate care and so that other patient's schedules will not be disturbed.

3. You will need to wear loose clothing to your treatment sessions.

4. It may be necessary for the therapist to work on/near _____ (body part) to provide effective treatment.

I understand that the above factors are critical to my success in this program and that my compliance with them will be necessary to optimize my care. I acknowledge that no guarantees have been made to me concerning the results or lack of results from treatment.

By my signature below I understand and acknowledge the risks associated with this treatment and give my permission to proceed.

_____ _____

Patient/Surrogate Signature Date

_____ _____ _____

Therapist Signature Date Time

ST. MARY'S MEDICAL CENTER

PT #:
MR#:

Patient Consent

1. Consent for Admission, Testing, and Treatment. I give St. Mary's Medical Center, Inc. and any treating physician and/or health care provider to administer such anesthetics and medication and/or to perform such medical and/or surgical procedures which are deemed necessary by my healthcare team. I give my permission to be admitted as an inpatient if so ordered by my physician. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the hospital.

2. Account Responsibility. I accept responsibility for payment of all charges and fees for hospital and professional services covering hospitalization and/or outpatient/emergency services of the below named patient. I (we) also accept responsibility for payment of all professional services provided to me during my stay by providers who are not employed by St. Mary's Medical Center and that separate bills may be generated by these service which include but are not limited to physicians, emergency medicine, anesthesia, and diagnostic and laboratory services.

I further authorize that any insurance benefits be paid directly to the institution which provided the services. I (we) agree to the release and disclosure of medical information required to verify coverage or process insurance claims. St. Mary's will bill your insurance carrier on your behalf for charges related to the services provided by our employees in our facility. We are not responsible for the handling of claims by the other providers rendering services to you while at St. Mary's. You will receive a bill from those institutions separately. Please note that you are responsible for the full amount of your account that is not covered by insurance (with the exception of certain government insurance plans).

If I am a Medicare Patient, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment for me.

3. Release Disclosure and Use of Patient Information. I authorize St. Mary's and my physicians to access information about my prescriptions from any health care provider or benefits manager including prescriptions that have been submitted for claims to any insurance plan. I authorize St. Mary's to receive or release my health information, whether written, verbal, or electronic to such employees, agents or third parties as are necessary for these purposes and to companies who provide billing services for physicians or other providers involved in my medical care. In addition, if at any time, I provide a wireless telephone number to St. Mary's at which I may be contacted, I consent to receive calls (including autodialed calls, prerecorded messages and automated appointment reminders) at that wireless number from St. Mary's, its affiliates, agents and independent contractors, including collection agents, regarding the services rendered, hospitalization, and/or my related financial obligations.

4. ***Patient Rights and Notice of Privacy Practices.*** I have received a copy of St. Mary's Medical Center's Patient Rights as well as the Notice of Privacy Practices.

5. ***Medication History.*** I authorize St. Mary's and my physicians to access information about my prescriptions through a prescription exchange called SureScripts. This information helps St. Mary's care for me in a safer and more efficient manner, especially if I am unable to tell the exact names and dosages of my medications

( ) **Request** for Private Room Assignment: I request that St. Mary's Medical Center assign me a PRIVATE room and I agree to pay the difference between the semi-private and private room rates.

_____
Signature

_____
Witness

_____
Relationship to Patient

_____
Date Time

CONSENT FOR ADMISSION

Adopted Date:
Revised Date: 7/11;4/13;7/13;11/13;4/16
Reviewed Date:

«LastName» , «FirstName»
«PatientNumber» / «AdmitDate»
«Gender» / «BirthDate»
«PatientAddress1» / «AttendingDoctorName»
«Room» / «MedicalRecordNumber»