



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	() Single () Married () Other	() Employed () Student () Other	
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	
() Job () Car () Home () Other Accident	() Yes () 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 STATEMENT

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.

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

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.

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 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
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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.

Patient Name (PRINT)_____ Date:_____

Signature:_____

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:_____



**Sovereign Rehabilitation, LLC
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.



Medical History Form

Name: _____ Male__ Female__ Height _____ Weight _____
Occupation: _____ Hobbies: _____

Have you **at any time** been diagnosed as having and of the following conditions?

Check(v) yes

- | | |
|---|---|
| <input type="checkbox"/> Cancer. If yes what kind? _____ | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Circulatory Problems | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Other Arthritic conditions |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema/ Bronchitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chemical Dependency (i.e., alcoholism) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> High Blood Pressure | |

Has anyone in your immediate family (parents and siblings) ever been treated for any of the following conditions? **Check(v) yes**

- | | |
|---|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Chemical Dependency(i.e., alcoholism) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Kidney Disease | |

Which of the following OVER-THE-COUNTER medications have you taken in the last week?

Check(v) yes

- | | |
|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Antihistamines |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Antacid |
| <input type="checkbox"/> Advil/ Motrin/ Ibuprofen | <input type="checkbox"/> Vitamins Supplements |
| <input type="checkbox"/> Laxatives | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Decongestants | |

Please list any **prescription** pills, injections and/or skin patches you are currently taking?

1 _____ 2 _____ 3 _____

4 _____ 5 _____ 6 _____

7 _____ 8 _____ 9 _____

List any medication(s) you are allergic to: _____

Are you latex sensitive? YES NO Are there any other allergies that we should know about?



List any medication(s) you are allergic to: _____

Are you latex sensitive? YES NO Are there any other allergies that we should know about?

If so what? _____

Do you have any metal implants or a pacemaker? YES NO If yes, where: _____

FOR WOMEN: Are you currently pregnant or think you might be pregnant? YES NO

Have you recently noted any of the following? **Check(v) yes**

- ___ weight loss/gain
- ___ nausea/ vomiting
- ___ dizziness/lightheadedness
- ___ fatigue
- ___ weakness
- ___ fever/chills/sweats
- ___ numbness or tingling

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

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

Please list any surgeries or other conditions for which you have been **hospitalized**, include the approximate date and reason.

1 _____ 2 _____

3 _____ 4 _____

5 _____ 6 _____

Please describe/date any fractures, dislocations, and/ or sprains that we should know about.

1 _____ 2 _____

3 _____ 4 _____

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