PARAMOUNT
Rehabilitation Services

PATIENT DEMOGRAPHICS

Patient Name: _____Sex: M or F

Guardian Name/Emergency Contact:_____

Patient DOB: _____

Phone Number (Cell) :_____(Home):_____

Email Address (For appt. reminder alerts):_____

Home Address: _____

City, State, Zip: _____

Referring Physician: _____

Primary Care Physician: _____

Diagnosis: _____

Date of Surgery (If Applicable): _____

Date of Follow-up Physician Appt: _____

Case Manager Name (If Applicable):_____

OFFICE USE ONLY

EVAL DATE & TIME: _____

EVALUATOR: _____

PATIENT ID: _____

CASE NUMBER: _____

SURGICAL NON-SURGICAL

PT OT SPEECH

Previous Patient? Y or N

Pacemaker/Defibrillator? Y or N

Auto Accident Related? Y or N

Workman's Comp? Y or N

Receiving Home Therapy? Y or N

Recent D/C from Hospital? Y or N

Primary Insurance

Type: _____

Subscriber: _____

Policy Holder DOB:_____

Group #:_____

Contract #:_____

Secondary Insurance

Type: _____

Subscriber: _____

Policy Holder DOB:_____

Group #:_____

Contract #:_____

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PAST MEDICAL HISTORY

Have you ever been told you have any of the following?

Cancer	Yes	No	**Dialysis**	Yes	No
Heart Bypass	Yes	No	**COPD**	Yes	No
Congestive Heart Failure	Yes	No	**Recent Weight Loss**	Yes	No
Cardiac Stents	Yes	No	**Hernia**	Yes	No
High Blood Pressure	Yes	No	**Allergy to Heat/Ice**	Yes	No
Low Blood Pressure	Yes	No	**Hepatitis**	Yes	No
Asthma	Yes	No	**Bowel/Bladder Problem**	Yes	No
Diabetes	Yes	No	**Shingles**	Yes	No
Osteoporosis	Yes	No	**Fibromyalgia**	Yes	No
Thyroid problems	Yes	No	**Kidney Disease**	Yes	No
Arthritis	Yes	No	**Stroke**	Yes	No
Pacemaker/Defibrillator	Yes	No	**Seizures/Epilepsy**	Yes	No
Blood Clot	Yes	No	**Other** _____		
Depression/Anxiety	Yes	No	**Dialysis**	Yes	No
Latex Allergy	Yes	No			

Currently, are you experiencing any of the following? (circle all that apply):

Fever/chills/sweats	Poor balance (falls)	Unexplained weight loss	Pregnancy
Numbness/tingling	Incontinence	Difficulty swallowing	
Circulation Problems	Shortness of breath	Blood Clot	
Dizziness	Nausea/vomiting	Headaches	

Have you ever been told you have any of the following? (IF YES YOU WILL NEED TO FILL OUT ADDITIONAL INFORMATION- PLEASE SEE RECEPTIONIST FOR SECONDARY FORM

H1N1	Yes	No	**VRE**	Yes	No
MRSA	Yes	No	**Current Open Wound**	Yes	No
Scabies	Yes	No	**Pink Eye**	Yes	No
TB	Yes	No	**Lice**	Yes	No
Current Cough or Cold	Yes	No	**Current Shingles**	Yes	No

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History of fractured bones (If yes, please list where below with approximate dates)?
Yes No

_____

_____

Any metal implants, loop recorder, baclofen pump, insulin pump (If yes please list which and location below)? Yes No

_____

Please list any lifting, weight-bearing, or other restrictions/precautions related to your condition that have been given you by your physician:

_____

_____

Please list your surgical history with approximate dates:

_____

_____

Please list your current medications:

_____

_____

Please circle any of the following that you have recently had:

X-Ray CAT Scan PET Scan EMG MRI Other Diagnostic Testing

Please list results from any above circled testing (if known):

_____

_____

Is there anything else you think we should know about your general health or current condition?

_____

_____

How did you hear about Paramount please circle all that apply:

My Doctor Recommended Paramount Website Facebook Drove By

Family or Friend Recommended Paramount Past Patient Other: _____

Please circle below if you would like to receive the following types of reminders for each scheduled appointment:

Phone Call Reminders Text Reminders Email Reminders:_____

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All Information on this Form is Confidential

OT PT ST DME

I hereby give permission to Paramount Rehabilitation Services to evaluate and treat and/or provide DME product(s). I agree to be financially responsible for all charges incurred at Paramount Rehab, including my co-payment and insurance deductible. I further understand my insurance may not cover the services provided. I understand that if my insurance company does not pay for these services, then I will be responsible for any bill that is accrued. Furthermore, I authorize my insurance company to pay directly to Paramount Rehab Services under the terms of the policy issued by my company. Payment is authorized upon your receipt of any itemized bill for services rendered to me. Payment of the amount, on whole or in part, shall be considered the same as if paid by your company directly to me

Patient
Signature:_____**Date:**_____

Parent/Guardian
Signature: _____**Date:**_____

Acknowledgement of Receipt of Notice of Privacy Practices

The undersigned patient or legally authorized representative ("agent") of the patient acknowledges that he or she is aware of the privacy practices of this facility (HIPAA). If undersigned patient is unaware of these policies, he or she is aware that a copy will be made available upon request.

Patient
Signature:_____**Date:**_____

Parent/Guardian
Signature: _____**Date:**_____

No Show/Cancellation Policy

I understand that if I do not come to an appointment or do not cancel with a 24 hour notice, I will be charged $25.00 for that visit. The $25.00 will not be billed to my insurance company. I understand that I will be responsible for paying the $25.00 fee on the next visit.

Patient
Signature:_____**Date:**_____

Parent/Guardian
Signature: _____**Date:**_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

INFORMED AUTHORIZATION/CONSENT FOR THE RELEASE OF MEDICAL RECORDS: I hereby authorize: PARAMOUNT REHABILITATION SERVICES to release/obtain the medical records of:

Patient Name: _____ Date of Birth: _____

Release information to the person (s) listed below:

_____

_____

_____

Obtain information from person (s) listed below:

_____

_____

_____

Please check (X) what is specifically to be released:

(✔) Medical Records (✔) Phone Conversation ( ) Other-specify below

_____

I do expressly and voluntarily authorize the disclosure of the said medical records to the person(s) and/or entity (ies) as stated above. This authorization will remain in effect for a period of one year from the date signed below unless revoked in writing by the person to which it pertains (or his/her parent, legal guardian, or legally authorized agent) to the Medical Records Department. These medical records are being disclosed under the provisions of the applicable Michigan State and Federal Law.

Patient
Signature: _____ Date: _____

Parent/Guardian
Signature: _____ Date: _____

Witness: _____ Date: _____

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COMPLIANCE/CANCELATION POLICY

We understand that coming to physical, occupational, or speech therapy on a regular basis is a big commitment but it is very important for progress.

- Why is compliance so important?
  - Your Doctor has prescribed treatment for you, and unless you follow the protocol you will not get better.
  - 1-3 visits per week enables our clinicians to monitor your progress closely and make more frequent modifications if needed.
  - You may have a limited time frame on your health benefit coverage (i.e. 60 consecutive days, etc). You don't want to run out of health benefits prior to completing treatment.
  - Good compliance will ensure that you reach your goals as quickly as possible.
  - If you complete your physical rehab treatment program, you will be eligible to receive one month free of our Stepdown Program. This will enable you to come back 2x per week for 4 weeks to maintain your strength and to make sure you are still doing all your home exercises properly.
- Please be aware that we provide one-on-one care, and often have a waiting list for patients who are waiting to be seen. Because of this, our policy regarding cancellations/no-shows is as follows:
  - **We require 24 hour notice for cancellation; failure to follow this policy will result in discharge from our practice. If you are discharged, your physician/case manager will be notified on non-compliance.**
  - **Note: We understand that unexpected situations can arise (emergency/illness). We simply ask that you contact us as soon as possible to cancel/reschedule.**
  - **A $25.00 charge will be imposed upon violation of this policy and you will not be seen until it is paid. This fee is not billable to insurance**
- Thank you for trusting us with your care!

Signature: _____ Date: _____

Witness: _____ Date: _____