



Center For Rehabilitation and Fitness
22255 Greenfield Road, Suite 118
Southfield, Michigan 48075-3728
(248) 849-3907
FAX: 248-849-5737

Today's Date: _____ S.S. #: _____

NAME (as it appears on your driver's license): _____

Date of Birth: _____ Sex: M F Marital Status: _____

Home Address: _____ City: _____ State: _____

Home Phone: _____ Alternate Phone: _____

Zip Code: _____ Is a Nurse or Therapist currently coming to your home? Yes No
(IF THE ANSWER TO ABOVE IS YES-SEE FRONT OFFICE STAFF BEFORE CONTINUING)

Employer: _____ Work Phone: _____

Occupation: _____

Primary Medical Insurance: _____ Subscriber's Name: _____

SS#/ID#/Contract#: _____

Subscriber's Employer: _____ Subscriber's Birth date: _____

Secondary Medical Insurance: _____ Subscriber's Name: _____

Subscriber's Employer: _____ Subscriber's Birth date: _____

Is your name written the same on your insurance card as it is on your driver's license? Y N
If not, how is it written? _____

Primary Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Is your treatment due to a work related injury or accident? Yes No Where and When Injury Occurred

Is your treatment due to an auto accident? Yes No

If this is a Workman's Compensation or Auto Accident Claim, complete the following information:

Company Name: _____ Claim # _____

Company address: _____ City/Zip: _____

Contact Name: _____ Phone: _____



PROVIDENCE

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For Patients with MEDICARE INSURANCE, please complete the following:

Are you covered under Black Lung, V.A. or other Federal Grant? Yes No

Are you currently employed? Yes No

Are you receiving Medicare for a disability? Yes No

Disability Date: _____

Are you covered under your Employers Group Health Plan (EGHP)? Yes No

Is your spouse currently employed? Yes No

IF yes, are **you** covered under your spouse's EGHP? Yes No

Are you covered under anyone else's EGHP? Yes No

Are you receiving Kidney Dialysis? Yes No

Are you receiving Medicare due to Kidney Dialysis? Yes No

Is a Nurse or Therapist **coming to your home** currently? **YES NO**

(IF THE ANSWER TO ABOVE IS YES – PLEASE SEE FRONT OFFICE BEFORE CONTINUING)

Thank you for providing us with the most complete and up to date information for us to appropriate bill for your services. Please understand it is your responsibility to know what is covered under your insurance policy. We are aware of which insurance's are accepted through Providence, but unfortunately this does not give us a guarantee of payment. We will inform you if we believe any treatment will not be covered.

FOR OFFICE USE ONLY. REGISTRAR INITIALS WHEN COMPLETED.

Address verified in Invision?		Insurance Correct in Invision?	
Unpaid balance screen printed?		Rx and Ref. Exp Date in QA?	
HIPAA Date entered in Invision?		CoPay and Advanced Directive Explained?	
Primary and Referring MD entered?		If applicable, unpaid balance addressed?	

Rehabilitation Services Attendance Policy

- _____ 1. I agree to call to cancel my appointments at least 24 hours in advance.
- _____ 2. I agree that I will be no more than 15 minutes late for my appointments. I understand that arriving late will be considered a "no show" and that my treatment time may be limited or possibly not provided.
- _____ 3. I agree not to schedule a vacation or extended leave of absence for the duration of my scheduled treatment sessions.
- _____ 4. I understand that a **total of two (2)** cancellations and/or "no shows" will result in discharge from therapy. I understand that my physician will be notified of my failure to show for appointments and the resultant discharge from therapy.
- _____ 5. I will **refrain** from using my **Cell Phone** during my sessions as to not interfere with my treatment time or other equipment usage.

P.T. Days: _____ Time: _____ O.T. Days: _____ Time: _____
 SP. Days: _____ Time: _____

Advance Directive Notification

_____ I have been informed of my right to have an Advance Directive and have been offered the Advance Directive Policy pamphlet.

Co-Pay and/or Deductible Notification

While we make every attempt to verify the co-pays and deductibles your insurance requires, **YOU ARE RESPONSIBLE** to know your level of financial responsibility for co-pay and deductibles. These amounts are our best estimate of your costs based upon the information available to us.

_____ I have been informed that my insurance requires me to pay a co-pay of _____ per _____.

_____ I have been informed that my insurance requires me to pay a deductible of _____.

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____



GENERAL CONSENT TO OUTPATIENT TREATMENT

CONSENT TO PHYSICIAN OFFICE, CLINIC, OR OUTPATIENT SERVICES

I request and authorize physician office, clinic, or outpatient care as my physician, his assistants or designees (collectively called "the physicians") may deem necessary or advisable. This care may include, but is not limited to, routine diagnostic radiology and laboratory procedures, administration of routine drugs, biologicals and other therapeutics, and routine medical and nursing care. I authorize my physician(s) to perform other additional or extended services in emergency situations if it may be necessary or advisable in order to preserve my life or health. I understand that my (the patient's) care is directed by my (the patient's) physicians, and that other personnel render care and services to me (the patient) according to the physicians' instructions.

I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of such diagnostic procedure or treatment.

I understand that samples of body fluids and/or tissues may be withdrawn from me (the patient) during routine diagnostic procedures. I authorize the facility to perform other tests on these body fluids and/or tissues in order to further medical research and knowledge and/or to dispose of these fluids and tissues. If the specimen contains fetal tissue and you do not select a private funeral home, then SJHS may send the tissue to the funeral home providing service to SJHS where it will be cremated with other tissue from SJHS.

I authorize the facility to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including but not limited to **commercial pharmacies i.e., Walgreen, CVS and other drug treatment records** for verification of my medications.

I have been informed and understand that HIV (human immunodeficiency virus)/AIDS and HBV (hepatitis B virus) test may be performed on me without my consent if a health professional, facility employee or First Responder sustains an exposure to my blood or other body fluid.

ASSIGNMENT OF INSURANCE BENEFITS

Medicare Certification: I certify that the information provided by me in applying for payment under Title XVII of the Social Security Act is correct and request payment on my behalf of all authorized benefits.

I hereby authorize and instruct my insurance carrier to make payment directly to the facility benefits otherwise payable to me. **I agree to personally pay for any facility or physician charges that are not covered by or collected from any applicable insurance program, including any deductibles and coinsurance amounts.**

PERSONAL VALUABLES

I understand that I (the patient) am responsible for any and all personal valuables that I bring with me to the facility, clinic or physician's office. I hereby release the facility, clinic or physician's office from any liability for the loss or damage of any and all personal possessions which I choose to keep with me during my care and treatment.

TEACHING INSTITUTION

I have been informed and understand that this facility is affiliated with a teaching institution and the procedures performed may require observation, cooperation, and services of multiple health care providers. I authorize residents and/or students to participate in my care.

I HAVE HAD THE OPPORTUNITY TO READ THIS FORM (OR HAVE IT READ TO ME), ASK QUESTIONS AND HAVE THESE QUESTIONS ANSWERED.

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

The St. John Health Notice of Privacy Practices provides information about how protected health information about me (the patient) – including information about human immunodeficiency virus (HIV), AIDS-related complex (ARC); and acquired immunodeficiency syndrome (AIDS); and including substance abuse treatment records protected under the regulations in 42 Code of Federal Regulations, Part 2, if any; and psychological and social services records, including communications made by me to a social worker or psychologist (if any) – may be used and disclosed. I have been offered an opportunity to review the Notice before signing this consent. I understand that the terms of the Notice may change and that I may obtain a revised copy by accessing the St. John Health website at www.stjohn.org or by contacting the Privacy Officer listed in the notice.

I understand that I have the right to request restrictions on how my protected health information is used or disclosed for treatment, payment or health care operations. My physicians and the facility are not required to agree to this restriction, but if they agree, they will be bound by the agreement.

By signing this form, I acknowledge that I have been offered and/or received the St. John Health Notice of Privacy Practices.

Name of Patient (print) _____

Signature of Patient _____

Date _____

Signature of Spouse _____

Date _____

Signature of Witness _____

***Consent of Legal Guardian, Patient Advocate or Nearest Relative if Patient is Unable to Sign
or is a Minor***

Signature of Guardian, Patient Advocate or Nearest Relative _____

Date _____

Relationship _____

Address _____

Phone Number _____

Signature of Witness _____

Medical History Information:	Patient Name:	MR#:	Comments	Comments
Heart Attack/ Congestive Heart Failure/pacemaker	Yes / No		Smoking	Yes / No
Cancer	Yes / No		Alcohol	Yes / No
Diabetes	Yes / No		Present Weight	
Seizures	Yes / No		Present Height	
High Blood Pressure	Yes / No		Allergies	Yes / No
Pregnant (presently)	Yes / No		Headaches	Yes / No
Metal Implants	Yes / No		Bowel/Bladder Problems	Yes / No
Arthritis	Yes / No		HIV	Yes / No
Breathing Problems	Yes / No		Hepatitis	Yes / No

Other Medical Conditions, please list: _____

Restrictions by physician, of any kind: _____

Past Surgeries, please list: _____

Current Medications, please list: _____

Have you received Physical Therapy, Occupational Therapy, or Speech Therapy previously? Yes No

If yes, what was the diagnosis? _____

When/Where did you receive therapy? _____

Have you been hospitalized recently? Yes No

If yes, why? _____

When/Where were you hospitalized? _____

"We know violence is a problem for many people, so we routinely screen all patients for violence in their lives. Is this a problem for you in any way"? Yes / No

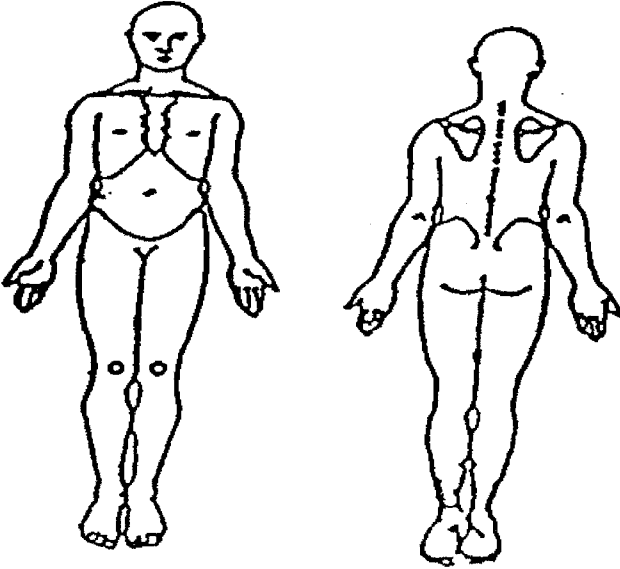
If yes, why? _____

Do you have any religious or cultural beliefs that will affect your care? Yes No

If yes, please explain. _____

**PLEASE INDICATE ON THE DIAGRAM WHERE YOU
HAVE PAIN:**

Pain



Other Symptoms (pins, needles, numbness, tingling)

