GENESIS
Rehab Services

1534 119th Street,
Whiting, IN 46394
Phone: (219) 655-5285
Fax: (219) 655-5472

Patient Name: ______________________________ Sex: M / F

Patient Age: ______ Yrs. Date of Birth: _____/_____/_______

Height:_____________ Weight: ___________ Lbs.

Patient Demographics

Social Security Number:______-____-_________

Home address: House/Apt Number:_________Street:____
City:____ Zip Code:__________________ State:______________
Home Phone: (_____)_____________________ Cell Phone Number: (_____)_________________________
E-Mail:____@ ____

Work Address: Name of Company:____
Street: ____, City:____
Zip Code:_______________ State:__________ Work Phone:(______)___________________ Ext:________

Patient Signature:_________________________________ Todays Date:_________/_____/___________

Emergency Contact Number:______________ Name:_______________________, Relation:______________

Insurance Holder: Patient/Self Spouse Parent Legal Guardian

Information of Primary insurance holder

Name of Primary Insurance Holder: First:_____________________, (MI)_______,
Last:___________________________

Date of Birth:______/______/____________ Age:________ Years Sex: M/F

Social Security Number of Primary insurance holder:______-____-_________

Check If address is the same as patients.

Home address: House/Apt Number:_________Street:____
City:____ Zip Code:_____________________ State:______________
Home Phone: (_____)_____________________ Cell Phone Number: (_____)_________________________
E-Mail:____@ ____

Work Address: Name of Company:____
Street: ____, City:____
Zip Code:_______________ State:__________ Work Phone:(______)___________________ Ext:________

Patient Signature:_________________________________ Todays Date:_________/_____/___________

Please present your drivers license/other identification and Insurance card to the front

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Social Security Number:__________-_____-_________
Sex: M / F Height:_____________ Weight:________ lbs.

Home Medications, Vitamins / Dietary Supplements

Drug	Dose	Frequency	Route	Changes (date)

I have reviewed the list of home medications. The list is accurate to my knowledge and understanding. I will inform the staff of any changes in my medications.

Signature of patient or Care Giver:_______________________________ Date:______/_____/_________

Signature of Therapist:____ Date:_____/_____/__________

Reviewed:_______________ Dated:___________ Reviewed:_________________ Dated:_______________

Reviewed:_______________ Dated: ____________ Reviewed:_________________ Dated:_______________

Reviewed:________________ Dated: ____________ Reviewed:_________________ Dated:_______________

Reviewed:________________ Dated: _____________ Reviewed:_________________ Dated:_______________

Reviewed:________________ Dated: _____________ Reviewed:__________________Dated:_______________

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OUT PATIENT INFORMATION SHEET

Are you currently receiving Home health, nursing or therapy services? ☐ YES ☐ NO

HISTORY: Please place a check mark (✓) next to only those that you can answer YES:

	YES	NO		YES	NO
CAD – (Coronary Artery Disease)			CHF (Congestive Heart Failure)		
CVA or Stroke			Chronic kidney disease		
COPD (chronic obstructive pulmonary disease)			Asthma		
Gastrointestinal Bleeding			Gastrointestinal problems		
Infection			Blood Transfusion		
Dental Disorder			Depression		
Implantable Cardioverter Defibrillator (AICD)			Multi-Drug Resistant Organism (MDRO)		

	YES	NO		YES	NO
Hypertension (HTN)			Multiple Sclerosis		
Diabetes Mellitus Type I or II			Parkinson's Disease		
Cancer			Osteoporosis		
Arthritis			Seizures		
Sleep Apnea			Anemia		
Deep vein Thrombosis			Pacemaker		

Other Medical History:____
____

Surgical History: ____
____
____

Allergies Food or Drug:____
____

Other
issues/Comments:____
____

Do you have any concerns or issues that you want to discuss with the therapist privately?

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PRESENT PROBLEM/ Reason for Visit:____

____

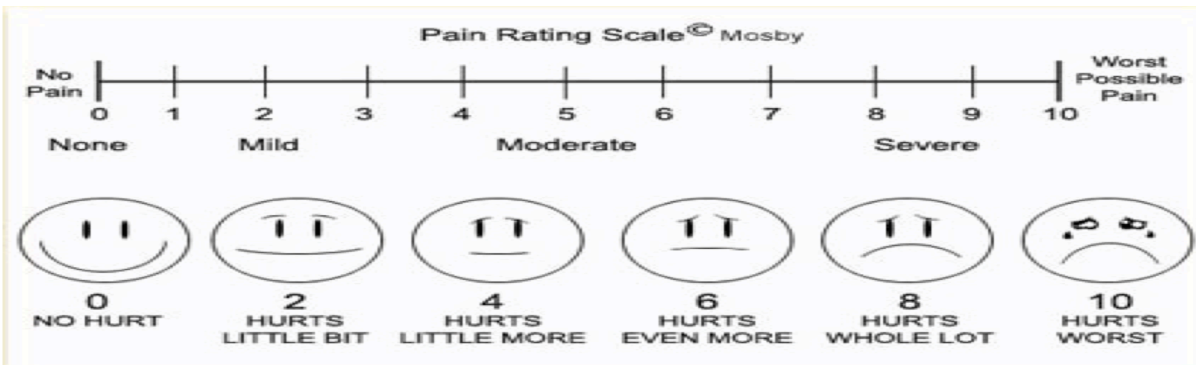
Did you have this problem before? Yes No. If yes,
When?______________________________

Have you received any Physical Therapy here or anywhere else this year? Yes No

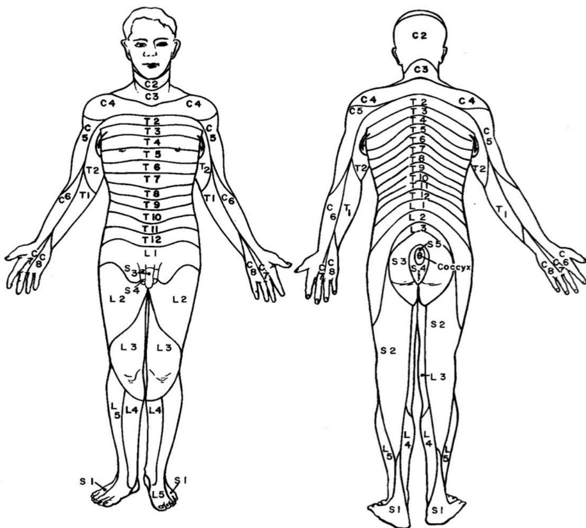
If yes, How many visits:____________

Do you have any pain at this time? Yes No

Please Rate your pain:



Where is the pain located? Please mark on the chart.



Q: For how long have you had this pain?

A:____

Frequency of pain: Intermittent/Constant

Quality of pain: Tender/Dull/Achy/ Cramping/ Sharp/ Burning/ Stabbing/ Weakness.

What relieves the pain?______________________

____

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HEALTH CHANGES: Check box if you have recently noticed any:

- None
- Unexplained weight change
- Dizziness
- Nausea/Vomiting
- Fever/Chills/Sweats
- Numbness/Tingling
- Chest congestion or cough
- Sleep disturbances
- Fatigue
- Weakness
- Feeling down, Depressed, Hopeless?
- Having little interest / pleasure in doing things

General Information:

Occupation (previous/present): ____

Leisure Activities: ____

Have you had any falls? ☐ yes ☐ No. If yes, when? ________________________

Workman's compensation? ☐ yes ☐No

Are you currently working? ☐ Yes ☐No

Have you been recently hospitalized? ☐Yes If yes, when and where?__________________
☐No ______________________________

Learning Assessment

Do you need assistance with learning? ☐ yes ☐ No

If yes, answer the following questions relative to the individual who will be providing assistance. If No, Answer the questions relative to your needs.

Name:______________________________

Relationship: ☐Patient ☐Family ☐Care giver ☐Mother/Father

Any barriers to learning? ☐Yes Specify______________________________
☐ No

Preferred Learning Method: Listening Reading Demonstration Pictures/Video

Primary Language: ☐ English ☐Spanish ☐Other__________________________

Signature of Patient/responsible party:______________________ Date:__________

Signature of Therapist:______________________ Date:__________

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CONSENT FOR TREATMENT OF A MINOR: As a parent and/or legal guardian, I authorize **Genesis Rehab Services LLC to** treat the minor patient named in the attached forms while I am not present.

Name of Patient: ________________________________ **Date of Birth of Patient:** _______________

Parent/Guardian signature: ____ **Date**: ________

CONSENT FOR CARE AND TREATMENT: Your Physical Therapist will complete an evaluation by examination and interview. Your individual treatment program will then be designed. A variety of treatment techniques may be used. I, the undersigned, do hereby agree and give my consent for **Genesis Rehab Services LLC** to furnish physical therapy care and treatment considered necessary and proper in evaluating or treating my physical condition.

CONSENT FOR RELEASE OF MEDICAL RECORDS: I hereby authorize my referring physician to release any of my pertinent medical information to **Genesis Rehab Services LLC** for use in the evaluation of my condition and the design of my individual treatment program.

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize **Genesis Rehab Services LLC to** furnish information to insurance carriers concerning this treatment and I hereby assign all payment for services rendered.

WORKER'S COMPENSATION CLAIMS: If you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

CANCELLATION AND NO-SHOW POLICY: If you are unable to keep a scheduled appointment, please notify us at least 24 hours in advance. We will make every attempt to reschedule your appointment. If you miss your appointment without calling in advance, you will be charged a $25.00 no-show fee. This payment takes effect on your second missed appointment without previous notice. If cancellations or no-shows become excessive (3 maximum), we will take you off of the schedule and ask you to call us the morning of the day you wish to be seen. We will fit you into the schedule as close as possible to the time you request. All cancellations and no-shows are documented in your medical record. Case managers and referring physicians for worker's compensation patients are notified after each missed appointment. All workers' compensation patients with excessive missed appointments (3 maximum) will be removed from the schedule and the case manager and physician will be notified. The case manager must notify us before further appointments can be made. Initials_________

FINANCIAL POLICY: We will bill your personal insurance carrier solely as a courtesy to you. You are ultimately responsible for your bill. If your insurance carrier does not remit payment to us within 60 days, the balance owed will be due in full from you. In the event that your insurance company requests a refund of payments made to us, you may be responsible for the amount of money refunded to your insurance company. If any, the insurance company for services billed by us makes payment directly to you; you recognize an obligation to promptly remit the payment(s) to us. If formal collection procedures become necessary, you will be responsible for any additional costs incurred.

PATIENT PAYMENT/COPAY/COINSURANCE/DEDUCTIBLE: Genesis Rehab Services LLC will bill patient or guarantor for any charges that are the patient's responsibility after receipt of the Insurance company's explanation of benefits (EOB). The EOB will reflect what charges are the patient's responsibilities and our billing will correspond to these amounts. All accounts are net 30 days from date of invoice.
The above information has been explained to me.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

____

Patient/Guardian/Responsible Party **Date**