GENESIS Rehab Services
9430 Wicker Ave
St John, IN 46373-9768
Phone: (219) 627 3069
Fax: (219) 627 3099

Patient Name: ________________________________ Sex: M / F

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

Height:______________ Weight: ______________ Lbs.

Race/Ethnicity:____

Patient Demographics

Social Security Number:______-____-__________ Next Physician Appointment:_____/______/_______

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 driver's license/other identification and Insurance card to the front desk.

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Patient Name: ____

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

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.

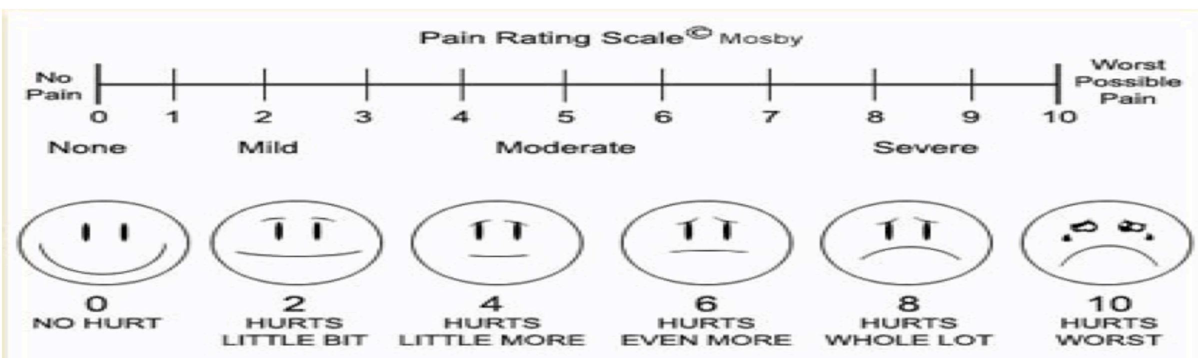
If yes, When?____

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

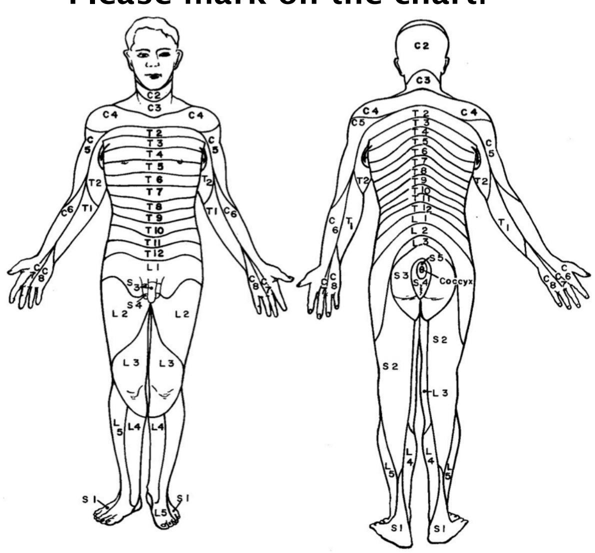
If yes, How many visits:___________

Do you have any pain at this time? ☐ Yes ☐ No

<u>Using the Chart below, please rate your pain:</u>



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 ☐No

If yes, when ______________ and where____
(Date) (Place)

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 ☐ NO Specify_____________________________________

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 CARE AND TREATMENT: I ________________________________ hereby consent to evaluation and/or treatment of my condition by ***Licensed Therapist*** (*i.e. Physical Therapist/Physical Therapy Assistant/Occupational Therapist/ Certified Occupational Therapy Assistant*) employed by or under contract with Genesis Rehab Services LLC.
The physical therapist has fully explained to me the nature and purposes of the procedures, evaluation and course of treatment, and has witnessed my signature of this consent in his or her presence.

The physical therapist has informed me of expected benefits and possible complications or discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that there is not a guarantee that the proposed course of Treatment, will improve my condition and that is possible, although unlikely, that the course of treatment may cause additional pain or discomfort or aggravate my condition. I have been given on opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form.

Date ______________________ Signature____

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**: ___________________

Patient/relative or guardian ____
(Print Name)

____
(Relationship, if signed by person other than client)

I hereby certify that I have explained the nature, purpose, benefits, risks of, and alternatives to the proposed evaluation and treatment have offered to answer any questions and have fully answered all such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.

Physical therapist____ Date_________________________

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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.

Is there a family member or friend you want us to share your information with? YES ☐ NO ☐

If yes, Who____ Security Pin:______________________________

Please note that you can revoke the consent to release information to the above-mentioned person at any time.

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 **$35.00 no-show fee/cancellation 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**