



PATIENT INTAKE AND CONSENT FORM

"We Change Lives"

Internal Use Only:	MRN# <input style="width: 100%;" type="text"/>	Account Type <input style="width: 100%;" type="text"/>
First Name _____ MI _____	Social Security # _____	Date of Injury/Onset _____ Today's Date _____
Last Name _____	Date of Birth _____ Age _____	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
Address _____	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	Injury Area: _____
City _____ State _____ Zip _____		
Home Phone _____		
Work Phone _____		
Cell Phone _____		
Employer _____	Occupation _____	
Address _____	Contact at Employer _____	
City _____ State _____ Zip _____		
Referring Physician _____	Phone Number _____	
Clinic Name: _____	Address: _____	
Primary Insurance _____	Insured Name _____	
Group # _____ ID # _____	Address _____ City _____	
Insured Employer _____	State _____ Zip _____ Phone _____	
Relationship to Insured _____	Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Secondary Insurance _____	Insured Name _____	
Group # _____ ID # _____	Address _____ City _____	
Insured Employer _____	State _____ Zip _____ Phone _____	
Relationship to Insured _____	Insured Date of Birth _____ Insured Sex: <input type="checkbox"/> M <input type="checkbox"/> F	
Emergency Contact _____	Daytime Phone Number _____	
Are you receiving or have you recently received home health services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Are you receiving or have you recently received other therapy services? <input type="checkbox"/> Yes <input type="checkbox"/> No		
How did you hear about us? _____		

CONSENT TO OCCUPATIONAL THERAPY

(Please read before you sign)

1. **CONSENT TO TREATMENT:** I consent to rehabilitation and related services at Destination Life Therapy & Wellness. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.
2. **TREATMENT OF MINORS:** I, as parent/guardian of a minor receiving treatment here under, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.
3. **LIABILITY:** I know and agree that Destination Life Therapy & Wellness is not responsible for loss or damage to personal valuables.
4. **WAIVER AND RELEASE:** I hereby release, discharge and acquit Destination Life Therapy & Wellness it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services.
5. **AUTHORIZATION OF PAYMENT:** I hereby assign all benefits directly to Destination Life Therapy & Wellness and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.

I certify that all of the information provided herein is true and correct. I agree to abide and comply with Destination Life facility policies.

Patient/Guardian Signature _____ **Witness Signature** _____

I have received information regarding advance directives. I have previously signed an advance directive prior to this admission.

___ Yes ___ No If yes, the name and address of my patient representative authorized to make medical decisions on my behalf is:

Name: _____ **Phone:** _____ **Address:** _____

Patient's Initials: _____



MRN #: _____

MEDICAL HISTORY FORM

Patient's Name: _____

Today's Date: _____

Are you presently working? Yes No

Date of Injury: _____

Have you experienced these symptoms before? Yes No

(If yes, when?) _____

Indicate how you sustained this condition:

- Work related injury Athletic/Recreation injury Cause unknown
- Motor vehicle accident Injury related to lifting Recurrence of prior condition
- Other: _____

Have you had surgery related to this condition? Yes No

If yes, what type of surgery? _____ Date of Surgery: _____

Are you presently taking medication? Yes No

If yes, please list and specify condition(s) _____

What specific activities are you having difficulties with? _____

What are your personal goals you hope to achieve from occupational therapy? _____

Have you had any occupational therapy or physical therapy for this condition? Yes No If yes, please explain

PLEASE CHECK IF YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

- | | | |
|--|---|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> COPD | <input type="checkbox"/> Ringing in your Ears |
| <input type="checkbox"/> Chest Pain/Angina | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Osteoporosis/Osteopenia | <input type="checkbox"/> Special Dietary Guidelines |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Arthritis | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Hernia | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Recent Fractures | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Vascular Disease | <input type="checkbox"/> Headaches | <input type="checkbox"/> Depression |
| <input type="checkbox"/> CVA/Stroke/TIA | <input type="checkbox"/> Dizziness/Fainting | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Liver/Gallbladder Problems | <input type="checkbox"/> Allergies: _____ |
| <input type="checkbox"/> Skin Abnormalities | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Cancer: _____ |
| <input type="checkbox"/> Sexual Dysfunction | <input type="checkbox"/> Bowel/Bladder Problems | Are you Pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Metal Implants | Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No |

List any allergies: _____

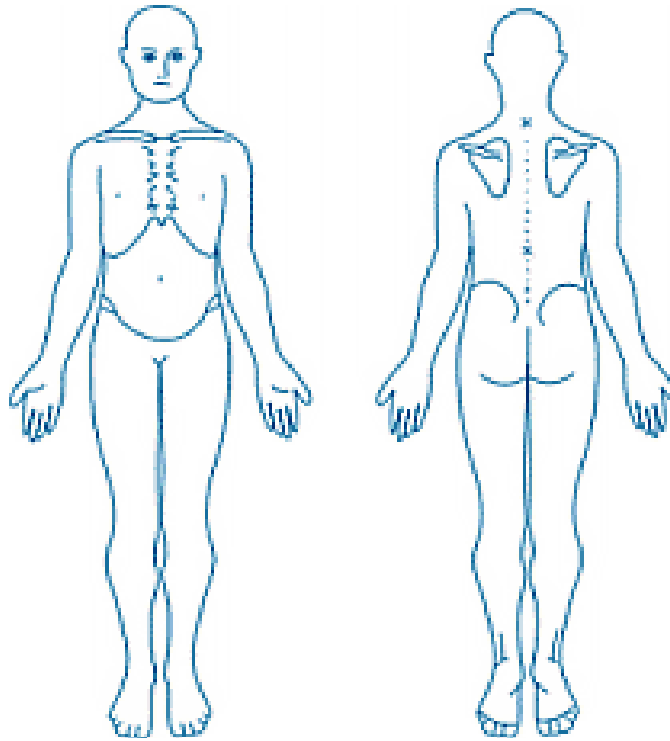
List Medication: _____

Did you have any XRay or MRI reports conducted within the last 6 months? _____ If yes, we will need a copy of the written report

Patient/Guardian Signature _____ Date _____

MEDICAL HISTORY FORM- CONTINUED

Please indicate below where your symptoms are located:



Please circle the appropriate number that best describes your pain level:

- 0 No Pain
- 1 Mild Pain; you are aware of it, but it doesn't bother you
- 2 Moderate Pain that you can tolerate without medication
- 3 Moderate Pain that requires medication
- 4-5 More Severe Pain; you begin to reduce your activity level
- 6 Severe Pain
- 7-9 Intensely Severe Pain
- 10 Most Severe Pain; it may require a visit to the Emergency Room

Patient/Guardian Signature _____

Date _____

Therapist Signature _____

Date _____



MRN #: _____ Patient Name: _____

FINANCIAL POLICY

Thank you for choosing Destination Life Therapy & Wellness as your therapy provider. We are committed to providing the best possible care for you. In order to achieve this goal, we need your assistance in understanding our payment policy. Please understand that payment of your bills is considered part of your treatment. The following is a statement of our Financial Policy. Please read and sign prior to your treatment.

Payment of services is due prior or upon completion of each treatment visit. We accept CASH, MASTERCARD, VISA, DISCOVER, or PERSONAL CHECKS. Once your complete insurance information is on file, we will be happy to submit your claims to your insurance company.

_____ INITIALS

Private Insurance

We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that your insurance is a contract between you, your employer, and the insurance company. We are not party to that contract. We must emphasize that as your provider, our relationship is with you, and not your insurance company. While the filing of insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the date of services rendered.

It is our policy to call and verify benefits and eligibility to estimate your payment portion. However, there is no guarantee from the insurance company of their payment amount. We may not know the exact amount due until the claim has been processed. At this point, there may be more due on your account. In this event, we will mail you a statement, and appreciate your prompt payment.

Regarding insurance plans where we are a participating provider, we will take the contracted rate assigned by the insurance company and make proper adjustments to your claim.

_____ INITIALS

Non-Covered Expenses

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You may be responsible for payment of charges denied due to the insurance company's arbitrary determination of usual and customary rates. There may also be charges that your insurance does not cover due to limitations of your policy, or what they consider reasonable and necessary. It is your responsibility to know what the policy limitations are. Our goal is to improve your condition successfully based on what the doctor deems reasonable and necessary treatment, and not on what your policy limitations are. Therefore, unless you alert us prior to treatment, you will be financially responsible for non-covered expenses.

_____ INITIALS

Electrodes: Upon the initial evaluation your Occupational Therapist may determine that it would be beneficial for you to receive electrical stimulation as part of your treatment plan. It is our recommendation to purchase personal electrodes at a cost of \$8 that will be kept at the clinic for your individual use. Should you choose not to purchase personal electrodes; the clinic will provide shared electrodes. (It is mandatory would like that to you purchase purchase personal personal electrodes electrodes at a if you cost of have \$8.00 if you have an incisions, wounds, or any infectious disease.)

- I would like to use the clinic's shared electrodes at a cost of \$0.00
- I would like to purchase my own electrodes for \$8.00

_____ INITIALS

Information

Please be on time for your appointments so that you may be given the full benefit of your scheduled treatment. Late arrival of greater than 10 minutes shall be charged \$10 and may result in a shortened treatment or cancellation. It is our policy to reschedule any canceled appointments for the same week at the time of your call. **There is a \$35 charge for a cancellation without a 24 hour notice.** Attending your scheduled appointments is crucial to treatment and recovery from injury. If you miss 3 appointments within a one month time frame you will be subject to discharge.

_____ INITIALS

Information

I give my permission to Destination Life Therapy & Wellness to release information, verbal and written, from my medical record to my physician, insurance company, rehab nurse, case manager, attorney, employer, school, related health-care provider, or other assignees as it relates to my treatment. I further authorize Destination Life Therapy & Wellness to obtain medical records from my physician or other medical professionals as it relates to my treatment

_____ INITIALS

I have read, understand, and agree to this Financial Policy. I am also aware of, and understand my policy benefits for treatment. I understand, if I do not wish to acknowledge or follow the facility policies, I will be discharged.

Patient/Guardian Signature _____

Date _____

Witness Signature _____

Date _____



MRN #: _____

PATIENT INFORMATION CONSENT FORM

Disclosure Authorization – For Release of Protected Health Information (PHI)

I have read and fully understand **Destination Life Therapy & Wellness's** Notice of Privacy Practices. A copy of the Notice of Privacy Practices is available in the front waiting area or a hard copy may be obtained upon request. I understand that **Destination Life Therapy & Wellness** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Destination Life Therapy & Wellness's** Occupational Therapist will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Destination Life Therapy & Wellness's** Notice of Privacy Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name: _____

Date: _____

Communication of Health Information

I give permission to Destination Life Therapy & Wellness to disclose and discuss any information related to my OR my child's medical condition(s) with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Initials: _____

Contact Information

I wish to receive appointment reminders and facility updates in the following manner(s):

Home Telephone : _____

- OK to leave message with detailed information
- Leave message with call-back number only
- OK to leave message with family members or other persons living in the same household

Work Telephone : _____

- OK to leave message with detailed information
- Leave message with call-back number only
- OK to leave message with secretary, assistant, or other individual who regularly answers the phone

Cell Telephone _____

- OK to leave message with detailed information
- Leave message with call-back number only

Email (Please specify email address) _____

- OK to leave message with detailed information (for appointment reminders)
- I would not like to be contacted via email

- I would like to participate in the facility media. I am aware that the facility takes video and photos to show patient's progress. These photos can be used for patients viewing, advertisement, and marketing.
- I would not like to participate in the facility media. I am aware that the facility takes video and photos to show patient's progress. These photos can be used for patients viewing, advertisement, and marketing

Patient Signature: _____

Date: _____