Patient Information

First Name: ________________________ **MI:** _________

Last Name: ______________________________________

Preferred Name: __________________________________

DOB: ___/_____/________ **SSN** ______ - ______ -______

Marital Status: Single Married Widow Divorced

Gender (circle): Male Female

Height: _______________ **Weight:** _________________

Home Address: ___________________________________

City: __________________ **State:** ______ **Zip:** _________

Home Phone #: __________________________________

Cell Phone #: ____________________________________

Work Phone #: ___________________________________

Email Address: ___________________________________

Send appointment reminders: (Choose preference)

Text Call Email

Emergency Contact Information:

Name: ____

Phone #: ____

Can information be released to this emergency contact? (Circle) YES NO

Employer: _______________________________________

Address: ____

City: __________________ **State:** ______ **Zip:** _________

Job Title: _______________________________________

Primary Care Physician: ____________________________

Did they refer you to Physical Therapy? Yes No

If no, who is the referring physician?

____

Last date seen by your physician? ___________________

Next Physician Appointment Date: __________________

Primary Insurance: ________________________________

Secondary Insurance: ______________________________

Provide Group # & Subscriber ID if unable to present card to us:

____

Insured Party: Self Spouse Parent Other

Insured Party Information (if not self)

First Name: ________________________ **MI:** _________

Last Name: ______________________________________

DOB: ___/_____/________ **SSN** ______ - ______ -______

Home Address: ___________________________________

City: __________________ **State:** ______ **Zip:** _________

Phone #: ____

Are you currently receiving services from a Home Health Care Provider? Yes No

Within the last 30 days, have you received services from a Home Health Care Provider? Yes No

Is your condition related to:

☐ Employment Injury ☐ Auto Accident ☐ Other

I authorize that this information is true and correct. If something changes, I will notify Salt Creek Rehab.

X____ Date_________________

Relationship of Person signing to Patient (If not self) ______________________________________

For office use only: ___ Rx Received ___ Insurance Cards Copied ___ Insurance Verified Insurance Co-Pay: _________

Referring Physician: ____________________________________ ___ Scheduled Appts ___ Auth Req? (Y or N)

Salt Creek Rehabilitation

Medical/History Questionnaire

Today's Date: ________________ Patient Name: ____ Date of Birth: ______________

Location of body part receiving physical therapy: ____

Primary concern; including when & how your symptoms began:____

____

Have you ever been treated for this condition before? Yes No (When/Where: ____)

Have you had any imaging done for these symptoms? (MRI, Xray, CT Scan, etc.)____

On a scale of 0-10, what is your pain currently: ______ **How would you describe your pain:** ________________________________

What make your symptoms better:______________________________ **Worse:**____

Is this visit related to a work injury? Yes No Claim Number, if Known: ____

Is this visit related to a motor vehicle accident? Yes No Claim Number, if Known: ____________________________________

Is this visit related to an accident where someone else's insurance is or may be responsible for payment? Yes No Unsure

Please check conditions you have suffered from in the past or currently:

- ☐ Allergies
- ☐ Alzheimer's
- ☐ Arthritis
- ☐ Artificial Joint (s) __________
- ☐ Bone Condition or Osteoporosis
- ☐ Cancer Current (Type:__________________)
- ☐ Cancer Survivor (Type:__________________)
- ☐ Cardiovascular/Heart Disease
  - ○ Chest Pain
  - ○ Heart Attack
  - ○ Pacemaker
- ☐ Cauda Equina Syndrome
- ☐ Cerebral Vascular Accident or Stroke
- ☐ Congenital Condition
- ☐ COPD or other Respiratory Disease
- ☐ Current Infection
- ☐ Currently Pregnant or could be Pregnant
- ☐ Diabetes Mellitus Type 1
- ☐ Diabetes Mellitus Type 2
- ☐ Eyes/Ears/Nose Condition
- ☐ Fibromyalgia
- ☐ Fracture/Suspected Fracture
- ☐ Gastrointestinal Condition
- ☐ High or Low Blood Pressure
- ☐ History of Falls
- ☐ Huntington's Disease
- ☐ Immunosuppression
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Muscular Dystrophy
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Pain Chronic
- ☐ Pain Injury
- ☐ Pain Surgery/Procedure
- ☐ Parkinson's Disease
- ☐ Peripheral Vascular Disease
- ☐ Rheumatoid Arthritis
- ☐ Seizures/Epilepsy
- ☐ Skin Condition/Rashes/Other
- ☐ Spinal Injury/Condition
- ☐ Steroid or Prednisone Therapy
- ☐ Traumatic Brain Injury
- ○ Vertigo, Weakness or Dizziness

Other Health Conditions & more information if marked above: ____

____

List date and type of surgeries, if any: ____

____

Current Medications: ____

Patient Registration and Consent for Medical Treatment

1. I authorize consent for medical treatment and understand rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.
2. I authorize Salt Creek Rehab to release information from my medical records to any healthcare provider involved in my care and treatment or any person or organization liable for all or part of my charges, such as insurance, third-party payor, Medicare or Medicaid Programs or workers' compensation carrier. I understand upon disclosure of information, Salt Creek Rehab is no longer responsible for the confidentiality of information known or possessed by the payer.
3. I understand there is no guarantee of payment from any insurance or other payer. I agree to pay all charges for the services provided by Salt Creek Rehab which are not paid my insurance or other payer.
4. All charges are due and payable when I receive the bill. I agree to pay all legal expenses necessary for the collection of any debt. I understand that any credit or refund that I may be owed will be forwarded to the address on file. I understand I am responsible for a $25.00 returned check fee in addition to any other associated bank charges on return of payment.
5. I accept the responsibility to obtain all referrals or pre-authorizations and to comply with all requirements of any insurance or medical coverage plan upon which I am relying for medical coverage of Salt Creek Rehab charges.
6. I authorize payment of any insurance (including auto insurance or healthcare related insurance) benefits for healthcare services or goods may be made directly to Salt Creek Rehab.
7. I understand a 24-hour notice is required for canceling an appointment and **I will be charged $25.00 for any missed appointment** without required notification. I also understand I will be responsible for this charge and that my insurance company will not be billed that day. Habitual absences may lead to involuntary discharge from Salt Creek Rehab.
8. I understand that a physical therapy diagnosis is not a medical diagnosis by a physician.
9. I agree Salt Creek Rehab is not responsible for loss or damage to personal valuables.

I acknowledge I have read this form, understand its contents, that I am duly authorized to sign this agreement, consent to, and accept its terms. I am responsible for payment and/or co-payment that is due at the time of service. I have received the Patient's Rights & Responsibilities and HIPAA policy. I acknowledge the information stated above is true.

______________________________	____________________	____________________
Patient or Responsible Party Signature	Relationship to Patient	Date

Need to cancel? Please call 785-528-1123. **Our "No call – No Show" fee is $25.00.**