



Patient Intake Sheet
PLEASE PRINT CLEARLY AND COMPLETE ALL SECTIONS

Patient Information			
Last Name	First Name	Middle Initial	Date of Birth
Street Address			Suite or Apt. #
City	State	Zip	Social Security Number
Home Phone	Work Phone	Cell Phone	
E-Mail Address	Martial Status	Employment Status	
Employer/School Name		Title/Position	
Employer/School Address			

Referring Physician Information		
Physician's Name	Address	Phone

Primary Care Physician Information		
Physician's Name	Address	Phone

In Case of Emergency Please Contact			
Last Name	First Name	Relationship	
Address	City	State	Zip
Home Phone	Work Phone	Cell Phone	

Reason For Today's Visit:		How did you hear about us? Doctor ___ friend ___ other _____	
<input type="checkbox"/> Job <input type="checkbox"/> Car <input type="checkbox"/> Home <input type="checkbox"/> Other Accident		<input type="checkbox"/> Yes <input type="checkbox"/> No	
Is this Injury/Condition Related to?		Do you have Med Pay Coverage through your Auto Insurance?	
Date of Accident or Injury		Date of Illness or First Symptom	
Name of Insurance Adjuster or Contact		Phone Number	
Please Briefly Describe your injury/accident/illness			
Attorney Name		Number	



RESPONSIBLE PARTY STATMENT				
As the Responsible Party, I agree that all charges not directly paid by my insurance company will be my responsibility.				
Responsible Party's Signature		Social Security Number	DOB	Today's Date
Primary Insurance Information				
Primary Insurance Company		ID Number	Group Number	
Address For Claims		City	State	Zip
Policy Holder (if other than the patient)		Sex	DOB	
Social Security Number		Phone Number	Relationship to the Patient	
Address (of policy Holder)		City	State	Zip
Employer (of Policy Holder)				

Sovereign Rehabilitation Payment Policy	
We are happy to extend our services by filing your primary and secondary insurance for you. Please select from the following payment choices.	
<input type="checkbox"/>	SELF PAY: Please pay the balance in full at the time of service. In the event that you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with an agency or attorney for collection
<input type="checkbox"/>	WORKERS' COMPENSATION: We will bill your Workers' Compensation Carrier for your charges. Please note that you will remain financially responsible for any and all charges if your carrier denies coverage or your claim is controverted.
<input type="checkbox"/>	PRIMARY AND SECONDARY INSURANCE: We will bill your primary and secondary insurance carriers. We assume payment of insurance benefits is not forthcoming on charges older than 60 days. Charges outstanding for more than 60 days from the date of filing will be due in full from you regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been fully processed by your insurance carrier.
PLEASE BE AWARE THAT WE REQUIRE PAYMENT FOR ALL MONIES DUE THAT YOUR INSURANCE WILL NOT COVER AT THE TIME OF SERVICE	
All supplies are payable at the time of service and cannot be charged to your insurance carrier. However, we will file for any covered supplies allowed by your insurance carrier. Supplies are non refundable.	
Thank you for allowing us the opportunity to serve you!	

I hereby assign all medical benefits to which I am entitled to Sovereign Rehabilitation in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable cost associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees and all court costs and additional legal fees associated with the recovery of this debt. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Sovereign Rehabilitation as may be directed by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.	
Authorized Signature	Today's Date



Sovereign Rehabilitation, LLC
Notice of Patient Information Practices
Revised January 14, 2011

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Sovereign Rehabilitation, LLC

Sovereign Rehabilitation is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Sovereign Rehabilitation uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Sovereign Rehabilitation may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Other times we may need to answer a request from a group health plan or insurer that may require PHI to be shared with the sponsor of the plan. Certain aspects of our services are performed through contracts with outside persons or organizations, such as auditing, credentialing, outcomes data collection, social service screening, etc. At times it may be necessary to have your medical record reviewed by one or more of these Business Associates or organizations. At all times, we require our business associates to safeguard the privacy of your information.

Sovereign Rehabilitation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of others. Any disclosure, however, would only be to someone able to help prevent the threat. We may provide de-identified information for research studies. We also provide information when required by law.

In any other situation, Sovereign Rehabilitation's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time. If your request hinders the quality of care, according to the law we reserve the right to deny your request.

Sovereign Rehabilitation may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic and updated on our website www.sovereignrehab.com. You may also request an updated copy of our Notice of Information Practices at any time either electronically or for a paper copy. For an electronic copy you may download it from our website sovereignrehab.com. A paper copy may be obtained from any clinic location.



PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time through confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the Business manager at the location where you are attending therapy. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances Sovereign Rehabilitation will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them. To request restrictions, you should contact the Business manager in the appropriate location to obtain and complete the required form. In your request you must tell us 1) what information you want to limit; 2) whether you want to limit our use, disclosure or both; 3) to whom you want the limits to apply

Further information about this Notice, if you have privacy issues, or if you believe that your privacy rights have been violated, you may please contact us at the Privacy Officer, Sovereign Rehabilitation 678-674-1711 or you may also notify the Secretary of the Department Of Health and Human Services if you believe that your privacy rights have been violated. You will not be penalized for filing a complaint with either party



PATIENT INFORMATION CONSENT FORM

I have read and fully understand Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that Sovereign Rehabilitation may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation of 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 company in writing. I also understand that Sovereign Rehabilitation will consider request for restriction on a case-by-case basis, but does not have to agree with the request for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Sovereign Rehabilitation's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the Company in writing at any time.

Patient Name (PRINT) _____ Date: _____

Signature: _____

I can be contacted in the following manner:

_____ o.k. to send a text message to my cell phone _____.

_____ o.k. to email my email address at _____.

APPROVED PARTIES

I hereby authorize one or all of the designated parties listed below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature _____ Date: _____



PATIENT NAME: _____ DATE OF BIRTH: ___/___/___

AREA OF SYMPTOMS: _____ MALE FEMALE

OCCUPATION: _____ HOBBIES: _____ HEIGHT _____ WEIGHT _____

MEDICAL HISTORY

Anxiety	<input type="radio"/> Yes <input type="radio"/> No	Circulation Problems	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No
Speech Problems	<input type="radio"/> Yes <input type="radio"/> No	Currently Pregnant	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No
Allergies	<input type="radio"/> Yes <input type="radio"/> No	Depression	<input type="radio"/> Yes <input type="radio"/> No	Metal Implants	<input type="radio"/> Yes <input type="radio"/> No
List:		Due to: Injurv Financial Other		Where?	
Arthritis	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Dizzy Spells	<input type="radio"/> Yes <input type="radio"/> No	Seizures	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Conditions	<input type="radio"/> Yes <input type="radio"/> No	Fractures	<input type="radio"/> Yes <input type="radio"/> No	Strokes	<input type="radio"/> Yes <input type="radio"/> No
Cardiac Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Gallbladder Problems	<input type="radio"/> Yes <input type="radio"/> No	Vision Problems	<input type="radio"/> Yes <input type="radio"/> No

Describe any other conditions , allergies, chronic conditions, or precautions: Please also list any results from recent x-rays or tests.

Fall History

Injury as a result of a fall in the past year? Yes No Date of Fall: _____
 Two or more falls in the last year? Yes No Dates of Falls: _____

Surgical History

Body Region: _____ Surgery Type: _____ Date of Surgery: _____
 Body Region: _____ Surgery Type: _____ Date of Surgery: _____
 Body Region: _____ Surgery Type: _____ Date of Surgery: _____
 Body Region: _____ Surgery Type: _____ Date of Surgery: _____
 Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Current Medications - including OVER THE COUNTER medications you have taken in the past week

Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____
 Drug: _____ Dosage: _____ Reason for Taking: _____

Please **Check(v) yes** for any of the following whose care you are under?

List the providers name in the space provided.

Medical Doctor(MD) _____
 Dentist _____
 Psychiatrist/Psychologist _____
 Chiropractor _____
 Cardiologist _____
 Other _____

Would you like to speak to a social worker ? Yes No

1. How would you rate your ability to perform routine daily activities:
 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
 Unable to perform No Problems

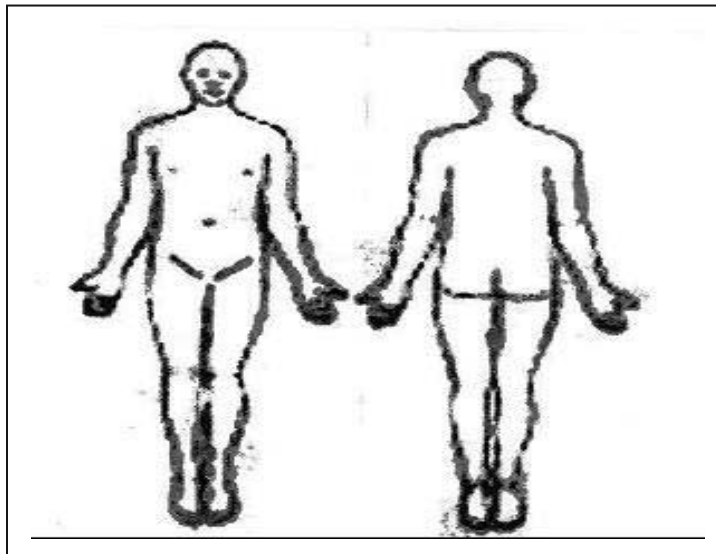
2. How would you rate your ability to perform activities associated with your job:
 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
 Unable to perform No Problems

3. How would you rate your current pain:
 0 1 2 3 4 5 6 7 8 9 10
 None Emergency Room

4. How many days since your current injury? _____

Please draw you pain on the body to the right using the following symbols.

- /// Stabbing Pain
- XXX Burning
- 000 Pins and Needles
- === Numbness



Patient Signature: _____ Date: _____

Therapist Signature: _____ Date: _____



Cancellation & No Show Policy:

As our goal is to meet the needs of our patients, we will make every effort to schedule your appointments as efficiently as possible. **It is your responsibility to make every effort to keep your scheduled appointment and to arrive promptly at the scheduled time.** We do realize that unanticipated events can occur and may prevent you from keeping your appointment. In fairness and consideration to the other patients that need to be seen as soon as possible, we hereby request that you notify our office immediately when you realize you will not be keeping your appointment.

If you need to cancel or reschedule your appointment, you must do so at least **24 hours before your schedule office visit to avoid paying a \$20.00 fee.** This is **NOT** covered by your medical insurance or Workers Compensation benefits. This notice of 24 hours is necessary so that we may schedule other patients needing immediate appointments.

This cancellation/ rescheduling fee must be paid on or before your next scheduled appointment.

Thank you for your attention to this matter.

Special Note: Worker's Compensation patients, please note that we will need to notify your adjuster and/or Nurse Case Manager in the event that you cancel/ reschedule your appointment.

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

Patient Signature

Date



Supply or Procedure Waiver Form

Date: _____

Patient Name: _____

Uncovered supply or Procedure with Code: _____

Amount Owed by Patient: _____

By signing below I understand that the above stated supply or procedure is not covered by my insurance plan through Sovereign Rehabilitation. I understand that I will be responsible for the payment in full of the above item at the time of service. I also understand that I agree not to bill the above procedure through my insurance since it is not a covered expense for Sovereign Rehabilitation.

Patient Signature

Date

Front Desk Signature

Date