VITAL CARE REHABILITATION, LLC

Patient Intake Form

Patient Name_____ **Date of Birth**_____ **Date:**_____

Y N (Please Check Mark)

( )( ) Are you entitled to group health benefits through your own or your spouse's current employer?

( )( ) Is your condition related to an accident? If yes, ( )Work ( )Auto ( )Other

( )( ) Do you intend to file a lawsuit or is litigation pending? If yes, please provide:

Attorney Name_____ Phone Number_____

Address_____

Name_____

Address_____

City/State/Zip_____

Home Phone_____

Work Phone_____

Employer Name_____

Employer Address_____

City/State/Zip_____

Social Security Number_____

Email _____

Emergency Contact Information

Name_____

Phone Number_____

Relationship to Patient_____

Name of Insurance Company_____

Insurance Co. Phone Number_____

Insurance Co. Address_____

Name of Primary Insured_____

Date of Birth_____

Insured's Address_____

Insured's Phone Number_____

Sex ( )M ( )F

Do You have a Secondary Insurance?( )Yes ( ) No

Name of Insurance Company_____

ID Number_____

Group Number_____

Appointment Reminder Consent

Please tell us the best way to contact you to remind you of your appointments. Please choose one.

( )Text:_____** Cell Carrier(required)_____

( ) Email:_____

**Standard text messaging rates apply.

VITAL CARE REHABILITATION, LLC

Important Notices & Policies

Notice of Privacy Practices & Non-Discrimination Policies

These policies describe your rights as a patient, how your medical information may be used and how to file a grievance if you feel your rights have been violated. A copy of this information is available to you.

I_____ would like to ( )receive ( )refuse a copy of Vital Care Rehabilitation's Notice of Privacy Practices and Non-Discrimination Policies.

Signature_____ **Date**_____

Company Policies

- **15 Minute Late Policy** Being late doesn't allow you to get the quality care you deserve and compromises the care of other patients. Being late by more than 15 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.
- **24-Hour Advance Notice Fee** If you wish to change or cancel an appointment we require a minimum ***24 hour advance notice.*** Anything less will result in a ***$50 fee*** charged to your account. Whether you attend your appointment or not we still accrue the expenses (for staff wages, rent, etc.) We don't charge you the actual cost for that appointment but rather a mere ***$50 fee.*** We do NOT make money with this charge; it is a deterrent from making last minute changes and to allow someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible.
- **Copays are Due Upon Arrival**
- **Cell Phones Must be Shut OFF or Silent** We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off.
- **Children Requiring Supervision are NOT Allowed to Attend Sessions With You** You may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.
- **Financial Hardship** If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.
- **Important Notice From the Federal Government** It is unlawful to routinely avoid paying your copay, deductible, or coinsurance payments… even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's- Take What Insurance Pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a) (5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Dept. of Health and Human Services. Contact by phone:(202)619-1343, by fax: (202)260-8512, by email: paffairs @oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Dept. of Health and Human Services, Room 5541 Cohen Building, 333 Independence Ave., S.W. Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, (202)619-0089.

VITAL CARE REHABILITATION, LLC

Treatment and Financial Consent

Release of Information

I hereby authorize Vital Care Rehabilitation, LLC to release my medical records to the following:

Name_____Address/Phone_____

Name_____Address/Phone_____

Consent for Care and Treatment

I hereby give my agreement and consent to Vital Care Rehabilitation, LLC to furnish appropriate rehabilitative care and treatment, as considered necessary and in my best interest to treat my physical condition. I understand that the benefits and risks to all interventions will be explained and that the patient holds the final judgment in such matters.

Patient: _____ Date: _____

Parent/Guardian_____ Date: _____

Financial Consent/Assignment of Benefits

It is the policy of Vital Care Rehabilitation, LLC to collect copays, co-insurance, and deductibles at the time of service. **Ultimately it is your responsibility to know your benefits. We recommend that you call your insurance company to have your benefits explained to you.** However, as a courtesy we verified your benefits with your insurance company. The following information was given to us by your insurance company and is an **estimate ONLY** of your responsibility. The plan benefits that were given to us by your insurance company are as follows:

BCBS ADV Patients: Evaluation & Treatment will be a double copay.

Plan:_____ **( )In-Network ( )Out of Network Prior Auth needed ( )Y ( )N**

Patient Financial Responsibility

Type	Amount	Frequency		Amount	Frequency
Deductible	_____	_____	**Copay**	_____	_____
Co-Insurance	_____	_____	***Cap**	_____	_____

*I understand that my insurance company has a financial and/or number of visits cap. I understand that once my cap has been reached, I will be given the option to continue care if deemed reasonable and necessary by my physical therapist. Furthermore, I understand that if I continue care after my cap has been reached, I will be financially responsible for all services rendered to me.

By signing below I agree that my benefits have been explained to me and I agree to the financial terms. I understand that the benefit information given to me today is an estimate of my responsibility and that my final responsibility will be determined when my claims are processed by my insurance company. I understand I will be billed for any remaining balance after my insurance has paid.

I hereby authorize Vital Care Rehabilitation, LLC to submit claim forms and personal health information (PHI) to my insurance. If I enroll in another plan, it is my responsibility to inform Vital Care Rehabilitation, LLC of the change, otherwise I will be responsible for payment.

Patient Signature:_____ **Date:**_____

Benefits explained by:_____ **Date:**_____

VITAL CARE REHABILITATION, LLC

Direct Payment Notice

IMPORTANT NOTICE ABOUT DIRECT PAYMENT FOR YOUR HEALTH CARE SERVICES

The Arizona constitution permits you to pay a health care provider directly for health care services. Before you make any agreement to do so, please read the following important information:

If you are an enrollee of a health care system (more commonly referred to as a health insurance plan) and your health care provider (Vital Care Rehabilitation) is contracted with the health insurance plan, the following apply:

1. You may not be required to pay the health care provider directly for the services covered by your plan, except for cost share amounts that you are obligated to pay under your plan, such as copayments, coinsurance and deductible amounts.

2. Vital Care Rehabilitation's agreement with the health insurance plan may prevent Vital Care Rehabilitation from billing you for the difference between the provider's billed charges and the amount allowed by your health insurance plan for covered services.

3. If you pay directly for a health care service, Vital Care Rehabilitation will not be responsible for submitting claim documentation to your health insurance plan for that claim. Before paying your claim, your health insurance plan may require you to provide information and submit documentation necessary to determine whether the services are covered under your plan.

4. If you do not pay directly for a health care service, Vital Care Rehabilitation may be responsible for submitting claim documentation to your health insurance plan for the health care service.

Your signature below acknowledges that you received this notice before paying directly for a health care service.

Signature:_____ Date:_____

Print Name:_____

VITAL CARE REHABILITATION, LLC

Patient Health History

Patient Name_____ **Patient Date of Birth**_____

Medical History

What are you coming to Physical Therapy for?_____

If you are here for post-operative rehabilitation…..

What type of surgery?_____

When?_____

How did your condition start?

( ) Suddenly
( ) Gradually
( ) Lifting
( ) No apparent reason
( )Pulling
( )Injured at work
( )Bending
( )Other

What activities make your condition worse?

( )Exercise (during)
( )Exercise (after)
( )Sitting
( )Walking
( )Bending forward
( ) Bending backward
( ) Coughing/Sneezing
( ) Sleeping/Lying

What reduces the pain or minimizes symptoms?

( )Lying Down
( )Sitting
( )Standing
( ) Pain Pills
( )Injection for pain
( )Muscle relaxants

Have you had any of these diagnostic tests?

Xrays	( )Yes	( )No	Date_____
CT Scan	( )Yes	( )No	Date_____
EMG/NCV	( )Yes	( )No	Date_____
MRI	( )Yes	( )No	Date_____
Arthrogram	( )Yes	( )No	Date_____

Y N

( )( ) Allergies:_____
( )( ) Diabetes: Type ( )1( )2 (Check One)
( )( ) Neuropathy?_____
( )( ) High blood pressure
( )( ) Heart disease_____
( )( ) Pacemaker/other electronic device_____
( )( ) Stroke (CVA/TIA) Date:_____
( )( ) History of Blood Clots or other Vascular Disease: Peripheral Artery Disease, Venous Insufficiency, Other:_____
( )( ) Cellulitis or other active infections?_____
( )( ) Lung Problems: Asthma/Emphysema/COPD/ Valley Fever/Other:_____
( )( ) Osteoporosis/Osteopenia
( )( ) Fibromyalgia
( )( ) Autoimmune Disease:_____
( )( ) Cancer/Tumors: What Type?_____
( )( ) Did you have Lymph Nodes removed?
( )( ) Radiation?_____
( )( ) Chemotherapy?_____

Please provide your medication list to the front office, or list all medication you take and the reason you take them.

Surgical History

_____
_____
_____
_____
_____
_____

Medication	Reason
1._____	
2._____	
3._____	
4._____	
5._____	
6._____	

VITAL CARE REHABILITATION, LLC

Psych-Social Screening

Patient Name_____ **Date of Birth**_____ **Phone #**_____

****THIS IS A PSYCH-SOCIAL SCREENING****

Vital Care Rehabilitation is a Comprehensive Outpatient Rehabilitation Facility (CORF). We are interested in the physical and emotional well-being of our patients. We have a licensed social worker on our team available for patients who may need counselling or resources available in the community.

IF YOU DO NOT WISH TO PARTICIPATE IN THIS SCREENING- PLEASE SIGN AND DATE BELOW.
DO NOT FILL OUT ANY QUESTIONS IN THE NEXT SECTION.

Signature_____ **Date:**_____

IF YOU WOULD LIKE TO BE EVALUATED FOR SOCIAL SERVICES, PLEASE ANSWER THE QUESTIONS IN THE NEXT SECTION OF THIS FORM AND SIGN AT THE BOTTOM.

1. What transportation do you use to come to our facility?_____

2. Would you like information on the following resources (Check all that apply):

( )Meal/Food Preparation ( )Transportation ( )Housecleaning
( ) Home Repair ( ) Financial Assistance ( )Support Groups
( ) In Home Nursing Care ( )Other, please describe_____

3. Who do you live with? ( )spouse ( )family ( )roommate ( ) alone ( )other_____

4. Who do you identify as support? ( )spouse ( )family ( )friends ( )church ( )other_____

5. What assistance do you need with daily activities/tasks?_____

6. Are you currently under the care of a Counselor/Psychotherapist**?** ( )Yes ( )No

Please check any of the following symptoms that you have experienced within the last 2 months.

( ) Loss of interest in previously enjoyable activities ( )Poor concentration
( ) Sleeping too much or too little ( )Difficulty making decisions
( ) Insomnia (trouble going to or staying asleep) ( )Hopelessness regarding the future
( ) Loss of appetite or change in eating habits ( )Impairing alcohol consumption
( ) Weight gain or loss ( )Irritability, difficulty controlling your temper
( ) Withdrawal from people or relationships ( )Sadness or excessive crying
( ) Feeling you are reliving a traumatic experience, having repeated distressing memories, or nightmares. Comments_____

Thank you for participating. Our Social Worker may call you to discuss your concerns.

Patient Signature_____ Date_____

Office Use Only **Psychologist/Social Worker: Are P/S services indicated ( )**Yes ( )No
Comments_____

_____

_____

Social Worker Signature:_____Date_____