PATIENT INTAKE AND CONSENT FORM

"We Change Lives"

Internal Use Only: MRN# ____ Account Type ____

First Name ______________ MI ____
Last Name ______________
Address ______________
City__________ State ______ Zip__________
Home Phone ______________
Work Phone ______________
Cell Phone ______________

Social Security # ______________
Date of Injury/Onset______________ Today's Date ______________
Date of Birth ______________ Age ________
Sex: ☐ M ☐ F
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Injury Area:______________

Employer ______________
Address ______________
City ______________ State ______ Zip__________

Occupation ______________
Contact at Employer ______________

Referring Physician ______________
Clinic Name: ______________

Phone Number ______________
Address: ______________

Primary Insurance ______________
Group # ______________ ID # ______________
Insured Employer ______________
Relationship to Insured ______________

Insured Name ______________
Address ______________ City______________
State ______ Zip ________ Phone ______________
Insured Date of Birth _________ Insured Sex: ☐ M ☐ F

Secondary Insurance ______________
Group # ______________ ID # ______________
Insured Employer ______________
Relationship to Insured ______________

Insured Name ______________
Address ______________ City ______________
State ______ Zip ________ Phone ______________
Insured Date of Birth _________ Insured Sex: ☐ M ☐ F

Emergency Contact ______________ Daytime Phone Number ______________

Are you receiving or have you recently received home health services? ☐ Yes ☐ No
Are you receiving of have you recently received other therapy services? ☐ Yes ☐ 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. I waive all liability related to care.
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:

☐ Diabetes
☐ Chest Pain/Angina
☐ Heart Disease
☐ High Blood Pressure
☐ Heart Attack
☐ Pacemaker
☐ Vascular Disease
☐ CVA/Stroke/TIA
☐ Seizures
☐ Skin Abnormalities
☐ Sexual Dysfunction
☐ Nausea/Vomiting

☐ COPD
☐ Thyroid Problems
☐ Osteoporosis/Osteopenia
☐ Arthritis
☐ Hernia
☐ Recent Fractures
☐ Headaches
☐ Dizziness/Fainting
☐ Liver/Gallbladder Problems
☐ Kidney Problems
☐ Bowel/Bladder Problems
☐ Metal Implants

☐ Ringing in your Ears
☐ MRSA
☐ Special Dietary Guidelines
☐ HIV
☐ Hepatitis
☐ Asthma
☐ Depression
☐ Anxiety
☐ Allergies: ______________________
☐ Cancer: ________________________
Are you Pregnant? ☐ Yes ☐ No
Do you smoke? ☐ Yes ☐ No

List any allergies: ____

List Medication: ____
____

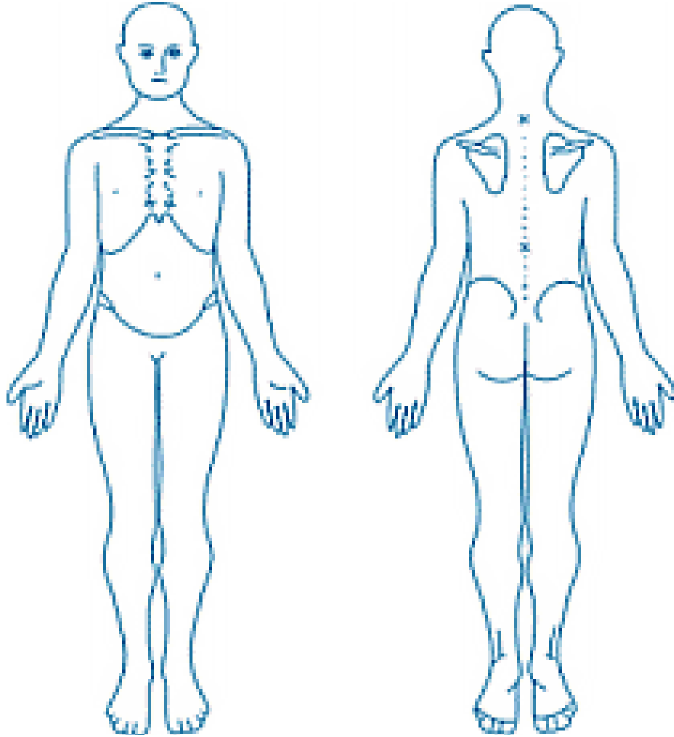
Did you have any XRay or MRI reports conducted within the last 6 months? __________ If yes, we will need a copy of the written report

Patient/Guardian Signature____ Date ______________________________________

MRN #:	Patient Name:

MEDICAL HISTORY FORM- CONTINUED

Please indicate below where your symptoms are located:



Mental Health History

Average Hours of Sleep: _______ Smoke: Y/N

Mental Health Diagnosis ________________________________

Check the following that apply:

- Aggression
- Lack of Concentration
- Increase Sadness
- Withdrawal or Isolation
- Hopelessness

Range of Motion Testing *(office use only)*

	Right	Left
Flex		
Ext		
IR		
ER		
ABD		
ADD		

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 is 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

Cancellation / Missed Visits

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

- o 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.
- o 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

Failure to complete these enrollment forms or provide our office with required documentation can cause a delay or denial of services

Patient Signature: ____ Date: ______________________