NEW CLIENT INFORMATION

NAME: _____ **DATE:**_____

ADDRESS: _____

CITY: _____**STATE:**_____ **ZIP**_____

HOME PHONE:_____ **WORK PHONE:** _____

***Email:**_____
IN CASE OF EMERGENCY PHONE NUMBER:_____
NAME OF CONTACT:_____
RELATIONSHIP: _____

BIRTH DATE: _____ **MARITAL STATUS: S M D W** **GENDER:** _____
SOCIAL SECURITY #: _____

1. **IS THIS CONDITION RELATED TO CAR ACCIDENT?** • **YES** • **NO**
   IF YES, INSURANCE CARRIER _____
   CLAIM #: _____
   IF YES, LAWYER'S NAME: _____
2. **IS THIS CONDITION RELATED TO ANY OTHER ACCIDENT?** • **YES** • **NO**
   IF YES, LAWYER'S NAME: _____
3. **IS THIS CONDITION WORK RELATED?** • **YES** • **NO**
   IF YES, CASE MANAGER:_____
   PHONE:_____
4. **HOW DID YOU HEAR ABOUT US?**
   - **Referred by a Friend? Name:** _____
   - **Internet Search?**
   - **Referred by Physician? Name:** _____
   - **Other:** _____
5. **IF REFERRED BY YOUR PHYSICIAN, WHEN WAS THE LAST DATE VISIT SEEN?** _____.
6. **WHO IS YOUR PRIMARY CARE PHYSICIAN?**_____
   NAME AND ADDRESS:_____
7. **HAVE YOU RECEIVED ANY OTHER TREATMENT AT ANOTHER FACILITY FOR SAME DIAGNOSIS?** _____
   IF, YES WHICH FACILITY? _____

WELLCARE REHABILITATION PATIENT POLICY

1. **I, _____, understand that my appointments are scheduled in order to receive individualized care at Wellcare Rehabilitation. I am aware of the importance of attendance and timely arrivals in order to reach my therapy goals.**

2. **I understand that the amount of time being blocked in the therapist's schedule for my sessions will not be used by someone else if I do not show up for my appointment.**

3. **I am aware there is a $25 charge for all cancellation/no-show appointments if not cancelled within 24 hours and a $35 charge for all returned checks and for no show appointments for private massage.**

4. **I am aware there is a $50 flat rate chart preparation and distribution fee if release for outside distribution (Attorneys etc.)**

_____ _____

Patient Signature **Date**

_____

Parent Signature if Minor

CONSENT FOR TREATMENT

I give my consent for Michael Kenton, MSPT, CPT, doing business with Wellcare Rehabilitation to perform the treatment of Physical Therapy as authorized and prescribed by my physician.

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare and private insurances and third party payers to Michael Kenton MSPT, CPT doing business as Wellcare Rehabilitation. A photocopy of this assignment is to be considered as valid as the original. I authorize said assignee to release all information necessary including medical records; this authorization remains in effect until I revoke it in writing.
I am aware that I am responsible for any deductibles and /or co-insurance amounts as specified in my insurance plan. In addition, I am aware that in the event that my insurance denies payment I am responsible for payments of my bill.

Patient: _____

Signature_____ Date:_____

If patient is a minor:

Name of responsible party: _____

Relationship to patient _____

Signature: _____

MEDICAL HISTORY QUESTIONNAIRE

PATIENT NAME: _____

Please tell us about yourself. <u>Check</u> the <u>Boxes</u> and list details that apply to you.

- **High Cholesterol**
- **High/ Low Blood Pressure (circle)**
- **Varicose Veins**
- **Lung Disease**
- **Coughing Blood**
- **Shortness of Breath**
- **Cough/Sputum**
- **Back Injury**
- **Neck Pain**
- **Back Pain**
- **Knee Pain**
- **Surgeries/Operations** (Please List)

_____
_____
_____
_____
_____
_____

- **Orthopedic Problems** (Please List)

_____
_____
_____
_____

- **Pacemaker**
- **Awaken At Night-Urination**
- **Smoke**

- **Heart Attack**
- **Heart Disease**
- **Chest Pain/Discomfort**
- **Rheumatic Fever/Heart Murmur**
- **Cancer**
- **Epilepsy**
- **Diabetes**
- **Gout**
- **Stroke**
- **Arthritis**

other _____

- **Current Medications** (Please List)

_____
_____
_____
_____
_____
_____

- **Physical Activity Limitations**

_____
_____
_____
_____

Weight: _____ Height: _____

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and disclosure of your Protected Health Information
Your protected health information will be used by Wellcare Rehabilitation or disclosed to others for the purposes of treatment, obtaining payment or supporting the day to day health care operations of the practice.

Notice of Privacy Practices
You should review the notice of Privacy Practice for a more complete description of how your Protected Health Information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a restriction on the use of your information
You may request a restriction on the use and disclosure of your protected health information.

Wellcare Rehabilitation may or may not agree to restrict the issuance or disclosure of your protected health information.

Wellcare Rehabilitation agrees to your request, the restriction will be binding on the practice. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will no be affected.

Reservation of Right to change Privacy Practices
Wellcare Rehabilitation reserves the right to modify the privacy practices outlined in the notice.

Signature
I have reviewed this consent form and give my permission to Wellcare Rehabilitation to use and disclose my health information in accordance with it.

_____
Name of Patient

_____
Signature

_____
Date