PHOENIX
Rehabilitation and Health Services, Inc.

PATIENT INFORMATION: Account Number _____

Patient Name: _____ _____ ____ _____
Last First MI Salutation

SSN: _____ DOB: _____/_____/_____ Sex: M or F

Address: _____ Marital Status: S M D W

City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Cellular: (_____) _____-_____

E-mail Address (For Company Promotional Purposes): _____

Employer: _____ Work Phone (_____) _____-_____

Address: _____ Occupation/Position: _____

City: _____ State: _____ ZIP: _____

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

Responsible Party Name: _____ Home Phone: (_____) _____-_____

SSN: _____ DOB: _____/_____/_____ Sex: M or 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 or NO (If NO, please complete below)

Subscriber's Name: _____
Subscriber's DOB: _____
Subscriber's SSN: _____
Relation to patient: _____

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

Subscriber's Name: _____
Subscriber's DOB: _____
Subscriber's SSN: _____
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
I understand that if my insurance plan requires a co-payment for treatment, my co-payment will be collected at the time of my visit. A surcharge may be applied in order to collect late co-payments. This surcharge will cover expenses incurred by PHOENIX Rehabilitation and Health Services, Inc. to generate additional bills and/or utilize collection services.

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**

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PHOENIX
Rehabilitation and Health Services, Inc.

Patient Name: _____

Today's Date: ___/___/___ Date of Birth: ___/___/___

What is the condition for which you are seeking treatment (Chief Complaints)? _____

_____

Have you had Physical Therapy or Chiropractic for any condition in the last 12 months? ☐ Yes ☐ No If yes, # of visits: _____

Have you had recent surgery for this condition? ☐ Yes ☐ No If yes, date/type of surgery: _____

For Office/Clinician Use Only:

Are you experiencing pain? ☐ Yes ☐ No If yes, location(s): _____

How would you rate your pain on a 0 to 10 scale (*0 = no pain 10 = maximal pain*)? _____ /10

☐ This is my rating of pain with the use of medications ☐ This is my rating of pain without the use of medications

How frequent is your pain? ☐ Constant ☐ Intermittent When is the pain the greatest? ☐ Morning ☐ Afternoon ☐ Night

When is your pain most present? (*Please check any that apply*) ☐ At Rest ☐ During Activity ☐ After Activity ☐ At Work

☐ After Work ☐ Standing ☐ Sitting ☐ Walking ☐ Bending ☐ Kneeling ☐ Other: _____

How would you describe your pain? (*Please check any that apply*) ☐ Dull ☐ Shooting ☐ Ache ☐ Throbbing ☐ Numbness

☐ Tingling ☐ Burning ☐ Stabbing ☐ Radiating ☐ Other: _____

What provides you with relief from your pain? ☐ Medication ☐ Heat ☐ Cold/Ice ☐ Rest ☐ Activity ☐ Other: _____

Does the pain prevent you from falling asleep? ☐ Yes ☐ No Is it difficult to find a comfortable sleep position? ☐ Yes ☐ No

Are you awakened by pain: ☐ Yes ☐ No Other sleep issues: _____

Prior to the onset of your symptoms, how much of your normal daily activities were you able to perform? ☐ 100% ☐ Other: _____ %

CURRENTLY, how much of your normal daily activities are you now able to perform? _____ %

Prior to the onset of your symptoms, how much of your recreational activities were you able to perform? ☐ 100% ☐ Other: _____ %

CURRENTLY, how much of your recreational activities are you now able to perform? _____ %

Prior to the onset of your symptoms, how much of your work activities were you able to perform? ☐ N/A ☐ 100% ☐ Other: _____ %

CURRENTLY, how much of your work activities are you now able to perform? _____ %

When did your symptoms begin? ___/___/___ How did your symptoms begin? _____

What best describes the onset of your symptoms? ☐ Gradual ☐ Sudden ☐ Traumatic ☐ Insidiously ☐ Post-op ☐ Other: _____

For Office/Clinician Use Only:

Please list previous surgeries with (dates): _____

Please list diagnostic tests (X-Ray, MRI, etc.) and results: _____

Please list specialists you have seen for your symptoms: _____

Do you have any of the following medical conditions? ☐ Osteoarthritis ☐ Osteoporosis ☐ Rheumatoid Arthritis
☐ Cancer ☐ Diabetes ☐ Shortness of Breath ☐ Dizziness ☐ High Blood Pressure ☐ Headaches
☐ Asthma ☐ Epilepsy ☐ Infectious Disease ☐ Kidney Disease ☐ Vascular Disease ☐ Cardiac Condition
☐ Multiple Sclerosis ☐ Syncope/Fainting ☐ CVA/Stroke ☐ Other: _____
Do you have any of the following? ☐ Pacemaker ☐ Metal Implant ☐ Joint Replacement *Details:* _____

Have your been recently hospitalized? ☐ Yes ☐ No Dates & Details: _____

Are you currently taking any of the following types of medications? ☐ Pain Medication ☐ Diabetic Medication
☐ Cholesterol Medication ☐ NSAIDS ☐ Cardiac Medication ☐ Antidepressants ☐ Allergy Medication
☐ Muscle Relaxants ☐ Steroids ☐ High Blood Pressure Medication ☐ Other: _____
Do you have a vision or hearing impairment? ☐ Yes ☐ No Describe: _____ Are you pregnant? ☐ Yes ☐ No ☐ N/A

For Office/Clinician Use Only:

Are there any contraindications for treatment we need to be aware of? ☐ Yes ☐ No Describe: _____

What are your goals and expectations from treatment? _____

Welcome 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.

Do you have a medical prescription (or referral) for therapy? YES or NO

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): _____