Sovereign Rehabilitation

Patient Intake

Patient Contact Information			
Patient Name		Today's Date:	
Address		Gender:	Female or Male (circle one)
City, State, Zip		SSN:	
Home Phone		Marital Status:	Single Married/Partner Divorced Widowed
Cell Phone		Email:	
DOB, Age:		Student:	Yes/No (circle one), Full or part time?
Referring Physician:		Primary Care Physician:	

Other Contact Information			
Emergency Contact:		Phone:	
Relationship to Pt.:			

Employer Information			
Employment Status:	Employed: Full time / Part time Other (please describe):		
Employer Name:		Phone:	
Address:			

Responsible Party Information			
Guarantor Name:		Primary Phone:	
Address:		Work Phone:	
		SSN:	
Employer:		DOB, Age:	
		Relationship to Patient:	

Are you on Medicare, a Medicare replacement plan, or have Medicare as a secondary insurance? **(Circle One) YES or NO**

Primary Insurance Information			
Carrier Name:		Phone:	
Policy Number:		Group Number:	
Policy Holder:		Relationship to Patient:	
Policy Holder DOB:			

Do you have a secondary insurance in addition to the insurance information listed above? (Circle One) YES or NO

Secondary Insurance Information			
Carrier Name:		Phone:	
Policy Number:		Group Number:	
Policy Holder:		Relationship to Patient:	

Authorization Information		
I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment.		I authorize payment of medical benefits to the provider or supplier for services described:
Signed:	**Date:**	**Signed:**

I authorize this organization to leave a message on my answering machine.	**(Circle One) YES or NO**
I authorize this organization to TEXT appointment reminders.	**(Circle One) YES or NO**
I authorize this organization to EMAIL appointment reminders	**(Circle One) YES or NO**
Signed:	**Dated:**

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.

Signed:	**Dated:**

HOW DID YOU HEAR ABOUT US? DOCTOR FRIEND WEBSITE ATTORNEY OTHER

If other, please specify:

Reason For Today's Visit (Please Briefly Describe your injury/accident/illness)	
How did you hear about us??	
Circle those that apply: Doctor Friend Family member Website Insurance Co. Attorney Other:	
Is this Injury/Condition related to an accident?	Where did the accident occur?
Yes or No (Circle One)	Work Car Other (Circle One)
Do you have Med Pay Coverage through Auto Insurance?	If "Other" please explain:
( ) Yes ( ) No	
Date of Accident or Injury	Date of Illness or First Symptom
Name of Insurance Adjuster or Contact (if applicable)	Phone Number
Name of Attorney (if applicable)	Phone Number

Sovereign Rehabilitation Payment Policy

Please select from the following payment choices by initialing the box to the left of the payment choice you make.

	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
	PRIMARY AND SECONDARY INSURANCE: We will bill your primary and secondary insurance carriers that you have listed above. 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.
	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.

PLEASE BE AWARE THAT WE REQUIRE PAYMENT FOR ALL MONIES DUE 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.

Cancellation and 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 $25.00 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.

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. I acknowledge that there is a $25 late fee for missed/late cancel (without 24 hours' notice) appointments. I acknowledge that cancellation fees are my financial responsibility and are not covered by insurance.

Signed:	**Dated:**

Notice of Patient Information Practices

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.

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 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.

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. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS
You have the right to review or obtain a copy of your personal health information at any time. 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.

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 or carrying out treatment, obtaining payment, evaluation 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.

Signed:	**Date:**

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. I authorize this organization to discuss my condition with the person/s listed.	
Authorized Designees:	
Name:	Relationship:
Name:	Relationship:
Signed:	**Date:**

MEDICARE PATIENTS ONLY			
What is the retirement date of the Medicare policy holder?			
Have you had Home Health Services in this calendar year?		**(Circle One) YES or NO**	
Have you had therapy services with another company this year?		**(Circle One) YES or NO**	
MSP (Medicare Secondary Payer): This form must be completed by every Medicare patient upon admission and subsequent readmission.			
Was your current condition related to:			
An Automobile accident?	**(Circle One) YES or NO**	An accident at home?	**(Circle One) YES or NO**
A work related accident?	**(Circle One) YES or NO**	If not at home, where?	
Any other accident for which another party may be held responsible (liability insurance)?			**(Circle One) YES or NO**
If none of the above, please explain how the injury happened:			
If you answered yes to any of the above questions, please supply the following information:			
Date of accident:			
Name and address of the responsible party, their liability insurance, or auto insurance company:			
Date their insurance was billed:			
Name and address of attorney (if one is involved):			
Signed:		**Date:**	

Notice of Exclusions from Medicare Benefits (NEMB) 2016

There are items and services for which Medicare will not pay.

- Medicare does not pay for all of your healthcare costs. Medicare only pays for covered benefits. Some items and services are not Medicare benefits and Medicare will not pay for them.
- Medicare is an 80/20 plan which means Medicare covers 80% of covered charges and you or your supplement policy will be responsible for the remaining 20%.
- When you received an item or service that is not a Medicare benefit, you are responsible to pay for it personally or through any other insurance that you might have.

Each calendar year, there is a limit on the dollar amount that Medicare will pay for outpatient therapy services rendered at a free standing, outpatient physical therapy clinic. The limits for 2016 are the following:

- **Physical therapy & Speech Therapy Combined: $1960.00**
- **Occupational Therapy: $1960.00**

For costs of therapy rendered here that go beyond this dollar amount, you must personally pay for it. You may also use any other insurance that you might have.

Each beneficiary who uses therapy services will find the total dollar amount that counted towards the yearly limits on your Medicare Summary Notice that is sent to you by Medicare.

****If you have signed up for an additional Medicare HMO/PPO plan, please let us know TODAY.**

Signed:	**Date:**

PATIENT NAME: _____ CURRENT AGE: _____
AREA OF SYMPTOMS:_____
OCCUPATION:_____HOBBIES:_____HEIGHT_____ WEIGHT_____

MEDICAL HISTORY

Describe any other conditions, allergies, chronic conditions, or precautions:

Allergies	O	Yes	O	No	Dizzy Spells	O	Yes	O	No	MRSA	O	Yes	O	No
Anemia	O	Yes	O	No	Emphysema/Bronchitis	O	Yes	O	No	Multiple Sclerosis	O	Yes	O	No
Anxiety	O	Yes	O	No	Fibromyalgia	O	Yes	O	No	Muscular Disease	O	Yes	O	No
Arthritis	O	Yes	O	No	Fractures	O	Yes	O	No	Osteoporosis	O	Yes	O	No
Asthma	O	Yes	O	No	Gallbladder Problems	O	Yes	O	No	Parkinsons	O	Yes	O	No
Autoimmune Disorder	O	Yes	O	No	Headaches	O	Yes	O	No	Rheumatoid Arthritis	O	Yes	O	No
Cancer	O	Yes	O	No	Hearing Impairment	O	Yes	O	No	Seizures	O	Yes	O	No
Cardiac Conditions	O	Yes	O	No	Hepatitis	O	Yes	O	No	Smoking	O	Yes	O	No
Cardiac Pacemaker	O	Yes	O	No	High Cholesterol	O	Yes	O	No	Speech Problems	O	Yes	O	No
Chemical Dependency	O	Yes	O	No	High/low Blood Pressure	O	Yes	O	No	Strokes	O	Yes	O	No
Circulation Problems	O	Yes	O	No	HIV/AIDS	O	Yes	O	No	Thyroid Disease	O	Yes	O	No
Currently Pregnant	O	Yes	O	No	Incontinence	O	Yes	O	No	Tuberculosis	O	Yes	O	No
Depression	O	Yes	O	No	Kidney problems	O	Yes	O	No	Vision Problems	O	Yes	O	No
Diabetes	O	Yes	O	No	Metal Implants	O	Yes	O	No					

Fall History

Injury as a result of a fall in the past year? O Yes O No Date of Fall:_____

Two or more falls in the last year? O Yes O 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: (if you brought a copy of your medications, please allow the front desk to make a copy)

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:_____

Are you a smoker? YES NO If yes, approx. how many packs a day do you smoke?:_____
Do you have any metal implants or pacemaker? YES NO if yes, where:_____
FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

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

____ 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

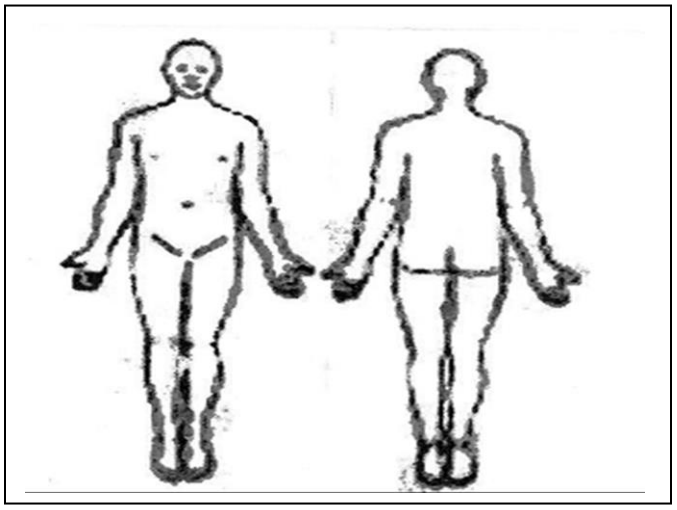
2. How would you rate your ability to perform activities associated with your job:
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   Unable to perform No Problems

3. How would you rate your **CURRENT** level of 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 your 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:_____