Advantage Rehab

Patient Information

Date: ___ / ___ / ___

Name: _____

Mailing Address: _____

Physical Address: _____

City: _____ State: ____ Zip: _____

Home Phone: (____) ____-_____

Cell Phone: (____) ____-_____

Work Phone: (____) ____-_____

Email Address: _____

Sex: M___F____Age:_____

Date of Birth: ___ / ___ / ___

Patient SSN**:** _____

[ ]Child [ ]Single [ ]Married [ ]Other

Employer**:** _____

Parent's name(s) if patient is a minor:

_____

Emergency Contact: _____

Relationship: _____ **Phone:** (____) ____-____

Insurance Information (If not in patient's name)

Name of Insurance**:** _____

Responsible Party: **:** _____

Birthdate of Responsible Party: ___ / ___ / ___

Relationship to Patient**:** _____

Method of Appointment Reminder:

[ ] Appointment card

[ ] Email

[ ] Voice mail

[ ] Text message *number to text:* _____

How did you hear about our Facility:

_____

Updated: ___ / ___ / ___

Signature**:** _____

Medical Information

Referring Doctor: _____

Complaint: _____

Date of Onset: ___ / ___ / ___

Do you use tobacco products: [ ] Yes [ ] No

Are you or could you be pregnant: [ ] Yes [ ] No

Do you have a pacemaker: [ ] Yes [ ] No

PLEASE CHECK APPROPRIATE BOX

Do you have or ever had:

Anemia	[ ] Yes [ ] No
Anxiety	[ ] Yes [ ] No
Autoimmune conditions	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No
Cardiac Conditions	[ ] Yes [ ] No
Chemical Dependency	[ ] Yes [ ] No
Circulation Problems	[ ] Yes [ ] No
Depression	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No
Dizziness	[ ] Yes [ ] No
Fractures	[ ] Yes [ ] No
Gallbladder Problems	[ ] Yes [ ] No
Hepatitis	[ ] Yes [ ] No
High Blood Pressure	[ ] Yes [ ] No
Incontinence	[ ] Yes [ ] No
Kidney Problems	[ ] Yes [ ] No
Lung Problems	[ ] Yes [ ] No
Metal Implants	[ ] Yes [ ] No
Osteoporosis	[ ] Yes [ ] No
Rheumatoid Arthritis	[ ] Yes [ ] No
Seizures	[ ] Yes [ ] No

Allergies:

Adhesive Tape	[ ] Yes [ ] No
Latex	[ ] Yes [ ] No

Other**:** _____

Pertinent surgical procedures:

_____

Patient Authorization and Acknowledgement Record

Initial

_____ **Authorization for Treatment**

I hereby give authorization for the performance of such rehabilitation procedures as permitted by Wyoming statutes under the appropriate scope of practice are, in the judgment of my Therapist, deemed necessary.

_____ **Authorization for release of Information**

I authorize Advantage Rehab to provide information from my medical record to persons involved in my medical care.

I authorize the release of medical information necessary to obtain payment of any benefits available to me to Advantage Rehab for services rendered.

I authorize Advantage Rehab to obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

I have read "Notice of Privacy Practices" mandated by HIPPA.

_____ **Authorization for Release of Payment**

I authorize the payment of any health care benefits applicable to the services rendered by Advantage Rehab covered under my plan be paid to Advantage Rehab directly.

_____ **Patient Agreement**

I understand I am responsible for any charges for services rendered to me during my course of treatment not covered under a current healthcare plan or service, including any fees or collections cost that may accrue.

I understand and agree to pay Advantage Rehab any charges which may not be paid by my health insurance or are determined to be my responsibility by my insurance provider including any fees or collections cost that may accrue.

I understand insurance benefits and other health care plans may or may not cover soft good products and I am responsible for all soft good purchases. I also understand soft goods priced under $150.00 will need to be paid for at time of purchase.

_____ **Appointment Cancellation policy**

We require a minimum of 24 hrs advanced notice of cancellation of a scheduled appointment. A **$40.00 fee** will be charged for **No Show** or **Cancellation** with less than 24-hour notice.

_____ **Medicare, Medicaid, and Other Health Care Program Benefits**

I acknowledge that all information I have provided to Advantage Rehab regarding my benefits under Medicare, Medicaid, and maternal or child health services are completed and accurate. I authorize Advantage Rehab to give the Social Security Administration or other intermediaries working for the Social Security Administration information necessary to process claims.

_____ **Workers Compensation**

I acknowledge that all information I have provided to Advantage Rehab regarding my benefits under Workers Compensation is complete and accurate. I authorize Advantage Rehab to give intermediaries for the Department of Work Force Services or other intermediaries working with workers compensation benefits information necessary to process claims.

I authorize Advantage Rehab to speak with _____ regarding my medical and billing information.

Patient Signature_____ Date _____

Printed patient Name _____ Date _____

Signature of Legal Representative/POA _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Advantage Rehab** maintains hard copies and electronic files, which include: records concerning my health history, symptoms, examinations, test results, and future health care plans.

I understand this information serves as a basis for my continuing care. My information is used as a means of communication among Advantage Rehab's personnel, and with medical personnel outside of this practice. This information is used to ensure third party insurances are accurately billed for services provided by Advantage Rehab under the correct diagnoses.

I have been given an opportunity to review the Notice of Privacy Practices for Advantage Rehab that provides a more complete review of information uses and disclosures. I understand I have the right to review Notice of Privacy Practices before signing this consent.

Advantage Rehab may change its Notice of Privacy Practices at any time and a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and Advantage Rehab is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

Opt Out:

From time to time, photos or videos may be taken of staff members, patients and clinic activities at the discretion of our staff and patients to be used for marketing opportunities related to Advantage Rehab. These marketing opportunities include but may not be limited to our website, Facebook page, newspaper advertising, etc.

☐ By checking this box, I choose to "Opt Out" and not have my picture, clinic activities or public information used for marketing or fundraising purposes.

I acknowledge that I have received a copy of the Notice of Privacy Practices for Advantage Rehab and agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative | Date | Relationship to Patient

_____

Printed name of patient

Effective date April 14, 2003
Revised date March 13, 2018

Medication List

prescriptions, over the counter, herbals, vitamins, minerals, & dietary supplements

Patient Name:_____

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

Patients Signature: _____
Date:_____

Physical Therapist: _____
Date:_____

Updated -
Patients Signature:_____
Date: _____

Physical Therapist:_____
Date: _____

Updated -
Patients Signature:_____
Date: _____

Physical Therapist:_____
Date: _____