

VIP REHAB, INC.
PATIENT INTAKE AND CONSENT FORM

First Name _____ MI _____
Last Name _____
Address _____
City _____ State _____ Zip _____
Home Phone _____
Cell Phone _____
E-mail _____

Date of Injury/Onset _____ Today's Date _____
Date of Birth _____ Age _____
SS # _____
Sex: _____ M _____ F
Marital Status: _____ S _____ M _____ D _____ W

Insured's Name _____
Insured's SS# _____ DOB _____
Phone Number _____
Relationship to Patient _____

Accident Related: _____ Yes _____ No
Accident: _____ Auto _____ Work _____ Other
Nature of Accident _____

Patient's Employer _____
Work Phone _____

Occupation _____

Referring Physician _____

Phone Number _____

Emergency Contact _____

Daytime Phone Number _____

Have you received any therapy at any other facility this year? _____ Yes _____ No
Have you received home health or hospice services in the last 12 months? _____ Yes _____ No
If so, which agency? _____

Please Initial

CONSENT TO TREATMENT: I consent to rehabilitation and related services at VIP Rehab, Inc. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

TREATMENT OF MINORS: I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim that I may have resulting from failure to do so.

LIABILITY: I know and agree that VIP Rehab, Inc. is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit VIP Rehab, Inc., its 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 medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to VIP Rehab, Inc. 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 Patient 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.

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.
I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature: _____ Witness Signature: _____

Medical/Demographic Information

Place an X on the blank(s) that best describe you or your needs.

1. Insurance (check all that apply)
 - Worker's Compensation
 - Self-pay
 - HMO/PPO/private insurance
 - Medicare
 - Medicaid
 - Auto
 - Other
2. With whom do you live? (check all that apply)
 - Alone
 - Spouse/significant other
 - Child/children
 - Other relative(s)
 - Group setting
 - Personal care attendant
 - Other: _____
3. Where do you live?
 - Private home
 - Private apartment
 - Board and care/assisted living/group home
 - Homeless (with or without shelter)
 - Long-term care facility (nursing home)
 - Hospice
 - Other
4. Do you use a: (check all that apply)
 - Cane?
 - Walker, rolling walker, rollator?
 - Manual wheelchair?
 - Motorized wheelchair?
 - Other
5. What medications do you take daily? _____

6. Do you have any other medical conditions that may affect this treatment or your rate of recovery?
 Yes No. If yes, please explain _____
7. Do you have any mental or cognitive disorders that could alter your recovery? Yes No
8. When did this problem first begin? _____
9. Have you been hospitalized in the past 30 days? Yes No
10. Have you had therapy for this same condition before? Yes No
11. How would you rate your general health? Excellent Good Fair Poor
12. Do you need this therapy in order to return to your desired living environment? Yes No
13. Do you need this therapy in order to reduce the level of assistance you require for eating, bathing, dressing, grooming, etc? Yes No
14. How much assistance do you currently require for eating, bathing, dressing, grooming, etc?
 Minimum Moderate Maximum
15. Do you have allergies or reactions to any drugs? Yes No
If yes, please list _____
16. Are you pregnant? Yes No If yes, # _____ of weeks.

17. Do you use tobacco? ___ Yes ___ No

18. DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS?
(Check all that apply)

- | | | |
|---------------------------------------|-----------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HEPATITIS/HIV |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HIGH BLOOD PRESSURE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> RESPIRATORY PROBLEMS | <input type="checkbox"/> DIZZINESS/FAINTING |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> KIDNEY PROBLEMS | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> METAL IMPLANTS | <input type="checkbox"/> LOW BLOOD PRESSURE |
| <input type="checkbox"/> HEADACHES | <input type="checkbox"/> HEART PROBLEMS | <input type="checkbox"/> SUBSTANCE ABUSE |
| <input type="checkbox"/> FRACTURES | <input type="checkbox"/> THYROID DISORDERS | <input type="checkbox"/> ALCOHOL ABUSE |
| <input type="checkbox"/> OTHER: _____ | | |

WE WOULD LIKE TO KNOW WHAT LED YOU TO CHOOSE VIP REHAB, INC.
(PLEASE CHECK ONE)

_____ PHYSICIAN RECOMMEDATION

_____ FRIEND OR FAMILY MEMBER

_____ HEARD ABOUT US ON; TV _____ RADIO _____

_____ PERSONAL EXPERIENCE

_____ OTHER, PLEASE EXPLAIN _____

PLEASE NOTE: IF YOU HAVE PRIVATE INSURANCE, WE WILL BE HAPPY TO ASSIST YOU IN DETERMINING YOUR BENEFITS. PLEASE UNDERSTAND, OUR INFORMATION IS ONLY AS ACCURATE AS THE INFORMATION GIVEN TO US BY YOU AND YOUR INSURANCE COMPANY. WE ARE ASSISTING YOU, THEREFORE, IT IS ULTIMATELY YOUR RESPONSIBILITY TO CHECK BENEFITS AND ASK QUESTIONS. THANK YOU FOR YOUR BUSINESS.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

PATIENT SIGNATURE

DATE

Name _____

1	2	3	4	5	6	7	8	9	10
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Please rate your pain by circling the appropriate number above where "0" is no pain at all and "10" is unbearable pain or pain that would send you to the ER.

Where is your pain located? _____

What is the frequency of your pain? Please circle one.

Infrequent Frequent Constant

Have you had any falls in the past 6 months? Yes or No

Do you experience dizziness when you stand after sitting or when you sit up after laying down?

Please list all your medications with strength and dosage:

Please list all surgeries with date performed:

Date:

_____ Hip Right / Left / Both _____

_____ Knee Right / Left / Both _____

_____ Shoulder Right / Left / Both _____

_____ Neck _____

_____ Back _____

_____ Other _____