ALLIANCE REHABILIATION SERVICES PATIENT DATA SHEET

First: MI: Last:

Date of Birth: Age: Gender: Male ☐ Female ☐

Mailing Address: _____

_____

_____

Physical Address: _____

_____

_____

_____

May we send you text messages relating to your care with us? ☐ Yes ☐ No

By providing your text number below, you understand that text messages will NOT be sent via secure, encrypted format.

OK To Call	OK To Text	Phone:	Best Time To Call
☐	☐	Home: _____	_____
☐	☐	Work: _____	_____
☐	☐	Cell: _____	_____

SSN:

May we send you emails relating to your care with us? ☐ Yes ☐ No

By providing your email address below, you understand that emails will NOT be sent via secure, encrypted format.

Email: _____

Preferred language:
Intepreter required? ☐ Yes

☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated ☐ Unknown

Student Status: ☐ Full-Time ☐ Part-Time ☐ None

Date of Injury: _____ Referring Physician: _____

Injury Area: _____

Auto or Work Accident: _____

EMPLOYMENT STATUS

Employment Status:
☐ Active Military ☐ Full-Time ☐ None ☐ Part-Time ☐ Retired ☐ Self Employed

Employer: Occupation:

Address:

Phone:

Employer: Occupation:

Address:

Phone:

INSURANCE INFORMATION

Primary Insurance

Policy Holder's Name: Holder's Birth Date:

Policy or Certificate #: Group #:

Policy Holder's Employer:

Secondary Insurance:

Policy Holder's Name: Holder's Birth Date:

Policy or Certificate #: Group #:

Policy Holder's Employer:

Are you receiving or have you received Home Health Services? ☐ Yes ☐ No

Are you receiving or have you received other therapy services? ☐ Yes ☐ No

How did you hear about us?

☐ Physician	☐ Hospital	☐ Marketing Ad - Print
☐ Employer	☐ Cross Referral	☐ Marketing Ad - TV
☐ Case Manager	☐ Friend - Word of Mouth	☐ Marketing Ad - Billboard
☐ Former Patient	☐ Attorney	☐ Marketing Ad - Direct Mail - Email
☐ Adjustor	☐ Self	☐ Marketing Ad - Facebook
☐ School	☐ Screens - Open Houses	☐ Marketing Ad - Other

Specify if other : _____

Note: Please provide us with the most updated information down below.

CONTACTS

DISCLOSURE OF MEDICAL RECORDS

I authorize the following individuals to have access to my medical and billing records:

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature of Patient Date

Please Initial Each as Applicable:

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office

CONSENT TO TREATMENT

I consent to rehabilitation and related services at:
ALLIANCE REHABILIATION SERVICES
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch and/or direct contact of a sensitive nature. _____

TREATMENT OF MINORS:

I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY

I know and agree that: ALLIANCE REHABILIATION SERVICES

is not responsible for loss or damage to personal valuables.

_____

WAIVER AND RELEASE

I hereby release, discharge and acquit:
ALLIANCE REHABILIATION SERVICES
its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. _____

AUTHORIZATION OF PAYMENT

I hereby assign all benefits directly to:
ALLIANCE REHABILIATION SERVICES
I also authorize release of any medical records to other healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical claims and otherwise permitted or required in the Notice Of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

_____

NOTICE OF PRIVACY

I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Witness Signature _____

ALLIANCE REHABILIATION SERVICES MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE:** _____

REFERRING PHYSICIAN'S NAME: _____ **DATE OF INJURY OR ONSET:** _____

CAUSE OF INJURY OR ONSET: _____ **ARE YOU PRESENTLY WORKING? Y N**

PRIMARY CARE PHYSICIAN'S NAME: _____ **DATE OF NEXT MD APPT:** _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____ **AND WHY**_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS:
_____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

_____

ALLERGIES: Medication _____**Reaction**_____**Medication**_____**Reaction**_____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

□ ANEMIA
□ ARTHRITIS
□ CANCER
□ CARDIOVASCULAR PROBLEMS
□ HOLTER MONITOR - currently wearing?
  □ PACEMAKER
  □ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
□ LOW BLOOD PRESSURE
□ CURRENTLY PREGNANT
□ DIABETES □controlled □uncontrolled
□ DEPRESSION
□ DIZZINESS/FAINTING
□ FRACTURES
□ HEADACHES
□ HEPATITIS/HIV
□ KIDNEY PROBLEMS
□ MRSA (Methicillin Resistant Staphylococcus Aureus)
□ OSTEOPOROSIS
□ RESPIRATORY PROBLEMS
  □ ASTHMA □ controlled □ uncontrolled
  □ COPD □ controlled □ uncontrolled
  □ Other
□ SEIZURES □ controlled □ uncontrolled
□ THYROID PROBLEMS

If checked any above, explain: _____

_____

□ **ANY OTHER MEDICAL PROBLEMS:** _____

_____

SIGNATURE OF PATIENT: _____ **REVIEWED BY Therapist:** _____**Date**_____

 Revised 06.02.2010kb

CONSENT TO USE OF LIKENESS AND TESTIMONIAL AND RELEASE

I, _____, hereby consent to allow Alliance Rehabilitation Services and its employees, agents, partners, and affiliates (collectively "Clinic"), to use my name, photograph videotape/audiotape recording, and/or written testimonial ("marketing materials") in Clinic's marketing brochures, publications, and/ or on their website and social media accounts, including but not limited to Facebook and Twitter, to promote the services offered by Clinic. I understand and agree that these marketing materials are owned by Clinic and will not be returned to me.

I hereby release, hold harmless, and forever discharge the Clinic from any and all claims, demands, and causes of action which I have or may have by reason of this authorization.

Further, I hereby affirm that I have read this Consent to Likeness and Release, and I fully understand the content, meaning, and impact of this agreement. This agreement shall be binding upon me and my heirs, legal representatives and assigns.

_____ _____
Participant Name Date

_____
Parent/Legal Guardian (If Participant is a Minor)

HIPAA AUTHORIZATION FOR DISCLOSURE OF PHI

I, _____, hereby consent and authorize Alliance Rehabilitation Services and its employees, agents, partners, and affiliates (collectively "Clinic") to disclose my Protected Health Information ("PHI"), as that term is defined in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for marketing purposes, as stated below. I understand that subsequent disclosures by recipients of my PHI may not be protected by the HIPAA Privacy Rule or other applicable medical record privacy laws.

Further, I authorize Clinic to disclose my PHI, in the form of written statements, photographs, and videotape/audiotape recordings, for purposes of promoting and advertising Clinic's services.

I understand that I may revoke this authorization at any time by giving written notice to Clinic, except to the extent that Clinic and its agents, employees, and representatives may have taken action in reliance on this authorization.

This authorization is effective on the date stated below for an indefinite period of time. A photocopy of this authorization form is valid and should be given the same force and effect as the original.

_____ _____
Participant Name Date

_____
Parent/Legal Guardian (If Participant is a Minor)