PATIENT INTAKE INFORMATION

Patient Intake and Worker Compensation / Insurance Information

☞ *Please have **insurance card(s)** available for copying* *Family Physician:* _____

☞ *Please fill in **ALL** blanks unless specified by the office staff* *Referring Physician:* _____

◆ Patient Information

Name _____ Age _____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Sex: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Social Security Number _____ - _____ - _____ Phone (_____) _____ - _____
Email Address _____ Mother's Maiden Name _____
In case of Emergency notify Name _____ Phone (__) ___ - ____

◆ Employer Information

Company Name _____ Phone (_____) _____ - _____
Supervisor's Name _____ Phone (_____) _____ - _____
Address _____ City _____ State _____ Zip _____
Occupation _____ **IF RETIRED PLEASE GIVE DATE OF RETIREMENT** _____

☞ Fill in the following section **ONLY** if Worker's Compensation is applicable

◆ Worker's Compensation Information

Please describe injury _____
_____

For office use only
Billing Company _____ Phone (____) - _____ - _____
Address _____ City _____ State ___ Zip _____
Adjuster's Name _____ Phone (____) - _____ - _____ Ext. _____
Claim # _____
Dates Verified Through From _____ Through _____

☞ **STOP** here if you are using Worker's Compensation.

◆ Responsible Party If Other Than Patient

Name _____ Phone (_____) _____ - _____
Address _____ City _____ State _____ Zip _____
Sex: ☐ Male ☐ Female Relationship _____ Date of Birth _____
Employer Name _____ Phone (_____) _____ - _____
Address _____ City _____ State _____ Zip _____
Occupation _____ Social Security Number _____ - ___ - _____

◆ Insurance Information

Medicare # _____ **Medicaid #** _____

☐ **Primary Insurance /** ☐ **Use As Secondary for Medicare**
Insurance Company _____
Phone (____) _____ - _____
Insured's SS # _____ - _____ - _____
Group Name _____
Group # _____
Policy # _____

For office use only
Effective Date _____
Pays at _____%
Co-Payment _____
Out of Pocket _____
Pre-certification Required ☐ Yes ☐ No
Insurance Contact Person _____
Deductible met? ☐Yes ☐No Amount _____

ANGELINA REHABILITATION CENTER, L.L.C.
✉ 402 S, John Redditt Dr. ◆ Lufkin, Texas 75904 ◆ ☎ (936) 632-2107 ◆ Fax: (936) 632-2108

PATIENT MEDICAL HISTORY

Patient Name: _____ Age: ___ Years Sex: ☐ Male ☐ Female Referring MD: _____
Last First MI

Diagnosis: _____ Date of Injury/Surgery: _____

Are you currently taking medication? ☐ No ☐ Yes If Yes please list _____

Please describe your past or present medical history: _____

Please check is you have problems with: ☐ diabetes ☐ heart ☐ lungs ☐ kidneys ☐ seizures ☐ reaction to medications, please describe in detail: _____

Do you have allergies? ☐ No ☐ Yes If Yes please describe: _____

Are you currently working? (check one): ☐ fulltime ☐ part-time ☐ light-duty ☐ no

My work requires (check all that apply): ☐ standing ☐ sitting ☐ bending ☐ crouching ☐ driving ☐ lifting ☐ pulling ☐ pushing Briefly describe: _____

Please list any exercise or recreational activities that you are normally involved in: _____

What is your main complaint or problem? _____

What goals do you hope to achieve as a result of Physical Therapy treatment? _____

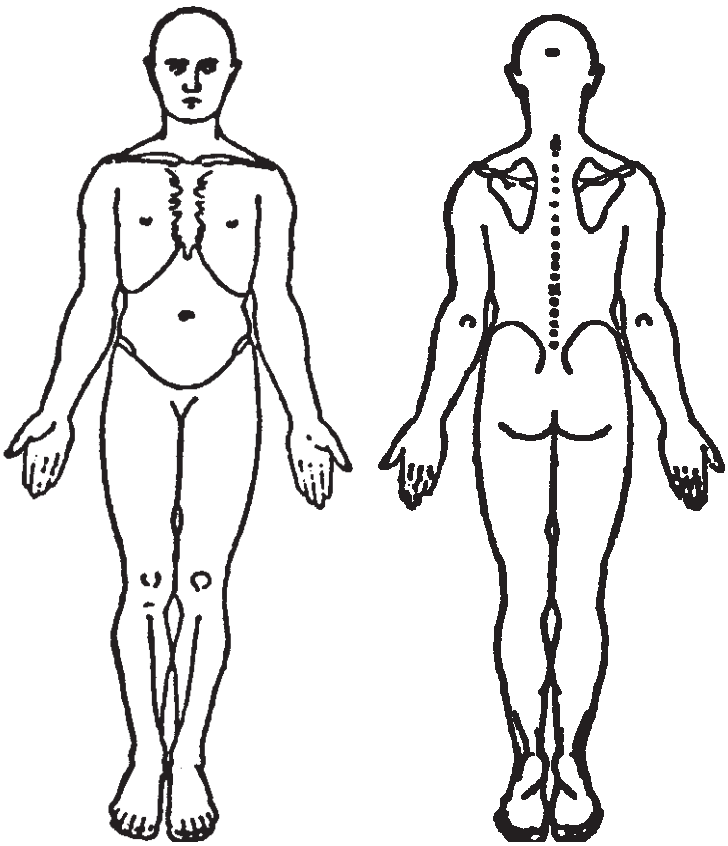
How did you find out about this facility? ☐ MD ☐ Friend ☐ Advertisement ☐ Internet ☐ other _____

Have you previously had treatment for this problem? ☐ No ☐ Yes If Yes please describe: _____

☞ Answer questions below using the diagram provided

1. Where is your pain/problem located? (draw an "**X**" on the diagram)
2. Rate your pain (0 = no pain; 10 = unbearable)
   0 1 2 3 4 5 6 7 8 9 10
   Mild Moderate Severe
3. Describe your pain? (check all that apply)
   ☐ sharp ☐ dull ☐ burning ☐ aching ☐ deep
4. Do you have any tingling or numbness? (draw a "**Z**" on the diagram)
5. Is your pain constant? ☐ No ☐ Yes
6. If **NO**, is it: ☐ frequent ☐ occasional
7. What positions/activities **increase** your symptoms?
   _____
8. What positions/activities **decrease** your symptoms?
   _____
9. Are your symptoms worse at the:
   ☐ beginning of day **OR** ☐ end of the day

Therapist Notes:



Signature: _____ **Date:** _____

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MEDICARE/MEDICAID ACKNOWLEDGEMENT

◆ **Medicare Acknowledgement**

I understand that in the opinion of Angelina Rehabilitation Center that the services or items that I have requested to be provided to me from _____until discharge from this episode may not be covered under the *Texas Medical Assistance Program* as being reasonable and medically necessary for my care.

I understand that the *Texas Department of Human Services* or its health-insuring agent determines the medical necessity of the services or items that I request and receive.

I also understand that I am responsible for payment of the services of items I request and receive if these services or items are determined not be reasonable and medically necessary for my care.

☞ Initial here _____

◆ **Medicaid Acknowledgement**

I understand that in the opinion of Angelina Rehabilitation Center that the services or items that I have requested to be provided to me on _____ until discharge from this episode may not be covered under the *Texas Medical Assistance Program* as being reasonable and medically necessary for my care.

I understand that the *Texas Department of Human Services* or its health-insuring agent determines the medical necessity of the services or items that I request and receive.

I also understand that I am responsible for payment of the services of items I request and receive if these services or items are determined not be reasonable and medically necessary for my care.

☞ Initial here _____

_____	_____	_____
Signature of Patient/Guardian	Date	Signature of Witness
_____		_____
Print Name of Patient/Guardian		Print Name of Witness

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ASSIGNMENT OF BENEFITS/MEDICAL RECORDS

ASSIGNMENT OF INSURNACE BENEFITS

In consideration of services rendered, I hereby transfer and assign to provider listed above, all rights, title and interest in any insurance benefits due to me for services rendered herein.

I hereby authorize my provider (s) to release any information needed to process this or any related claims.

I understand that I am financially responsible for and agree to pay at Lufkin, Angelina County, Texas for the charges of my insurance company(s) as well as those considered not covered or out of network/ managed care.

Execution of this assignment and acceptance of it does not impose any obligation upon the provider (s) for the collection of any insurance benefits that may be due in favor of the insured.

RELEASE OF MEDICAL RECORDS

I hereby authorize the release of all medical records or other information acquired in the course of and examination and / or treatment to Angelina Rehabilitation Center. I hereby authorize Angelina Rehabilitation Center to release any information acquired in course of the provider(s) examination and or treatment.

BENEFITS INQUIRY AUTHORIZATION

I hereby authorize Angelina Rehabilitation Center to inquire on my behalf on any / or all Medicare, Medicaid or any other insurance claims.

I authorize a copy of this authorization to be used in place of original.

I have fully read and understand the above Assignment of insurance benefits, release of medical records, and benefits inquiry authorization.

_____ _____

Signature of the Insured/ Patient Date

_____ _____ _____

Signature of Parent / Guardian Relationship Date

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HIPPA POLICY

ACKNOWLEDGEMT OF REVIEW OF NOTICE OF PRIVACY POLICIES (HIPPA)

I have had an opportunity to review our practices notice of privacy practices, which explains how your medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

I understand that in any situations, Angelina Rehabilitation Center will not release any of my protected Health Information (PHI) to my family, caregiver, or friend(s) without the expressed written consent from me, the patient, power of attorney, or in the case of a minor, parent/ legal guardian. I give consent to release information from this medical record to the specified individual(s) as designated by me:

( ) Yes, My Protected Health Information may be released to:

Names	Relationship to patient
_____	_____
_____	_____
_____	_____

( ) No, My Protected Health Information may not be released to anyone:

_____ _____ _____
Signature of the Insured/ Patient Print Name Date

_____ _____ _____
Signature of Parent / Guardian Relationship Date

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