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)

☐ ASTHMA	☐ DEPRESSION	☐ HEPATITIS/HIV
☐ ANEMIA	☐ DIABETES	☐ HIGH BLOOD PRESSURE
☐ ARTHRITIS	☐ RESPIRATORY PROBLEMS	☐ DIZZINESS/FAINTING
☐ PACEMAKER	☐ KIDNEY PROBLEMS	☐ SEIZURES
☐ CANCER	☐ METAL IMPLANTS	☐ LOW BLOOD PRESSURE
☐ HEADACHES	☐ HEART PROBLEMS	☐ SUBSTANCE ABUSE
☐ FRACTURES	☐ THYROID DISORDERS	☐ ALCOHOL ABUSE

☐ 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

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Person Giving Information:________________ Relationship to Patient:_____________

Patient Name:____

HIC Number:____

Patient Age:______________________ Patient Sex:____________________________

Basis for Patient Entitlement to Medicare

________Age ________Disability _____End Stage Renal Disease(ESRD)

Group Health Plan Information:

1. Is the patient or patient's spouse currently employed? ____Yes ____No

   If No: Retirement date of patient: __________________

   Retirement date of spouse: __________________

   If Yes, continue.

   Is patient or spouse employed? _______________________________________

   Are there: _________ 1. Less than 20 employees

   _________ 2. More than 100 employees

   Is employee actively working? _______Yes _______No

Insurance Company:__________________________ Policy Number:_______________

Insurance Plane Name:_________________ Plan Identification Number:____________

Is the patient employed? _____Yes _____No Full Time?_____ Part Time?______

Employer Name:____

Employer Address:____

City________________________ State________________ Zip Code______________

Employer Identification Number:____

Automobile, No Fault or Liability Insurance Information:

2. Is the illness/injury due to an accident (auto included)? _____Yes _____No

   If Yes, Continue:

Type of non-work-related accident: _____Automobile _____Other (describe) ________

Date of Accident:_______________ Insurance Situation: _______Liable _______Not Liable

Name of Policy Holder:___________________ Address of Policy Holder:__________________

Policy Number or Claim Identification Number:____

Workers Compensation Insurance Information:

3. Was the patient involved in a work-related accident? ______Yes ______No

Date of Accident:____________________

Is the Patient Working? _____Yes _____No _____Full Time? _____Part Time?

Employer Name:____________________ Employer Identification Number:________

Employer Address"____________________

City____________________ State____________ Zip Code____________

Name of Insurance Company:____________________

Name of Person or Company Insured:____________________

Insurance Company Claim or Policy Number:____________________

Workers Compensation Claim Number:____________________

Name of Workers Compensation Agency:______________ Address:____________

Has the case been settled? ______Yes, if so __________Date ______No

Name of Patient's Legal Representative for the case:____________________

Phone Number of Legal Representative:____________________

Veteran's Administration (VA) Authorization Information:

Does the patient have VA fee service car? ____Yes ____No

Has the VA issued a special authorization for these services? ____Yes ____No

Does the patient authorize you to bill the VA? ____Yes ____No

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Black Lung Insurance Information

Is the patient entitled to benefits under the Department of Labor's Block Lung Program? ____Yes ____No

Are the services provided on the Department of Labor's list of approved procedures for the treatment of Black Lung Disease? ____Yes ____No

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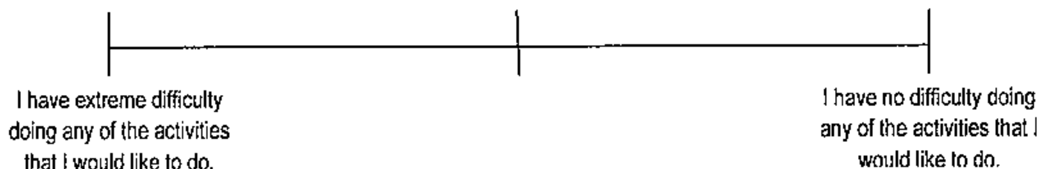
____________________ ____________________

Patient Signature Date Witness Signature Date

Difficulty-Baseline

Instructions: Please circle the level of difficulty you have for each activity today	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling Over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5.Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking-short distance	1	2	3	4	5	9
10. Walking-long distance	1	2	3	4	5	9
11. Walking-outdoors	1	2	3	4	5	9
12. Climbing Stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* of the activities you would like to do, please mark an "X" at the point on the line the best describes your *overall* level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs, kneel,* and *hop* without any difficulty, you would choose numbers: 12, 8, 13)

1.______ 2.______ 3.______

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Name ____

1	2	3	4	5	6	7	8	9	10

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 ____		