Adult Registration Packet
Physical / Occupational Therapy

Scan No. _____

Initials _____

PATIENT INFORMATION

Patient Name (Last, First, Middle Initial)		Marital Status: M S W D Circle One: Female or Male	
Address		Social Security Number	Date of Birth
City	State Zip Code	Email Address	
Best Contact Number	Emergency Contact Name/Number		

What type of appointment reminder do you prefer? □ Email □ Phone call

What format do you prefer for your rehab documents and home exercise program? □ Email □ Printed handouts

Are you receiving any nursing, aide, or therapy services in your home? □ Yes □ No *(If yes, notify the Front Office)*

For Medicare beneficiaries, have you received therapy in this calendar year? □ Yes □ No

Is this a Workers' Comp injury? □ Yes □ No **Date of Injury:** _____ **Adjustor:** _____ **Employer:** _____

INSURANCE INFORMATION

Primary:	**Secondary:**	**Tertiary:**
Policy/ID#:	**Policy/ID#:**	**Policy/ID#:**
Name of Policy Holder:	**Name of Policy Holder:**	**Name of Policy Holder:**
Relationship to Patient:	Relationship to Patient:	Relationship to Patient:
Date of Birth (Policy Holder):	Date of Birth (Policy Holder):	Date of Birth (Policy Holder):
SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):	SS# of Insured (Policy Holder):
Effective Date:	Effective Date:	Effective Date:
Group Number:	Group Number:	Group Number:
This is an estimation of benefits. It may change based on your insurance.		
YTD Deductible $:	YTD Deductible $:	YTD Deductible $:
YTD Deductible Met $:	YTD Deductible Met $:	YTD Deductible Met $:
Co-Pay Per Visit $:	Co-Pay Per Visit $:	Co-Pay Per Visit $:
Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:	Estimated Co-Insurance Per Visit $:
Insurance Coverage %:	Insurance Coverage %:	Insurance Coverage %:
Patient's %:	Patient's %:	Patient's %:
Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ **Are we in network? □ Yes □ No**	Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ **Are we in network? □ Yes □ No**	Total Visits Authorized: Visits Available: Auth End Date _____ $ Limit_____ **Are we in network? □ Yes □ No**

Integrity REHAB

Adult Medical History

Patient Name: _____
Date of Birth: _____

Name of your Primary Care Physician: _____ **Location:** _____

Check reason/s seeking therapy services:

1) _____Decreased Mobility 2) ____Pain 3) _____Weakness 4) ____Other:_____

Please list all diagnostic tests (X-Ray, MRI, CT scan, EMG study) performed for current problem

DATE	LOCATION	DIAGNOSTIC TESTS	RESULTS

Are you Pregnant? □ Yes □ No

Check current symptoms you are experiencing:

_____Bowel Leakage	_____Fever/Chills/Sweats	_____Nausea/Vomiting	_____ Urinary Leakage
_____Fatigue Weakness	_____Interrupted Sleep	_____Numbness/Tingling	_____ Weight Loss/Gain

Check the chronic conditions you are experiencing:

___Alcohol/Drug Addiction	___Defibrillator	___Kidney Disease	___Ringing in ears/ Dizziness
___Anemia	___Depression	___Multiple Sclerosis	___Stroke
___Arthritis	___Diabetes	___Osteoporosis	___Thyroid Problems
___Asthma	___Emphysema/Bronchitis	___Pace Maker	___Tuberculosis
___Bowel/Bladder Dysfunction	___Epilepsy	___Post Traumatic Stress Disorder	___Other: _____
___Cancer	___Grinding Teeth		_____
___Chemical Dependency	___Heart Problems	___Pulmonary Embolism	
___Circulation Problems	___Hepatitis	___Rheumatoid Arthritis	
___Clinched Jaw	___High Blood Pressure		

Please list any hospitalizations, injuries, surgeries, and other conditions you have had:

DATE	INJURIES/SURGERIES/OTHER	REASON

Please list all PRESCRIPTION (Rx) and OVER-THE-COUNTER (OTC) medications you are currently taking **(Include all injectable, oral, rectal, and topical medications)**:

Check the way you best learn. ___Listening ___Performing the task ___Watching

CONSENT FOR TREATMENT: I hereby authorize Integrity Rehab to provide therapy services to _____ that have been ordered by my (his/her) physician and are under the direct supervision of a licensed health care professional. I also understand that it is my (his/her) right to accept or refuse medical treatments.

AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT: In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payer sources, I certify that the information given by me or a person authorized by me is correct. This authorization and request shall begin on _____ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. If I fail to report changes with my insurance to Integrity Rehab's billing department I will be financially liable/responsible. I understand that I am financially responsible for all charges that my insurance company does not pay. I authorize the release of any information necessary in order to process any billing.

RELEASE OF INFORMATION/CONFIDENTIALITY: I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my (his/her) health care information from them to other health care providers involved in my (his/her) care, or any facility where I (he/she) may be admitted for the purpose of continuity of care. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). **For pediatric patients I agree to the Pediatric Speech Therapy Procedures.**

NOTICE OF NON-DISCRIMINATION: Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age.

GRIEVANCE/COMPLAINT PROCEDURE: Should I have a grievance or complaint; I understand that every attempt will be made to rectify the situation without fear of reprisal. I may contact the Clinic Director, Compliance Officer, or Administrator by calling (254) 699-3933 or emailing Compliance@IntegrityRehab.net. If the grievance or complaint is not resolved to my satisfaction, I may follow the printed "Consumer Information Notices" in the Reception area.

PHOTOGRAPHY: I **DO** ___ **DO NOT** ___ authorize Integrity Rehab to photograph, videotape, or audio record me (him/her) for medical education or reasons related to treatment and/or promotion of Integrity Rehab operations. Patient's name will not be used.

INFORMATION RECEIVED: I have reviewed a laminated copy of the following information to **read and understand:** 1) **Notice of Privacy Practices**, 2**) Cancellation and No-Show Policy,** and 3) **General Health** Guidelines**. I may request a copy to take home with me**. For **pediatric patients**, in addition to the preceding information, I have **reviewed** a laminated copy of **Pediatric Speech Therapy Procedures**.

In addition, the following NEW PATIENT INFORMATION is available upon request:

- Abuse, Neglect, and Exploitation
- Advance Directives
- Cell Phone Policy
- Children Policy
- Civil Rights
- Disaster/Emergency
- Employee Drug Testing
- Rights of the Elderly

I acknowledge that the information above has been provided to me or is accessible to me in my primary language, or via an interpreter. I certify that the information I have provided in this registration packet is accurate and complete.

Patient signature and date

Authorized agent signature and date **Relationship to patient**