PHOENIX
REHABILITATION AND HEALTH SERVICES, INC.

Account Number ___________________

PATIENT INFORMATION

Patient Name: ________________________ ________________________ ____ _______
Last First MI Salutation

SSN: ____________________________ DOB: _______/_______/_______ Sex: ☐ M ☐ F

Address: ____ Marital Status: ☐ S ☐ M ☐ D ☐ W

City: ____ State: ______________ ZIP: ________________

Home Phone: (______) ______-_________ Cellular: (______) ______-_________

Email (optional): ____

☐ Yes, I wish to receive PRHS's exclusive monthly newsletter and future news announcements via email. I understand I can unsubscribe at any time.

Employer: ____ Work Phone (______) _______-________

Address: ____________________________________ Occupation/Position: _________________________

City: ____ State: _____________ ZIP: _________________

Responsible Party: Relation to Patient (Check one): ☐ Self ☐ Spouse ☐ Child ☐ Parent ☐ Other

Name: _____________________________ Phone: (_____) _____-_________

SSN: ____________________________ DOB: ______/_______/_______ Sex: ☐ M ☐ F

Employer: ____ Work Phone: (_____) _____-_________

INSURANCE INFORMATION

Primary Insurance: _________________________ **Secondary Insurance:** ________________________
(Personal Insurance if Primary is Worker's Comp or Auto)

Policy #: ___________________________________ Policy #: ___________________________________

Group #: ___________________________________ Group #: ___________________________________

Is the patient the subscriber to this policy?
☐ YES ☐ NO (If NO, please complete below)

Is the patient the subscriber to this policy?
☐ YES ☐ NO (If NO, please complete below)

Subscriber's Name: _________________________ Subscriber's Name: ___________________________

Subscriber's DOB: __________________________ Subscriber's DOB: ____________________________

Relation to patient: _________________________ Relation to patient: ___________________________

INJURY INFORMATION

My condition is related to (Check one): ☐ Work ☐ Auto ☐ Sports ☐ Other ☐ None

Date of Injury/Accident/Onset: ________/________/________ Injury Area: ________________________

Referring Doctor: ______________________________ Primary Doctor: ____________________________

Diagnosis: ____

EMERGENCY CONTACT:

Name: _________________________ Phone: (_______) _______-_________ Relation: ________________

Patient Name: ______________________________ **Account #:** ______________________________

PHOENIX REHABILITATION AND HEALTH SERVICES, INC. FINANCIAL POLICY

We would like to **THANK YOU** for choosing PHOENIX Rehabilitation and Health Services, Inc. PHOENIX Rehabilitation and Health Services, Inc. accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment

CONSENT FOR CARE AND TREATMENT
I hereby give written consent for the provision of treatment. I authorize PHOENIX Rehabilitation and Health Services, Inc. to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition

INITIALS ____________

FINANCIAL RESPONSIBILITY
I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHOENIX Rehabilitation and Health Services, Inc. for any medically necessary therapeutic services that are deemed uncovered by my insurance policy.

INITIALS ____________

ASSIGNMENT OF BENEFITS
I hereby authorize payment directly to PHOENIX Rehabilitation and Health Services, Inc. any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHOENIX Rehabilitation and Health Services, Inc. for treatment.

INITIALS ____________

CO-PAYMENTS, COINSURANCE, AND DEDUCTIBLES
I understand that if my insurance plan requires a co-payment, coinsurance, and/or deductible for treatment, payment will be collected at the time of my visit according to my insurance benefits and the following PHOENIX Rehabilitation and Health Services policy: Copays are collected in full. $10 per visit is due for 10% coinsurance, $20 per visit for 20% coinsurance, etc. $50 per visit is due for a deductible until the deductible is met.

INITIALS ____________

LITIGATION ACCOUNTS
I understand that PHOENIX Rehabilitation and Health Services, Inc. will directly bill my appropriate insurance; however I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to PHOENIX Rehabilitation and Health Services, Inc.

INITIALS ____________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & AUTHORIZATION
I hereby acknowledge that I have received a copy of PHOENIX Rehabilitation and Health Services, Inc.'s Notice of Privacy Practices. I also understand that additional copies of this Notice are available for my review upon request. By way of my signature below, I provide PHOENIX Rehabilitation and Health Services, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices

INITIALS ____________

CERTIFICATION OF IDENTITY
I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

INITIALS ____________

I ACKNOWLEDGE THAT I READ AND UNDERSTAND ALL COMPONENTS OF THE PHOENIX REHABILITATION AND HEATLH SERVICES INC. FINANCIAL POLICY AS STATED ABOVE.

____ ____________________

Signature of Patient or Guardian (if patient is a minor) **Date**

FOR PHOENIX REHABILITATION AND HEALTH SERVICES INC. OFFICE USE ONLY
PHOENIX REHABILITATION AND HEALTH SERVICES INC. VERIFICATION OF IDENTITY
I certify that I have verified the identity of the above named party; verification of identity was made by:

- ☐ Health Insurance Card that is current
- ☐ Driver's License or other Photo ID that is current
- ☐ Utility bill or other correspondence showing current residence if the Photo ID does not display the patient's current address

____ ____________________

Signature of PHOENIX Rehabilitation and Health Services Inc. Representative **Date**

INJURY AND PAST MEDICAL HISTORY QUESTIONNAIRE

Patient Name:______________________________DOB:________________Date:______________

When did the condition for which you are seeking treatment begin? ____/____/____

Please describe the history and onset of the present condition:________________________________

____

Date of Surgery (if applicable):______________Type of Surgery:______________________________

What are your chief complaints due to your condition. Please check all that apply.

- ☐ Awakened by pain
- ☐ Burning
- ☐ Difficulty falling asleep
- ☐ Difficulty finding a comfortable sleeping position
- ☐ Difficulty walking
- ☐ Diminished motion
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headaches
- ☐ Irritability
- ☐ Loss of function
- ☐ Loss of motion – stiffness
- ☐ Nausea
- ☐ Numbness
- ☐ Pain
- ☐ Constant Pain
- ☐ Pain worse in AM
- ☐ Pain worse in PM
- ☐ Pain worse with activity
- ☐ Spasm
- ☐ Swelling
- ☐ Tingling
- ☐ Weakness
- ☐ Other: ______________

If you have pain, please rate your pain today on a scale of 0 to 10? (0 is no pain and 10 is worst possible pain or symptoms) ____/10

Where is your pain located and how would you describe it?_______________________________________

Rate your symptom intensity in the past 5 days:

Symptoms at their worst: ____/10

Symptoms at their best: ____/10

Please list any contraindications to treatment or precautions that we should know: ____________________

____

Occupation: ____

Work Status:

- ☐ Employed Full Time
- ☐ Employed Part Time
- ☐ Not employed
- ☐ Full time student
- ☐ Part Time student
- ☐ Retired
- ☐ Permanently Disabled

Current ability to work:

- ☐ Full Duty
- ☐ No formal restrictions
- ☐ Off Work
- ☐ Restricted duties/schedule

Please outline restrictions:____

Normal Work Duties:

- ☐ Sitting for extended periods
- ☐ Lifting moderate weights
- ☐ Typing/computer operation
- ☐ Standing for extended periods
- ☐ Lifting heavy objects
- ☐ Walking
- ☐ Repetitive Bending
- ☐ Operating Heavy Equipment
- ☐ Repetitive Lifting
- ☐ Driving

Which of these duties are you not able to perform and why?_____________________________________

____

____

Patient Name:________________________DOB:______________Date:____________

Please list any surgeries and procedures		
Type	Date	Results/Details

Please list any diagnostic tests and results related to your current condition		
Test	Date	Results/Details

Please list other specialist seen for your current condition other than prescribing physician			
Name	Specialty	Reason	Date of Last Visit

Please mark beside all conditions that you have a history of:

- ☐ Allergies
- ☐ Asthma
- ☐ Anxiety
- ☐ Bowel Dysfunction
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Headaches
- ☐ Heart Condition
- ☐ History of Smoking
- ☐ High Blood Pressure
- ☐ Joint Replacement
- ☐ Malaise/Fatigue
- ☐ Mental/Cognitive Disorder
- ☐ Metal Implants
- ☐ Nausea/Vomiting (current)
- ☐ Neurological Disorder
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Pregnancy (current)
- ☐ Rheumatoid Arthritis
- ☐ Shortness of Breath
- ☐ Stroke/CVA
- ☐ Syncope/Fainting
- ☐ Recent Weight Change
- ☐ Other______________

Please list any allergies:____

Please mark beside all medications you are currently using:

- ☐ Acetaminophen (Tylenol)
- ☐ Allergy Medication
- ☐ Antibiotics
- ☐ Antidepressants
- ☐ Aspirin/Anti-Coagulants
- ☐ Cardiac (Heart) Medications
- ☐ Cholesterol Medication
- ☐ Diabetes Medication
- ☐ GI Medication
- ☐ Blood Pressure Medication
- ☐ Ibuprofen (Advil/Motrin)
- ☐ Muscle Relaxer
- ☐ Anti-Inflammatories
- ☐ Osteoporosis Medication
- ☐ Pain Medication
- ☐ Steroids
- ☐ Other

____

____

____

Have you been recently hospitalized? ☐ Yes ☐ No If so, when were you discharged?____________

Have you received therapy in the past 12 months: ☐ Yes ☐ No If yes, how many visits?____________

In what type of home do you live? ☐ Single Level Home ☐ 2 Level Home ☐ Ground Floor Apartment ☐ Upper Level Apartment ☐ Other:____________

Whom do you live with? ☐ Spouse ☐ Parent(s) ☐ Children ☐ Alone ☐ Other____________

Are there stairs at the home? ☐ Yes ☐ No If so, how many?____________

Is there a handrail? ☐ Yes ☐ No If yes, ☐ Right side only ☐ Left side only ☐ Both Sides

Where is the bathroom located? ☐ Main Level ☐ Upper Level

Where is the bedroom located? ☐ Main Level ☐ Upper Level

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

Did you smoke in the past? ☐ Yes ☐ No If so, how many packs?________years?________

What are your goals and what do you expect to achieve with treatment?________________________

____

New Patient Survey

Thank you for choosing PHOENIX for your rehabilitation. We're glad you're here!
To help us reach others in our communities, please tell us…

Email Address (optional): ______________________________

☐ Yes, I wish to receive PHOENIX's exclusive monthly e-newsletter and future news announcements via email. I understand I can unsubscribe at any time.

Which of these applies or may have influenced your decision to choose PHOENIX?

Please check all that apply.

☐ **PHOENIX was recommended by my medical provider.**

- My doctor said specifically I should go to PHOENIX.
- My doctor's staff (physician assistant, nurse, front office) recommended I go to PHOENIX.
- I chose from list of therapy providers given to me by my doctor or staff personnel.

☐ **PHOENIX was recommended by my employer.**

- PHOENIX is listed on our Medical Panel of Providers.
- I was referred by an Occupational Health doctor.
- I was directed by a rehab nurse or case manager assigned to my work injury claim.

Please list employer or person overseeing your care: ______________________________

☐ **I found PHOENIX on-line on via the web.**

A. I did an internet search for physical or occupational therapy providers in my area. (i.e. Google, Yahoo, Bing, etc.)

B. I visited the PHOENIX website (www.phoenixrehab.com)

C. I searched for a therapist on the APTA or AOTA website.

D. I found PHOENIX via a social networking site or online community (i.e. Facebook, Twitter, LinkedIn, etc.)

Please list the web/internet method(s) you used (mark A, B, C or D): ______________________________

☐ **I came to PHOENIX because of a public relations opportunity.**

- I attended a social or business-related function at PHOENIX (i.e. open house, chamber mixer, etc.)
- I visited a PHOENIX exhibit/booth during a trade show (i.e. health fair, business expo)

☐ **I came to PHOENIX on recommendation made by another person.**

- PHOENIX was recommended to me by a friend or family member.

☐ **I am a former patient.**

- I came back because I am a former patient of PHOENIX (this location or other.)

☐ **I came to PHOENIX because of convenience.**

- This PHOENIX office is conveniently located to my home or place of work.
- This PHOENIX office offers convenient appointment hours.

☐ **I came to PHOENIX because of an advertisement.**

A. I saw an advertisement or listing in the yellow pages or telephone directory.

B. I saw an advertisement in the newspaper or other print publication.

C. I received a promotional piece in the mail or by email.

D. I read about PHOENIX on a brochure or flyer displayed in my community.

Please list the advertisement(s) you saw (mark A, B, C or D): ______________________________

☐ **I came to PHOENIX simply because—**

A. I noticed the PHOENIX sign(s) outside the office.

B. PHOENIX offered a specialty service (i.e. aquatic therapy, vestibular rehab, certified hand therapy, etc.)

C. I was directed by my insurance carrier.

D. I was directed by my attorney.

E. I am an acquaintance of a PHOENIX staff member.

Please list the specific reason(s) (mark A, B, C, D or E): ______________________________