Patient Information

PLEASE PRINT

ept REHABILITATION

Diagnosis: _____ **Onset/Injury Date:** _____

Referring Doctor: _____

Patient Information

Patient's Name: _____ Home Phone: _____
(last) (first) (m)

Mailing Address (Apt#/Sp#): _____ Message Phone: _____

City: _____ State: _____ Zip: _____ Sex: M ❑ F ❑

Social Security #: _____ Birthdate: _____ Age: _____

Responsible Party Name/Address: _____

Emergency Contact Name/Phone#: _____

If this case is litigated, please give your attorney's name, address, and phone #: _____

_____

Current Employer: _____ **Employer phone:** _____

Insurance Information

Are you a student? Yes ❑ No ❑ Who is the holder of the policy? Self ❑ Parent ❑ Spouse ❑ Other ❑

Have you had HOME HEALTH SERVICES IN THE LAST 60 DAYS? Yes ❑ No ❑

Primary Insurance: **Medicare Part B** Yes ❑ No ❑	**Secondary Insurance:**
Insurance Name:	**Insurance Name:**
Name of Insured:	**Name of Insured:**

Workers' Compensation Information

Employer at time of injury: _____ Claim #: _____

Compensation Carrier/Address: _____

Phone #: _____ Adjustor Name: _____

Medical Information

Do you have or have you ever had any of the following conditions:

Diabetes	Yes ❑ No ❑	Kidney Problems	Yes ❑ No ❑	Hernia	Yes ❑ No ❑
High Blood Pressure	Yes ❑ No ❑	Nervous Disorders	Yes ❑ No ❑	Seizures	Yes ❑ No ❑
Heart Disease	Yes ❑ No ❑	Allergies to Heat	Yes ❑ No ❑	IUD, Pregnant	Yes ❑ No ❑
Heart Attack	Yes ❑ No ❑	Allergies to Ice	Yes ❑ No ❑	Metal Implants	Yes ❑ No ❑
Pacemaker	Yes ❑ No ❑	Other Allergies	Yes ❑ No ❑	Other: _____	
Headaches	Yes ❑ No ❑	Previous Surgery	Yes ❑ No ❑	_____	

If yes, please explain: _____

Have you had physical/occupational therapy or chiropractic treatments this year? Yes ❑ No ❑ How many? _____

Current Medications: _____

Patient Information Consent: I have read and fully understand *ept*'s Notice of Information Practices. I understand that *ept* 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 *ept* 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 *ept*'s Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

I also authorize *ept* to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

I, the undersigned, give my consent for treatment and authorize the release of information to my physician and/or insurance company so my claim can be processed. I understand that I am financially responsible for Physical/Occupational Therapy charges not covered by my insurance plan, or for the total charges if no insurance applies.

Signature: _____ Date: _____