HOPE
Physical Therapy and Aquatics

INTAKE SHEET

Patient Information

First Name ____________________ (Preferred)________________ Last Name: ____________________

DOB: ____________ Sex: ______ Social Security # ________________ Marital Status:______________

Address: ___________________________ City: _______________ State: _______ Zip: __________

Phone: _______________________ Email: ____

Occupation: _______________________________ How did you hear about us? ____________________

The information needed below is the actual card holder's information.
If the patient is under the age of 18, we need parent or guardian information.

Insurance Information

Primary Insured's name: _________________________ Insurance identification #: ____________________

Relationship: ___________________ DOB: _____________ Sex: _______ Phone: ________________

Address: ___________________________ City: ________________ State: ______ Zip: __________

***If your injury is work related or due to a car accident, please let us know.**
Your health insurance will not cover services*

By signing below, I fully understand and certify the information provided is true and correct.

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PATIENT CONSENT

Authorization to RELEASE INFORMATION

______ I give permission to Hope Rehab League City, LLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment. A copy of this authorization shall be in effect and valid until rescinded in writing.

Authorization of INSURANCE BENEFIT PAYMENTS

______ I authorize direct payment of medical benefits through my insurance carrier or worker's compensation carrier to Hope Rehab League City, LLC, for services rendered. I understand that deductibles, percentages and/or copayments are due and payable at the time of my visit. The Notification of Patient Responsibility form is only an explanation of coverage obtained from my insurance company and is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

Consent for MEDICAL TREATMENT

______I do hereby voluntarily consent to treatment and care under specific instructions of Hope Rehab League City, LLC, and/or their representatives. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of treatments or examination by the medical professionals of Hope Rehab League City, LLC.

Consent to MESSAGES

______I authorize Hope Rehab League City, LLC representatives to leave/send necessary messages and appointment reminders through voicemail, text, or email at the phone numbers and email addresses I have provided.

- ☐ **Text message: Phone #:** ______________________________ **Cell Phone Carrier:** ________________________
- ☐ **Email:** ____

Consent to CONTACT EMERGENCY CONTACT

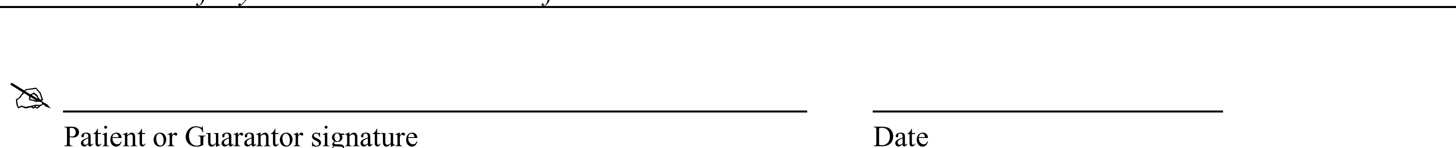
______I authorize Hope Rehab League City, LLC representatives to contact the following person in the event of an emergency:

Name: ______________________________ Relation: ______________________ Phone #: ________________________

MEDICAL TRAINING

Hope Rehab League City, LLC occasionally will have students and interns observing treatment as part of their educational requirements. These students follow the same rules of confidentiality and professionalism as do all our medical professionals. You are free to decline having a student or intern observe your session by informing a representative of Hope Rehab League City, LLC. I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Hope Rehab League City, LLC, and/or its affiliates or subsidiaries.

I have read and fully understand this consent form.



✍ ____ ________________________
Patient or Guarantor signature Date

NOTICE OF PRIVACY PRACTICES

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclose health information. Not every use or disclosure in a category will be listed. However, all the ways we are permitted to use and disclose information will fall within one of the categories.

FOR TREATMENT
We may use health information about you to provide you with rehabilitation or related services. We may disclose health information about you to other therapists, doctors (your medical/dental providers), nurses, technicians, clinical students or other clinical or support personnel needed to assist in optimal care. This might also include disclosing or using health information to educate and train a designated family member to assist with home rehabilitation or activities support.

FOR PAYMENT
We may use and disclose health information about you so that treatment and services you receive may be billed to and payment may be collected from your insurance company or liable party. We may need to disclose health information to your health plan and or payer about treatment you are going to have in order to obtain prior approval or to determine whether there is specific coverage for the services to be delivered to you.

CONSENTS, AUTHORIZATIONS AND ACCESS
Currently, there is no federal regulation that requires your healthcare provider to obtain consent for treatment, payment or associated healthcare operations. However, all providers are required to adhere to the privacy regulations stipulated in the Health Insurance Portability and Accessibility Act (HIPPA) effective April 2001.

The primary focus of the privacy section of the HIPPA is to require that health care providers manage all health care information in a confidential and "need to know" only basis. This includes paper documents, electronic data and telephonic communications. HIPPA requires that all patients have full access to their health information and that they are given the right to review copy and amend it, as specifically requested.

While consents for provider services are unnecessary, authorizations for use of health information outside of treatment, treatment-related operations and/or payment are required. A signed authorization form giving permission to utilize protected health information, for other than the aforementioned, must be obtained prior to disclosing or using private health information. The Act clearly states that the health care provider may not restrict access to services or in any way penalize a patient in the event of authorization declination or revocation.

Facility policy:
It is the policy of Hope Rehab that health information is only shared with the prescribing physician and practicing providers of Hope Rehab. A release of health information form is required if health information is to be shared with any other person or entity.

I have read and fully understand this notice of privacy practices.

______________________________ ______________________
Patient or Guarantor signature Date

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MEDICAL HISTORY

Name: ______________________________ DOB: ___________ Occupation: ______________________________

***Do you now or have you ever had any of the following**: (check all that apply)*

☐ Diabetes	☐ Open wounds	☐ Thyroid problems
☐ Arthritis	☐ Current infection(s)	☐ CVA / Stroke
☐ High blood pressure	☐ Hypersensitivity to Heat/Cold	☐ Previous fractures
☐ Heart disease	☐ Allergies	☐ Osteoporosis
☐ Pacemaker	☐ Females-Presently pregnant	☐ Anxiety
☐ Vascular disease	☐ Seizures	☐ Substance abuse
☐ Headaches	☐ Metal in body	☐ Previous surgeries
☐ Kidney problems	☐ Cancer/Tumor	☐ Incontinence
☐ Fever/Night sweats		☐ Other

PLEASE ANSWER ALL QUESTIONS TO THE BEST OF YOUR ABILITY.

1. Date symptoms/injury began ______________________________________

2. Where did symptoms / injury occur **Home** _____ **Work** _____ **Car Accident** _____ **Other**____ **Unknown**______

3. How did symptoms / injury occur ____

4. Identify three positions or activities that make your symptoms better _______________________________________

____

5. Identify three positions or activities that make your symptoms worse _______________________________________

____

6. Identify four daily activities which you are unable to do or have difficulty with: (ex. climbing stairs, grocery shopping, preparing a meal.)____

____

7. Have you had **Injections**_________ **X-rays** _________ **MRI**_________ **EMG**________ **Other** ________________

8. Have you been hospitalized for this problem? ☐ NO ☐ YES, How long? ___________________________________

9. Did you have surgery? ☐ NO ☐ YES, What type? ____

10. Are you taking **any** medication? ☐ NO ☐ YES, What type? ____

11. What are your personal goals for physical therapy? ____

12. Have you had physical therapy this year? ______ Yes _____ No

If so, what kind of therapy? **Home** ______ **Outpatient** ______ **Outpatient Hospital** _____ **In Patient**______

13. Do you Use Tobacco ________ Consume Alcohol _____________

14. Overall, how do you personally rate your health? ☐EXCELLENT ☐ VERY GOOD ☐FAIR ☐POOR

Use the symbols to mark your symptoms:
↓Shooting/sharp pain
O Dull/aching pain
||| Numbness
= Tingling