1844 North University Drive, Coral Springs, FL 33071 Phone: 954-255-1515 Fax: 954-255-1445

Information/Medical History

Name:____ Date:________________________
Date of Birth:_________________ Age:_________ Social Security #:________________________
Sex:____ Male ____ Female
Status:____ Single ____Married ____Other ____Employed ____Student
Emergency Contact:________________________Relationship:______________________________
Email:____
Phone #:__________________________ Mobile Phone#____________________________________
Referring Doctor:_________________________ Primary Care Doctor:_______________________

Auto Accidents and Personal Injury Only
Attorney:____________________________ Phone #:______________________________

Is the patients condition related to: Employment ___Y ___N Auto Accident ___Y ___N Other________
Describe what problem you are seeking treatment for today:__________________________________
____
____

Are you currently or have you in the past Year received Physical Therapy, Occupational Therapy, Speech Therapy of Chiropractic Services from another facility or at home? _____YES ______NO	IF YES: Location:____________________________ When:______________________________ Why:_______________________________

List all Medications you are currently taking:____
____
____

Check the box below if you have had or currently have any of the following conditions, surgeries or diseases:

□ Pacemaker	□ Legally Blind
□ Cancer: Type? When?	□ Hard of Hearing: Do you wear a hearing Aid?
□ Heart Attack: When?	□ Stroke: When?
□ Heart Bypass Surgery	□ Diabetes: How Long?
□ High Blood Pressure Is it controlled?	□ Allergic Reactions: to what?
□ Chest Pain: How often?	□ Seizures: How often?
□ Hip Replacement: When? Right or Left	□ Infections: When? Type?
□ Urinary Incontinence	□ Falls of loss of balance: How many times in the last 6 months?
□ Bowel Incontinence	

Please describe any other diseases, surgeries, conditions or hospitalizations that you have had:________
____
____

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Patient Information Consent Form

Patient Name:______________________ Date:_____________________

I have read and fully understand Health Rehab Plus Notice of Information Practices. I understand that Health Rehab Plus may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that Health Rehab Plus will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Health Rehab Plus' Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____

Patient Signature

I authorize and request my insurance company to pay directly to Health Rehab Plus the amount due for services rendered. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

I understand that I am responsible for any co-payments and/or co-insurance as specified by my insurance carrier. I hereby appoint Health Rehab Plus as my attorney-in-fact for the sole purpose of giving Health Rehab Plus the authorization to do any and all acts necessary to collect payments due on my behalf.

____

Patient Signature

I understand that I have a responsibility to participate in my treatment goals and that certain requirements by me the patient must be followed in order that such treatment goals can be achieved. The procedures, methods, and treatment approaches to be used have been discussed with me and I am consenting to such. The goals for my rehabilitation have been discussed with me and I am in agreement with such. I understand that to achieve my maximum rehab potential, I may be expected to participate in my treatment plan at home.

____

Patient Signature

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Contact Consent Form

I, ___________________________, DOB _____/_____/_____ consent and agree that Health Rehab and staff may contact me and leave voice messages as outlined below. These messages can include appointment information, billing information, information that identifies the practice and any pertinent clinical information. I understand that if I choose the option for callback information only, a message will be left solely with a first name and callback number. I am aware that restrictions placed on where messages can be left may impact clinician and staff ability to contact me with important information.

I wish to be contacted in the following manner (check all that apply):

E-mail messages:
___I consent to messages with detailed information as outlined above.
___Leave messages with first name and callback number only.
___Do not leave email address.

Home telephone number:
___I consent to messages with detailed information as outlined above.
___Leave messages with first name and callback number only.
___Do not leave messages on my home phone.

Work telephone number:
___I consent to messages with detailed information as outlined above.
___Leave messages with first name and callback number only.
___Do not leave messages on my work phone.

Mobile/Cell telephone number:
___I consent to messages with detailed information as outlined above.
___I consent to text messages with detailed information as outlined above.
___Leave messages with first name and callback number only.
___Do not leave messages on my mobile/cell phone.

I request and consent that Health Rehab may contact and leave messages with the following person(s) as indicated:

Name: ____________________________ Relationship:_______________________
Phone: ____________________________
____Leave detailed message
____Leave callback information only

I understand that I may revoke this consent in writing at any time, except to the extent that action had been taken relying on this consent.

Patient Signature: ______________________________ Date: ______________________

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Health Rehab - Health and Wellness Assessment

Instructions - Using the key below, rate how you have been feeling during the past week.

Key: 0-Absent 1-Mild 2-Moderate 3-Marked 4-Severe

1. To what degree has your injury or chronic pain impacted your daily activities? _______
2. Decreased self- esteem or self-confidence, low thoughts about myself. _____
3. I am worried about my physical health. _____
4. I have feelings of hopelessness (things will not get better). _____
5. I have feelings of fatigue, low energy, hard to get going. _____
6. My mood changes very rapidly. _____
7. I feel anxious, nervous or worried. _____
8. I feel rejected by others. _____
9. I wake up in the morning 1-2 hours earlier than I need to. _____
10. I would like to speak with the Health Rehab Plus on call social worker. (Yes/No) ________

Printed Name___________________________

Signature______________________________

Date__________________________________

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Cancellation & No-Show Policy

SOMETIMES YOU JUST HAVE TO CANCEL.

Something unexpected comes up. We understand that. And we know that sometimes you just have to cancel your scheduled appointment. But please keep in mind that there's another patient out there that would love to take your place.

PLEASE GIVE US 24 HOURS NOTICE.

Because appointments are in high demand, we request that you cancel at least 24 hours in advance and as early in the day as possible. This gives other patients an opportunity to receive timely medical care.

CANCELLATIONS AND NO-SHOWS ARE COSTLY FOR EVERYONE.

A no-show is a patient who misses an appointment without canceling with 24 hours notice or, worse, with no notice at all. While there's no penalty for the first two occurrences for a no-show/cancel, a fee of $25 will be charged to the patient's account for each subsequent no-show/cancel. It's a policy that helps us provide timely care for everyone. We thank you for your cooperation and ask that you sign below to indicate that you understand and agree to Health Rehab's no-show policy.

Patient's Signature: _________________________________

Date: ____