Medical History Form

Rehab 1st
physical + occupational therapy services

Patient Name_____ Nickname: _____
LAST FIRST MI

Are you: Receiving Home Health? ❑Yes ❑No **A resident in a Nursing Home?** ❑Yes ❑No **Receiving Hospice Care?** ❑Yes ❑No
Please state briefly why you or your physician are requesting therapy service: _____

_____

_____

Are you aware of your diagnosis? ❑Yes ❑No **Diagnosis as told by doctor:**_____
Are you aware of your choice for recovery? ❑Yes ❑No
Do you have allergies? ❑Yes ❑No If so, please list: _____

_____

What is your Code Status? ❑DNR ❑Full Code Comment:_____
Are you presently treated or have you ever had any of the following medical conditions? (Check all that apply)

❑Arthritis	❑Dizzy Spells	❑Hepatitis A, B, C	❑Seizures
❑Asthma	❑Emphysema	❑High Blood Pressure	❑Stroke
❑Bleeding Disorder	❑Fainting Spells	❑HIV	❑Tuberculosis
❑Breathing Problems	❑Fracture	❑Implant	❑Other:_____
❑Cancer	❑Heart Trouble	❑Pacemaker	❑Other:_____
❑Diabetes	❑Headaches	❑Pregnancy	❑Other:_____

Date of Injury (within 6 months):_____/_____/_____
How did the injury occur? _____

_____

_____

Have you been hospitalized for your condition? ❑Yes ❑No If yes, date?_____/_____/_____
Have you ever had surgery for your condition? ❑Yes ❑No If yes, date?_____/_____/_____
Have you ever received previous treatment for your condition? ❑Yes ❑No If yes, date?_____/_____/_____
Describe Treatment Received: _____

_____

_____

Are you receiving any other health, medical or chiropractic services by any other agency, organization or individual? ❑Yes ❑No
If yes, please explain:_____

_____

_____

Last seen by Physician: _____/_____/_____ **Next Appointment with Physician:**_____/_____/_____
Are you taking any medications? ❑Yes ❑No If yes, please list:_____

_____

_____

For this condition, have you ever had any of the following? ❑EMG ❑MRI ❑CAT Scan ❑X-Ray ❑Myelogram
Have you received Physical/Occupational Therapy services within the past 6 months? ❑Yes ❑No
If yes, where, when and why?_____

_____

❑ **I consent to Telehealth services if deemed appropriate by my provider during the course of my therapy services**
I believe the above information is true and correct to the best of my knowledge.

Patient Signature: _____ **Date:**_____/_____/_____

Rehab 1st physical + occupational therapy services - *Patient Information Sheet*

We're glad to have you! *Where have you seen Rehab 1st in the community?* (Mark all that apply)
□ TV □ Radio □ Newspaper □ Social Media □ Website □ Billboard □ Friend □ Other _____

Patient Name: _____ **Nickname:** _____
Last First MI

Phone: (____)____-____ (____)____-____ (____)____-____ **Marital Status:** ❑ Married ❑ Single ❑ Divorced ❑ Widowed ❑ Separated
Home Cell Work

Gender: □ M □ F **DOB:**____/____/____ **SSN:**____-____-____ **Email:** _____

Primary Address: _____
Street City State Zip County

Billing Name (if different from patient name): _____

Billing Address: _____
Street City State Zip County

Workers Compensation? ❑ Y ❑ N **Employer:**_____**Date of Injury:**____/____/____

Motor Vehicle Accident? ❑ Y ❑ N **State:**_____ **Date of Accident:**____/____/____

Is the patient a minor? ❑ Y ❑ N (If no, skip this section) **Name of Guardian:**_____

Guardian DOB:____/____/_____ **Guardian Phone #:**_____

Guardian Address:_____
Street City State Zip County

Policyholder Information	Primary Insurance	Secondary Insurance
Insurance Provider		
Policyholder Name / Relationship		
Policyholder Date of Birth		
Policyholder Address *(if different from above)*		
Policyholder Phone		
Employer		
Policy ID#		
Group #		

Emergency Contacts & Disclosure to Individuals Involved in Patient's Care

I authorize Rehab 1st Physical Therapy to disclose my health information that is directly related to my current treatment at Rehab 1st Physical Therapy to the individuals listed below for purposes of their role in my treatment or payment for the health services that I have received. Such persons involved in your care may include spouses, children, blood relatives, roommates, boy/girlfriends, domestic partners, neighbors and colleagues.

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

Name:_____ **Relationship:**_____ **Phone:**_____

CO-PAY: $_____	**CO-INSURANCE—PERCENTAGE:**_____**%**	**DEDUCTIBLE: $**_____ □ Met □ Not Met
Due each visit at time of service.	You will be billed once insurance payment is received.	This amount must be met by the patient before insurance kicks in.

Financial Responsibility: My insurance company has determined these amounts. The above information is what has been communicated to Rehab 1st, Inc. by my insurance company. This is not a guarantee. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur in my insurance coverage. I authorize release of payment directly to Rehab 1st, Inc. regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs incurred.

Consent to Treat/Privacy Policy: I hereby agree and give my consent to outpatient therapy treatment. It has been explained to me that therapy is not an exact science, and no guarantee has been made as a result of any treatment administered. I authorize release of any medical information needed to process my claim. I acknowledge that I have seen the *Notice of Privacy Practices.* I understand that I may ask questions about the *Notice of Privacy Practices* at any time. **INITIAL:**_____

Patient/Parent/Guardian Signature:_____ **Date:** _____

Witness Signature:_____ **Date:** _____

Appointment Reminder? ❑ Yes ❑ No **If yes, preferred Method:** ❑ Voice ❑ Text

PRIVACY NOTICE

PLEASE NOTE: WE ARE REQUIRED BY FEDERAL LAW TO PROVIDE YOU WITH A COPY OF OUR PRIVACY POLICY.
PROTECTING YOUR PRIVACY RELATING TO USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

At Rehab 1st, Inc. we are committed to safeguarding your private health information and maintaining your privacy. Rehab 1st Inc. is providing you this policy notice to help you understand how we handle health information that we collect and may disclose. This notice tells you how you can limit our disclosure of your health information.

Patient Rights for Understanding And Controlling the Utilization of Health Information: Rehab1st, Inc., will provide a written explanation of how healthcare provider can use, keep and disclose patient healthcare information (this privacy notice). Rehab1st, Inc., will ensure patient access to his/her medical record(s). Rehab1st, Inc., will obtain consent before healthcare information is shared for treatments, payment and other healthcare operation purposes. Rehab1st, Inc., will provide information for recourse for privacy protection violations. Patients have a right to request electronic copies of their records if their health care provider maintains records in electronic form. Patients also have the right to restrict the disclosure of some of their protected health information to a health plan when the patient has paid out of pocket in full for their care.

Our Policies and Procedures to Protect Your Health Information: At Rehab1st, Inc., we understand the importance of protecting your health information. That's why we protect the information we collect about you by maintaining, physical, electronic, and procedural safeguards that meet or exceed applicable law. Within Rehab1st, Inc., we educate our employees about the importance of confidentiality and privacy, and we train them in related policies and procedures. We also take appropriate disciplinary measures whenever necessary to enforce these rules.

Information: Rehab1st, Inc., is responsible for providing rehabilitation services that enable you to meet your optimal functional level. In order to provide you with the appropriate rehabilitation, Rehab1st, Inc., needs to obtain information that enables us to provide you with responsive, rehabilitation services. Your information comes to us from a variety of sources: You provide some of the information to us at the time of setting your appointment with the evaluating therapist. You provide most of your information to us at the time of your first appointment with us when you are requested to fill out forms giving, but not limited to, information concerning your name, address, social security number, employer, insurance coverage, health history, medications, etc. Your physician provides us with information concerning your treatment diagnosis when s/he orders a therapy evaluation and treatment for your medical condition. Your insurance company provides verification to us of your insurance coverage.

Here is how we put information to use for you: To provide you with the highest quality of rehabilitation services. Health information allows us to provide you with the appropriate rehabilitation services. To communicate with your physician concerning your progress in your rehabilitation program. Health information is shared with your physician to provide comprehensive rehabilitation services to you. To bill your rehabilitation services. Personal and health care information may be shared with your medical insurance company. Rehab1st, Inc., works hard to maintain complete and accurate information about you and your health services. If you ever believe that our records contain inaccurate or incomplete information about you, please let us know immediately, so we may correct any inaccuracies.

Disclosure of Protected Health Information: Patient health information will be used or disclosed for purposes of treatment, payment, and operations. Patient health information will be limited to the minimum necessary for the purpose of disclosure. Authorizations for disclosure of non-routine patient information will meet standards that ensure the authorization is informed and voluntary. Rehab1st, Inc.., may disclose health information without your authorization, including the following: Quality assurance activities, Public Health, Research, Judicial or administrative proceedings, Limited law enforcement activities, Emergency circumstances, Identification of a deceased person or cause of death, Facility patient directories National defense or security.

Marketing: Prior written authorization will be obtained from an individual to use his/ her protected health information for marketing purposes.

HIPAA regulations strengthen the limitations on the use and disclosure of protected health information (PHI) by covered entities and business associates for marketing and fundraising purposes. The new HIPAA regulations also prohibit the sale of PHI by covered entities or business associates without the consent of the patient.

Filing a Complaint: Rehab1st, Inc., will continually assess itself to ensure that patient privacy is respected. To file a privacy complaint, write to: VP Corporate Compliance, Rehab1st, Inc., 157 Baltimore Street, Suite 100, Cumberland, Maryland 21502