Attachment B1.003A
Attachment M7.005C

PATIENT INTAKE AND CONSENT FORM

Internal Use Only: A/C# Name A/C Type Office#

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex ☐M ☐F Marital Status ☐S ☐M ☐D ☐W

_____ Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Cell Phone _____

Responsible Party _____ E-mail _____

Address _____ Injury Area _____

City _____ Accident Related: ☐Yes ☐No

Phone Number _____ If Accident: ☐Auto ☐Work ☐Other

Relationship to Responsible Party _____ Nature of Accident _____

SS# _____

Employer _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: ☐M ☐F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? ☐Yes ☐No

Are you receiving or have you received other therapy services? ☐Yes ☐No

(Continued on next page)

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

Internal Use Only: A/C# Name A/C Type Office#

CONSENT TO TREATMENT: I consent to rehabilitation and related services at Decatur Hand & Physical Therapy Specialists . In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature. _____

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. _____

LIABILITY: I know and agree that Decatur Hand & Physical Therapy Specialists is not responsible for loss or damage to personal valuables. _____

WAIVER AND RELEASE: I hereby release, discharge and acquit Decatur Hand & Physical Therapy Specialists , it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.

_____

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. _____

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature_____ Witness Signature_____

DECATUR HAND & PHYSICAL THERAPY SPECIALISTS
MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____
REFERRING PHYSICIAN'S NAME: _____ DATE OF NEXT MD APPT: _____
CAUSE OF INJURY OR ONSET: _____ DATE OF INJURY OR ONSET: _____
ARE YOU PRESENTLY WORKING? Y ES NO

DO YOU CURRENTLY HAVE ANY "FLU TYPE" SYMPTOMS (I.E. FEVER, COUGHING)? YES NO
IF YES, WHAT SYMPTOMS: _____

DO YOU HAVE ANY OPEN CUTS, LESIONS OR WOUNDS? YES NO IF YES, WHERE: _____

HAVE YOU FALLEN IN THE PAST YEAR? (circle one) YES NO IF YES, HOW MANY TIMES: _____

IF YES TO FALLING, DID YOU SUSTAIN AN INJURY AS RESULT OF THE FALL? YES NO _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR

DO YOU USE TOBACCO? (circle one) YES NO, IF YES, HOW MUCH? _____

DO YOU WEAR GLASSES / CONTACTS?: YES NO

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN_____
AND WHY_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE? / WHAT WERE THE RESULTS?:
_____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: (If have a list of medications, please give to front office to photocopy) ☐ See List
_____
_____

ALLERGIES: _____
ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction_____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction_____

DO YOU CURRENTLY HAVE OR HAVE A HISTORY OF ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- □ ANEMIA
- □ ARTHRITIS
- □ CANCER
- □ CARDIOVASCULAR PROBLEMS
- □ HOLTER MONITOR - currently wearing?
  - □ PACEMAKER
  - □ HIGH BLOOD PRESSURE □ controlled □ uncontrolled
- □ LOW BLOOD PRESSURE
- □ CURRENTLY PREGNANT
- □ DIABETES □controlled □uncontrolled
- □ DEPRESSION
- □ DIZZINESS/FAINTING
- □ FRACTURES
- □ HEADACHES
- □ HEPATITIS/HIV
- □ KIDNEY PROBLEMS
- □ MRSA (Methicillin Resistant Staphylococcus Aureus)
- □ OSTEOPOROSIS
- □ RESPIRATORY PROBLEMS
  - □ ASTHMA □ controlled □ uncontrolled
  - □ COPD □ controlled □ uncontrolled
  - □ Other
- □ SEIZURES □ controlled □ uncontrolled
- □ THYROID PROBLEMS
- □ BLOOD THINNERS (Anticoagulants)

If checked any above, explain: _____

☐ ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____Date_____

APPOINTMENT AND CANCELLATION POLICY

At **Decatur Hand & Physical Therapy Specialists**, our goal is to provide quality Physical and Occupational therapy care in a timely manner. We have implemented an appointment/cancellation policy which enables us to better utilize available appointments for our patients in need of care.

We understand that everyone is busy and it is easy to forget appointments. As a courteous to you, we will contact you 24-48 hours prior to your appointment for confirmation. Please let us know your preference(s) of how to contact you.

___ Cell Phone: ( )_____
___ Home Phone ( ) _____
___ Work Phone ( ) _____
___ Text ( ) _____
___ Email _____

Cancellation Policy

Please be courteous and call Decatur Hand & Physical Therapy Specialists promptly if you are unable to attend an appointment. If it is necessary to cancel your scheduled appointment, we require that you give **at least 24 hours notice.** Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely care.

Not cancelling your appointment or late cancellations can be costly. When you miss a scheduled medical appointment, or if you cancel it **less than 24 hours**, we consider it as "**no show**". Missing more than 2 scheduled appointments without advance notice may result in scheduling your future appointments on a day to day to basis or cancellation of future appointments.

I hereby acknowledge that I have read and understand the above cancellation and no show policy and that I agree by these guidelines

_____ _____
Patient Signature Date