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 (if patient is responsible party, skip to primary insurance)			
Guarantor Name:		Primary Phone:	
Address:		Work Phone:	
		SSN:	
Employer:		DOB, Age:	
		Relationship to Patient:	

Primary Insurance Information (skip this section if provided desk with insurance card)			
Carrier Name:		Phone:	
Policy Number:		Group Number:	
Policy Holder:		Relationship to Patient:	
Policy Holder DOB:			

Secondary Insurance Information (skip this section if provided desk with insurance card)			
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. Therapeutic intervention may include dry needling as discussed with my physical therapist if appropriate for my condition. This consent is intended as a waiver of liability for any and all such treatment excepting acts of negligence.

Signed: **Dated:**

HOW DID YOU HEAR ABOUT US? (circle one) DOCTOR FRIEND WEBSITE ATTORNEY OTHER

If other, please specify: ______________________________

Reason For Today's Visit (Please Briefly Describe your injury/accident/illness)	
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 ($50.00 for patients participating in the Schroth program)**. 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 ($50 for patients participating in Schroth) for missed/late cancel (without 24 hours' notice) appointments. I acknowledge that cancellation fees are my financial responsibility and are not covered by insurance.

COVID-19 UPDATE: For the safety and well-being of you, our patients, and our employees, if during your course of therapy, you experience any of the following symptoms, please call to let us reschedule your appointments: Fever (Temperature 100°F or greater), any respiratory illness such as cough or difficulty breathing.

Signed:	**Dated:**

HIPAA Notice of Privacy Practices

YOU SHOULD HAVE BEEN PROVIDED WITH A COPY OF OUR HIPAA POLICIES AT CHECK-IN. IF YOU WOULD LIKE A COPY OF THE POLICIES, WE WILL GLADLY PROVIDE YOU ONE TO KEEP FOR YOUR RECORDS.

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES	
I acknowledge that I have received a copy of Sovereign's Notice of Privacy Practices. The Notice of Privacy Practices provides information about how Sovereign may use and disclose your health information. I understand that the Notice is subject to change.	
Name of Patient (Printed):	
Signed:	**Date:**
Signature of Personal Representative: (eg. Attorney-in-fact, guardian, parent if a minor)	**Relationship:**

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) 2021

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 2021 are the following:

- **Physical therapy & Speech Therapy Combined: $2110.00**
- **Occupational Therapy: $2110.00**

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:

Condition			Condition			Condition		
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

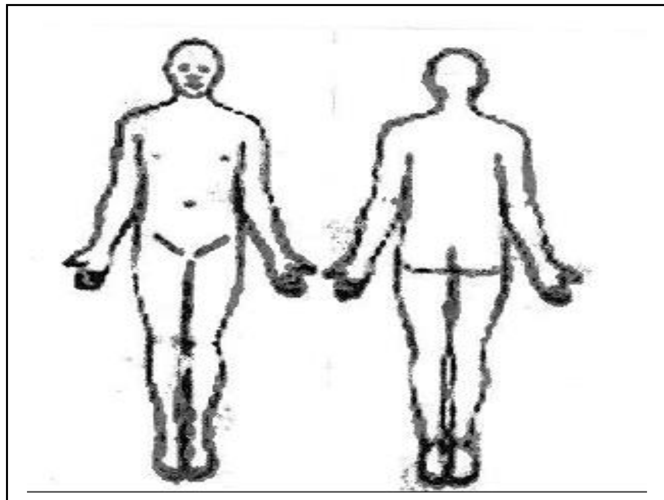
2. How would you rate your ability to perform activities associated with your job:
   0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
   Unable to perform No Problems

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:_________________________