ADVANCED REHABILITATION, LLC

Patient's Legal Name: _____
First Middle Last

Patient's Social Security Number: _____ Birth Date: _____ Gender: M / F

Mailing Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Primary Physician: _____ Referring Physician: _____

Patient's Employment/School Status: ☐ Full-time ☐ Part-Time ☐ Student ☐ None

Name of Employer / School _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Responsible Party Demographic Information

Patient's Relationship to Responsible Party: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other: _____

Name of Responsible Party: _____
First Middle Last

Mailing Address: _____ Apt/Suite: _____

City: _____ State: _____ Zip: _____

Birth Date: _____ Gender: ☐ Female ☐ Male Social Security Number: _____

Home Phone: _____ Cell Phone: _____

Emergency Contact Information

Contact Name: _____ Relationship: _____

Phone Number: _____ Phone Number: _____

Authorization to Release and Privacy Policy

- I hereby **authorize payment** directly to Advanced Rehabilitation, LLC for medical services rendered.
- I **authorize the release of my medical information** deemed necessary in the processing of a claim.
- I understand that **I am responsible for the amount billed, regardless of insurance coverage**.
- I understand that 1.5% interest may be added to my bill if I do not make weekly/monthly payments as agreed upon.
- **I have received a copy of Advanced Rehabilitation's HIPAA Policy** (Health Insurance Portability and Accountability Act).

List the name(s) of anyone of whom we are allowed to disclose your medical information with:

1. _____

2. _____

3. _____

SIGNATURE _____ **DATE** _____

Primary Insurance Information

Name of Insurance: _____

Policy Number: _____ Group Number: _____

Patient's Relationship Insured: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other: _____

Name of Responsible Party: _____
First Middle Last

Birth Date: _____ Gender: ☐ Female ☐ Male Social Security Number: _____

Secondary Insurance Information

Name of Insurance:_____

Policy Number: _____ Group Number:_____

Patient's Relationship Insured: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other: _____

Name of Responsible Party: _____
First Middle Last

Birth Date:_____ Gender: ☐ Female ☐ Male Social Security Number: _____

Workers Comp

Name of Insurance: _____

Employer: _____ Phone Number: _____

Claim Number: _____ Injury Date: _____

Adjuster's Name: _____ Phone Number: _____

Injury / Accident Information

Are we treating you for a condition as a result of an accident: ☐ YES ☐ NO Date of Accident or Injury: _____/_____/_____

If YES, what kind of accident? ☐Auto Accident ☐Worker's Compensation ☐School ☐Other _____

Has this injury/problem resulted in liability/litigation? (Is an attorney or third party involved?) ☐ **YES** ☐ **NO**

If yes, please list the contact name(s) and number(s):

_____

_____

_____

Briefly describe accident:

_____

_____

_____

_____

Occupational, Physical, Speech Therapy / Chiropractor Services

Are you currently receiving or have you recently received

Home Health, Hospice, PT, OT, Speech or Chiropractor services?

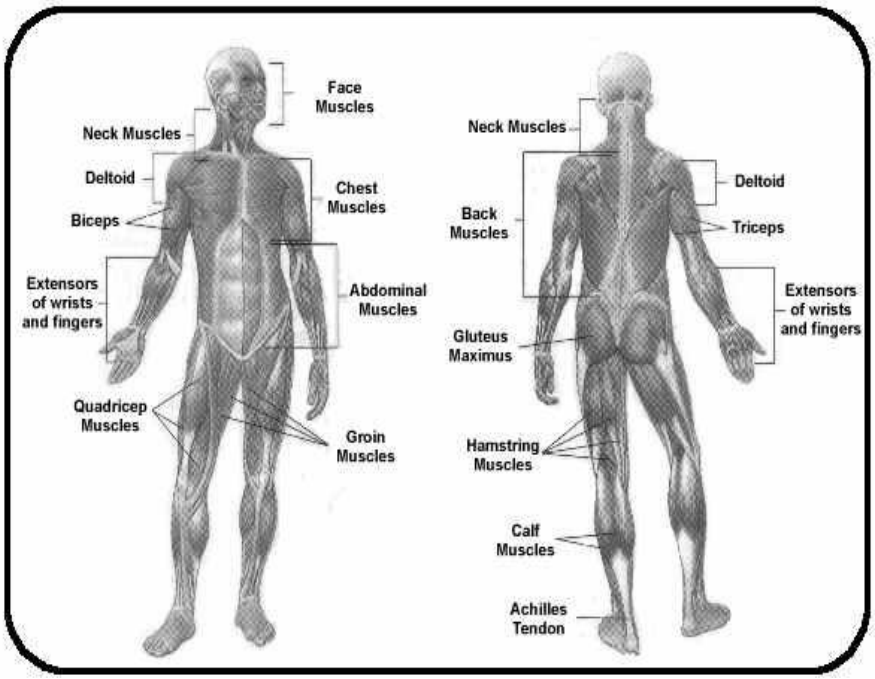
☐ YES or ☐ NO If YES, when/where did you receive these services?

Physical Condition

Please circle any below that best describe the reason you are here today

Left	Right	Both

Neck	**Head**
Upper Back	**Lower Back**
Shoulder	**Hip**
Arm	**Leg**
Elbow	**Knee**
Hand	**Ankle**
Wrist	**Foot**
Finger	**Toe**



Describe Your Pain

What is your pain level?

None 0 1 2 3 4 5 6 7 8 9 10 Severe

How frequent is your pain?

None 0 1 2 3 4 5 6 7 8 9 10 Always

Aching	Numbing	Pressure	Shooting	Throbbing
Burning	Piercing	Radiating	Stabbing	Tightness
Coldness	Pounding	Sharp	Tenderness	Tingling

Treatments / Test / Scans

Circle ANY apply to your visit today:

X-Rays **CT Scan** **MRI** **Physical Therapy** **Injections** **Surgery**

If you circled any of the above, please list when and where these were performed:

_____

_____

_____

_____

_____

Medical History and Medications

<u>* VERY IMPORTANT – PLEASE ANSWER ***</u>**

Do you have a <u>PACEMAKER</u>, an <u>ICD</u> (implantable cardioverter-defibrillators), or any other implanted devise that may be affected by electrical stimulation.

☐ YES ☐ NO

Please check any of the following that apply to your medical history:

- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Gout
- ☐ Heart /Problems
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Poor Wound Healing
- ☐ Rheumatoid Arthritis
- ☐ Other ____________________

Please list <u>ALL</u> medicines you are currently taking:

Medicine Name	**Dosage**	**Route Taken**	**Frequency Taken**
Ex: Neurotin	100 mg	By mouth	2 times a day