Carolina Rehabilitation / Brunswick Physical Therapy Associates / Edwards and Associates Physical Therapy
Intake Form

First Name_____ **MI**____ **Last Name**_____ **Nick Name**_____
Birthdate: ____/____/____ **SS #** _____-_____-_____ **Sex: Male / Female**

Mailing Address_____ **City**_____ **St**_____ **Zip**_____

Home Phone (_____) _____-_____ **Cell Phone** (_____) _____-_____ **Work** (_____) _____-_____
Would you like to receive reminders of appointments by: Text Message: Yes / No **Email:** Yes / No

Email Address: _____ **Employer:** _____ **Phone** (____) ____-____

Emergency Contact: _____ **Relationship:** _____ **Phone** (_____) _____-_____
Responsible Party/Guardian (if you are not the primary account holder) **Name:** _____

Relationship: _____ **Phone :**(_____) _____-_____ **SS #** _____-_____-_____

Referring MD: _____ **Next Visit**___/___/___ **Primary MD:** _____ **Next Visit** ___/___/____

Have you had ANY Physical or Speech Therapy during this calendar year? Yes / No
Are you currently or have you in the past 90 days received ANY home health nursing, therapy? Yes / No
Do you have an attorney? Yes / No Name **of Firm**_____ **Phone Number**_____

If you have an insurance card please give it to the receptionist to copy (even if this is workers comp) your co-pay or coinsurance is due at each date of service. Please call to cancel any appointments you cannot keep. If you do not call before your appointment you may be charged with an office visit of $35. Returned check fee is $35.00. These fees will not be covered by insurance.

Workers Comp or Auto Insurance

Workers Comp Yes / No **Auto Accident** Yes / No **Date Injured:**____/____/____
Case Manager:_____ **Phone Number**(____) ____-____
Carolina Rehabilitation Inc. will bill Workers Compensation claims with the proper insurance company. Caseworkers will be kept up to date on progress, and any missed appointments. If Workers Compensation denies my claim, Carolina Rehabilitation Inc. will file with my insurance company. I will be responsible for payments not covered or approved by workers compensation.
In the case of legal settlements pending or otherwise, regarding this injury. I agree to make full payment for this debt regardless of the settlement decision. I understand if a legal settlement cannot be reached I will be required to make payments of this debt, in an amount and time schedule to be set by Carolina Rehabilitation Inc.

Signature:_____ **Date:**____/____/____

Medicare Patients Only

Medicare Patients Statement to permit payment to the provider for therapy services. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. This authorization shall apply to the period covering these services.

Signature:_____ **Date:**____/____/____

Patient Responsibility and Consent to Treat

I understand that any balance remaining on my account for longer than 60 days may have a late charge of 1 ½ % per month (18% apr) added. I authorize payment of insurance benefits covering these services directly to Carolina Rehabilitation, Inc. I also hereby acknowledge my responsibility for full payment of this debt and waive my rights of defense under the statute of limitations. I also understand that it is my responsibility to obtain any referrals, pre-authorization, benefits and network provider information.

I acknowledge receipt of this notice of the privacy practices of Carolina Rehabilitation, Inc.

By signing this, I accept responsibility of charges and I consent to Physical Therapy Treatment as directed including modalities.

Signature:_____ **Date:**____/____/____

Carolina Rehabilitation

Information Release Form

Patient Name:_____

Birthdate: ____/____/_____

I _____**, give my permission to Carolina Rehabilitation to:**

CIRCLE ONE

Leave a message on my phone **Yes / No**

Discuss my Physical Therapy with others **Yes / No**

If yes, whom: _____ **Relationship:**_____ **Phone(____) ____-_____**

_____ **Relationship:**_____ **Phone(____) ____-_____**

_____ **Relationship:**_____ **Phone(____) ____-_____**

Release Physical Therapy Reports to Physicians other than referring:

Physician Name:_____ **Phone(____) ____-_____** **Fax (____) ____-_____**

Physician Name:_____ **Phone(____) ____-_____** **Fax (____) ____-_____**

Signature of Patient or Responsible Party: _____ **Date:**_____

Print Name and Relationship: _____

Staff Witness Signature:_____ **Date:**_____

Patient Name:_____ DOB:_____ Date:_____

Edwards & Associates Physical Therapy Pediatrics History Form

Dear Parent: This is a health questionnaire on your child. Please complete this form. Bring it with you at the time of an appointment.

Contact Information for Parent 1

Name:_____ Email:_____

Home Address: _____

Home Phone:_____ Work Phone:_____ Cell/Other:_____

Contact Information for Parent 2

Name:_____ Email:_____

Home Address:_____

Home Phone:_____ Work Phone:_____ Cell/Other:_____

This child lives with: Mother Father Mother/Father Mother/Partner Father/Partner Grandparent/Other

MIT Affiliation

Person: Position: Department:

FAMILY HISTORY

1. Parent 1 Age:_____ Current Health:_____
   Past Health Problems:_____
2. Parent 2 Age:_____ Current Health:_____
   Past Health Problems:_____
3. Marital Status of Parents:_____
4. Other Children in Family:

Date of Birth	Gender	Name	Healthy or Medical Issues?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRENATAL HISTORY

1. While pregnant, did mother have:
   a. Bleeding or spotting_____ no yes
   b. German measles (Rubella)_____ no yes
   c. Gestational diabetes_____ no yes
   d. High blood pressure_____ no yes
   e. Illness other than cold/flu_____ no yes
   f. Kidney disease_____ no yes
   g. Premature labor_____ no yes
   h. Threatened miscarriage_____ no yes
   i. Toxemia_____ no yes
2. Were medications or herbs taken during pregnancy? _____ no yes
   If yes, what kind:_____
3. Was a fertility treatment used for this pregnancy?_____ no yes
   If yes, what kind:_____

Patient Name:_____ DOB:_____ Date:_____

BIRTH HISTORY

1. Where was child born:_____
2. Was labor induced?_____ no yes
3. Was labor helped by medication?_____ no yes
4. Duration of labor:_____
5. Was child born early (less than 38 weeks)?_____ no yes
6. Was child born late (after 42 weeks)?_____ no yes
7. What was the method of delivery:
   - Breech
   - Caesarean (Please state reason): _____
   - Forceps
   - Spontaneous vaginal
8. Child's birth weight: _____
9. Apgar Score (if known): _____
10. During the hospital stay, did child have any of the following:
    a. Antibiotic treatment_____ no yes
    b. Blue spells_____ no yes
    c. Convulsions_____ no yes
    d. Jaundice_____ no yes
    e. Skin rash_____ no yes
    f. Did child remain in hospital longer than mother?_____ no yes
11. How was/is baby fed?
    - Bottle
    - Breast

DEVELOPMENTAL HISTORY:

1. At what age did child: Age
   a. Hold up head _____
   b. Roll over _____
   c. Sit unsupported _____
   d. Stand alone _____
   e. Walk _____
   f. Talk _____
   g. Toilet train _____
   h. Feed him/herself _____
   i. Dress him/herself _____

PAST MEDICAL HISTORY:

1. Has the child had:

a. Blood: anemia (iron deficiency, Sickle Cell, Thalessemia)_____ no yes
b. Blood transfusions_____ no yes
c. Chicken pox (Varicella)_____ no yes
d. Contusions_____ no yes
e. Convulsions_____ no yes
f. Fractures_____ no yes

Patient Name:_____ DOB:_____ Date:_____

g. German Measles (Rubella)_____ no yes
h. Hospitalizations_____ no yes
i. Measles (Rubeola)_____ no yes
j. Meningitis_____ no yes
k. Mumps_____ no yes
l. Operations_____ no yes

If yes, what illness?

m. Poison ingestion no yes
n. Other serious medical illnesses no yes

If yes, what kind?

o. Is your child currently taking any medications, vitamins or herbs? no yes

Medication	Strength/Dose	How Often?	Reason

p. Reaction to medication or food (allergy) no yes

If yes, please explain:

q. Any chronic or recurring pain? no yes

If yes, please explain:

2. Eyes:

a. Any visual problems?no yes
b. Do eyes look crossed? no yes
c. Does the child wear eyeglasses? no yes

3. Ears:

a. Any hearing problems? no yes
b. Three or more ear infections? no yes

6. Heart:

Have you ever been told your child has

a. A heart murmur? no yes
b. Heart defect? no yes
c. High blood pressure?no yes

7. Lungs:

Has your child ever had

a. Asthma/wheezing? no yes
b. Bronchitis or pneumonia? no yes
c. Chronic cough? no yes

8. Does your child tire easily? no yes

9. Abdomen

Has your child ever had

a. Blood in bowel movement? no yes
b. Difficulty with appetite or eating? no yes
c. Frequent abdominal pain? no yes
d. Frequent vomiting or diarrhea? no yes
e. Jaundice? no yes
f. Marked weight loss? no yes

If yes, please explain:

Patient Name:_____ DOB:_____ Date:_____

10. Kidney:

a. Does your child ever complain of burning or frequency of urination? no yes
b. Does your child wet the bed? no yes
c. Has there ever been blood in the urine? no yes
d. Has your child ever had a urinary tract infection? no yes

12. Extremities:

Has your child

a. Had weakness or paralysis of arms or legs? no yes
b. A persistent limp? no yes
c. Every worn corrective shoes or braces? no yes

13. Neurological:

Has your child ever had

a. Breath holding? no yes
b. Convulsions or seizures? no yes
c. Dizziness? no yes
d. Fainting? no yes
e. Frequent headaches? no yes
f. Temper tantrums? no yes

14. Is your child:

a. Impulsive? no yes
b. Lacking in self-control? no yes
c. Overactive? no yes
d. Does your child have problems with:
   i. Attending school? no yes
   ii. Attention span? no yes
   iii. Learning? no yes
   iv. Mood? no yes
   v. Parents? no yes
   vi. Peers? no yes
   vii. Siblings? no yes
   viii. Sleep? no yes

16. Any other concerns you would like to discuss?

_____
_____
_____

_____ _____ _____ _____

Parent Signature Date Provider Name Date Reviewed

Edwards and Associates Physical Therapy

Payment of Services

Patient Name:_____ Date of Birth:_____

Carolina Rehabilitation Inc./ Edwards and Associates Physical Therapy is concerned first with the health and rehabilitation of the patients under our care. We understand that payment for services can be difficult under some circumstances. In order to provide services we ask you to read and sign this document.

I hereby acknowledge my responsibility for full payment of this debt and waive my rights of defense under the statute of limitations. I also understand it is my responsibility to obtain any referrals, pre-authorization, benefits and network provider information, and provide them to Carolina Rehabilitation Inc./Edwards and Assoc Physical Therapy. I authorize payment of insurance benefits and or settlements covering these services directly to Carolina Rehabilitation Inc. / Edwards and Assoc Physical Therapy.

Medicare Patients Statement to permit payment to the provider for therapy services. I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. This authorization shall apply to the period covering these services.

Carolina Rehabilitation Inc. / Edwards and Assoc Physical Therapy will bill Workers Compensation claims with the proper insurance company. Caseworkers will be kept up to date on progress, and any missed appointments. If Workers Compensation denies my claim, Carolina Rehabilitation Inc. / Edwards and Assoc Physical Therapy will file with my insurance company. I will be responsible for payments not covered or approved by workers compensation.

In the case of legal settlements pending or otherwise, regarding this injury. I agree to make full payment for this debt regardless of the settlement decision. I understand if a legal settlement cannot be reached I will be required to make payments of this debt, in an amount and time schedule to be set by Carolina Rehabilitation Inc. /Edwards and Assoc Physical Therapy .

Signature _____

Date _____