PATIENT INFORMATION

Patient:

Name: (Last)_____________________(First)_____________________ MI:____ DOB:_________

Address: ___________________________City:_________________ State: _____ Zip: __________

County _________________ Phone (___) ______________ Alt Phone (___) ________________

SS#:______________________________ Marital Status: M / S /W (circle one)

Secondary Address (if applicable):____

Primary Physician

Physician's Name:_________________________________Specialty______________________

Address: ________________________ City:_________________ State: _____ Zip:_________ Phone (___) ___________________

Fax (___) _________________

Home Environment

Live Alone? ☐ Yes ☐ No — If No, with whom__________________________ Pets:_________

Stairs/Steps? ☐ Yes ☐ No — If Yes, how many? _____________ Handrails? ☐ Yes ☐ No

Need for Home Safety Evaluation? ☐ Yes ☐ No

Medical Information

Describe complaint: _______________________________________ Onset Date:___/___/______

★ Diagnoses: ____

Recent Hospitalization/Nursing Home / Home Health Care:__________________________________

List surgeries and approximate dates:____

Medical Equipment / Supplies Required: ____

List Medications:____

Any Barriers to Treatment *(Please mark (X) if you would like our social worker to work with you on any of the following concerns)*

Health Conditions_____ Transportation_____ Legal_____ Nutrition/Diet_____ Emotional_____

Housing______ Family Problems_____ Memory_____ Balance_____ Financial_____

Drugs/Alcohol_______ Scheduling____ Physical Handicaps_____ Pain_____ Other_______

Emergency Information

Contact Person: __________________________________ Phone #:________________________

Hospital Preference:_______________________________ Phone #:________________________

Personal Emergency Response Plan:____

Clinical Care Coordinator’s Signature:______________________________ Date:__________

MEDICAL INFORMATION

Mark (X) for any conditions that apply / date:

Infectious Diseases:

- ☐ Measles
- ☐ Mumps
- ☐ Whooping Cough
- ☐ German Measles
- ☐ Chicken pox
- ☐ Scarlet fever
- ☐ Tuberculosis
- ☐ Pneumonia
- ☐ Poliomyelitis
- ☐ AIDS/HIV Positive
- ☐ NONE

Musculoskeletal:

- ☐ Chronic back/neck
- ☐ Fractures
- ☐ Dislocations
- ☐ Arthritis/Fibromyalgia
- ☐ Osteoporosis
- ☐ NONE

Genitourinary:

- ☐ Pregnancy
- ☐ Incontinence
- ☐ Kidney problems
- ☐ Prostate
- ☐ NONE

Cancer:

- ☐ Details
- ☐ NONE

Cardiovascular:

- ☐ Irregular pulse
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Peripheral Edema
- ☐ Hypertension
- ☐ Low blood pressure
- ☐ Heart attack
- ☐ Heart failure
- ☐ Circulation problems
- ☐ NONE

Gastrointestinal:

- ☐ Diabetes
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ NONE

Respiratory:

- ☐ Asthma
- ☐ TB
- ☐ Valley fever
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ COPD
- ☐ Emphysema
- ☐ NONE

Neurological:

- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Paralysis
- ☐ Forgetful/confusion
- ☐ Stroke/TIA
- ☐ Seizure
- ☐ Fainting/dizzy spells
- ☐ NONE

Psychiatric:

- ☐ Anxiety / “Nerves”
- ☐ Depression
- ☐ Memory
- ☐ Concentration
- ☐ Phobia
- ☐ Voices
- ☐ Suicidal thoughts
- ☐ NONE

Allergies:

- ☐ Food related
- ☐ Environmental
- ☐ Medicines

Skin:

- ☐ Rashes / eczema
- ☐ Psoriasis
- ☐ Chronic wounds
- ☐ NONE

AGREEMENT FOR THE ESTABLISHMENT OF OUTPATIENT SERVICES

I hereby give my permission for authorized personnel to perform all necessary procedures and treatments as prescribed by my physician for the delivery of outpatient services. I understand that there may be circumstances beyond the control of the Facility, when there may be short interruptions in service. During these interruptions, I will contact my family physician if I determine I need care. I also understand that the hours of service may be changed by mutual consent of the Patient (or responsible party) and the Facility. I understand that a $25.00 fee will be assessed for cancellations made less than 24 hours before a scheduled session (except in cases of emergency).

I acknowledge that I have read the Patient Bill of Rights and the Saguaro Rehabilitation & Aquatic Therapy Notice of Policy Practices, and can request my own copy. I hereby give my permission to release to, or receive from hospitals, physicians, or other agencies involved in my care, the medical records and information pertinent to my care. I understand that my health information will only be used for the purposes of treatment, payment, and health care operations, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and outlined in the Saguaro Fitness and Rehabilitation Notice of Privacy Practices.

I request that payment of authorized benefits be made on my behalf to Saguaro Rehabilitation & Aquatic Therapy, LLC.

Patient Signature:____ Date: __________________

Witnessed By: ____ Date: __________________

<u>For Medicare Patients Only</u>
Authorization To Release Information And Payment Request

I certify that the information given by me applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request.
I request that payment of authorized benefits be made on my behalf to Saguaro Rehabilitation & Aquatic Therapy LLC

Patient Signature:____ Date: __________________

Witnessed By: ____ Date: __________________

PATIENT BILL OF RIGHTS POLICIES

The following is a list of policies and information that is made available to each patient before beginning any therapy program at Saguaro Rehabilitation and Aquatic Therapy. This Manual is kept in the front lobby and can be re-read at any time. Please read and understand what the policies mean before initialing this form and beginning treatment. If there are questions or concerns, please let us know.

As a prospective patient, I am initializing these policies, therefore certifying that I have read the information and understand its meaning as to the care I will receive at this facility. *I realize that some of the policies may not pertain to me personally but are carried out for all patients when these cases apply.*

_______*(int)* **What is a Comprehensive Outpatient Rehabilitation Facility (CORF)**

_______*(int)* **Disclosure of Ownership and Business Information**

_______*(int)* **Patient Bill of Rights Policy**

_______*(int)* **Non-Discrimination Policy**

_______*(int)* **Access to Services for Persons with Impaired Hearing, Vision or Speech**

_______*(int)* **Program Accessibility for Persons with Physical Handicaps**

_______*(int)* **Communication Policy for Patients with Limited English Proficiency Policy**

_______*(int)* **HIPAA Regulations (Health Insurance Portability and Accountability Act of 1996)**

_______*(int)* **Advanced Healthcare Directive Rights**

______ **Yes, I have an Advanced Healthcare Directive, contact:**________________________

Name: *Phone:*

______ **No, I authorize medical professionals and others to prolong my life as long as possible within the limits of "generally accepted healthcare standards."**

CONSENT TO RELEASE MEDICAL RECORDS

I authorize Saguaro Rehabilitation & Aquatic Therapy, LLC to use and disclose my personal health information for the purposes of treatment, payment, and health care operations, as defined under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and outlined in the Saguaro Rehabilitation & Aquatic Therapy Notice of Privacy Practices. I acknowledge that I can request a copy of the Saguaro Rehabilitation & Aquatic Therapy Notice of Privacy Practices at any time.

I understand that this Consent is valid for a period of 180 days, unless revoked with written notice by the patient.

Patient's Signature:____ Date:________________

Relationship, if not the patient:

Witness:____ Date:_______________