PATIENT INFORMATION FORM FOR NEW AND RE-ESTABLISHED PATIENTS (Consults, New Patients, Limited Consults)

(Please complete the following)

DATE _____ NAME _____ DOB _____ AGE _____

R/L HANDED _____ MARITAL STATUS _____ # OF CHILDREN _____ AGES _____ HEIGHT _____ WEIGHT _____

CURRENT PROBLEM(S) _____

_____

_____

WHEN DID IT START? _____

REASON PROBLEM STARTED _____

WHAT TESTS (and results) HAVE YOU HAD FOR THIS PROBLEM?

_____

WHAT TREATMENT (heat, ice, rest, medications [by name], therapy)

HAVE YOU HAD FOR THIS PROBLEM? BE SPECIFIC:

_____

_____

HOSPITALIZATIONS FOR THIS PROBLEM _____

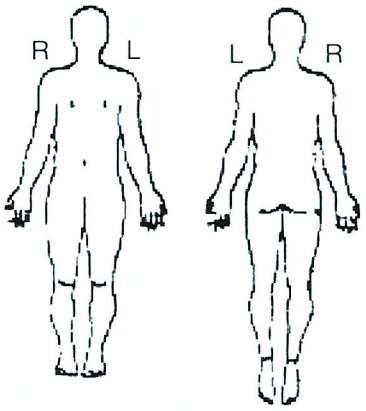
WHO REFERRED YOU? _____

PHYSICIANS' NAMES: Primary Care: _____

PHYSICIANS YOU HAVE SEEN FOR THIS PROBLEM _____

_____

WHERE IS YOUR PAIN?



Aching = ^ ^ ^ ^ ^ Burning = -------

Stabbing = /////// Numbness/Tingling = oooooo

DOES PAIN AWAKEN YOU FROM A SOUND SLEEP? Yes ❑ No ❑ SEVERITY (Normal = 0 - - - - > Excessive = 10) _____

WHAT MAKES THE SYMPTOMS BETTER ? _____

WHAT MAKES THE SYMPTOMS WORSE? _____

OTHER ASSOCIATED SYMPTOMS (numbness, pain elsewhere) _____

PAST HISTORY

OTHER MEDICAL PROBLEMS _____

SURGERIES AND DATES _____

PREVIOUS ACCIDENTS _____

CURRENT MEDICATIONS _____

ALLERGIES TO MEDICATIONS _____

OTHER PROBLEMS: Review of Systems

	Yes	No		Yes	No		Yes	No
	Yes	No	Bladder	❑	❑	Psychiatric	❑	❑
Head	❑	❑	Bowel	❑	❑	Weight Gain	❑	❑
Throat	❑	❑	Fever/Chills	❑	❑	Weight Loss	❑	❑
Chest	❑	❑	Muscles	❑	❑	Appetite	❑	❑
Heart	❑	❑	Bones	❑	❑	Blood	❑	❑
Abdomen	❑	❑	Skin	❑	❑	Endocrine Glans	❑	❑

DESCRIBE _____

SOCIAL HISTORY:

OCCUPATION (Type and Employer) _____

ARE YOU PARTICIPATING IN SPORTS? _____ WHAT TYPE? _____

ARE YOU WORKING NOW? Yes ❑ No ❑ LAST DAY WORKED _____ DO YOU PERFORM HOUSEWORK? Yes ❑ No ❑

SMOKE? Yes ❑ No ❑ HOW MUCH? _____ ALCOHOL? Yes ❑ No ❑ STREET DRUGS? Yes ❑ No ❑

FAMILY HISTORY: (Medical problems in close relatives) _____

FOR FEMALES ONLY: COULD YOU BE PREGNANT? Yes ❑ No ❑ ARE YOU BREAST FEEDING? Yes ❑ No ❑

_____ _____

PHYSICAL EXAMINATION: ** Can use **N** for Normal

1) NAME _____ DATE _____

RESP _____ HGT _____ WT _____ B/P _____ PULSE _____ TEMP _____

2) APPEARANCE _____

GAIT _____

	Inspection/Palpation	Range-of-Motion	Stability	Strength and Tone
3-6) NECK				
BACK				
RUE				
LUE				
RLE				
LLE				

7) SKIN: NECK _____ BACK _____ RUE _____ LUE _____ RLE _____ LLE _____

8) COORDINATION

9) REFLEXES

10) SENSATION

11) MENTAL STATUS

12) MOOD AFFECT

LANGUAGE

KNOWLEDGE/MEMORY

13) PERIPH. PULSES, VARICOSITIES, EDEMA, ETC.

14) LYMPH NODES, AXILLA, NECK AND/OR GROIN

TEST RESULTS:

OTHER REPORTS:

DIAGNOSES:

PLAN:

RISK OF COMPLICATIONS/SEVERITY:

INSTRUCTION/COUNSELING:

GOALS:

PROGNOSIS:

OTHER/PATIENT QUESTIONS:

3/3 Elements	99202	99203	99204	99205
HPI	1-3 Elements	4 or More Elements	4 or More	4 or More
ROS	N/A	Related to HPI & 2-9 Negs.	Related to HPI & 2-9 Negs.	10
PFSH	N/A	1 item from any 3 areas	1 item from any 3 areas	1 from each of 3 areas
EXAM	Affected body area only	6 Elements	12 Elements	All Elements
DECISION MAKING (See sheets in rooms for more detail)	1 Minor problem	2 or more minor problems	2 or more minor problems	2 or more stable chronic or 1 with exacerbation

RETURN VISIT _____ PHYSICIAN SIGNATURE _____

Rehabilitation Physicians, PC

PRIVACY NOTICE ACKNOWLEDGEMENT

Patient Name _____ Account Number _____

EFFECTIVE DATE OF THIS NOTICE: April 14, 2003

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

"I hereby acknowledge that I have been provided a copy of this practice's NOTICE OF PRIVACY PRACTICES. I further understand that the practice will offer me updates to this NOTICE OF PRIVACY PRACTICES should it be amended, modified or changed in any way."

Patient or Representative's Name (please print)	Patient or Representative's Signature	Relationship to Patient	Date
_____	_____	_____	_____

The patient presented for treatment on this date was provided with a copy of the practice's Notice of Private Practice. A good faith effort was made to obtain a written acknowledgement of receipt of the Notice. However, an acknowledgement was not obtained because:

☐ Patient refused to sign ☐ Patient was unable to sign or initial because: _____

FINANCIAL & ATTENDANCE EXPECTATIONS

Attendance

Our physicians strive to provide appointment access to our patients in a timely manner. In an effort to do so we ask that our patients contact our office when they are unable to keep a scheduled appointment. We understand that life situations may arise resulting in one's inability to attend a scheduled appointment; however we do ask for the consideration of calling the office to inform us as soon as possible, preferably at least 24 hour notice. If notice is not provided it is considered a no show.

- Missed appointments are documented in the medical record.
- Refills may be held until a patient is seen by their physician.
- A no show fee of $25.00 is applicable to all no show appointments.
- No show fees must be paid before a patient can receive additional appointments.
- Patients that no show for multiple appointments are subject to dismissal from the practice.

PATIENT INITIALS: _____

Financial Responsibilities

- Rehabilitation Physicians, PC, RPPC Labs LLC and RPPCPT PLLC are required by contract with all insurance carriers to collect copays, deductibles, co-insurance and any non-covered services provided.
- It is the responsibility of our practice staff to collect copays and account balances at the time of service.
- If payments are not made, further appointments will be rescheduled or held until payment is made.
- If you do not have insurance, payment is required before services are rendered.
- Payments can be made with cash, check, or credit/debit card. We also accept card on file for future payment once insurance has adjudicated your claims.
- There will be a $15 fee placed on the account in the event of a returned check.
- It is the patient's responsibility to provide current and active insurance information.
- It is the patient's responsibility to notify us and provide information regarding auto liability or workman's compensation claims.
- Payment for insurance claims under investigation or litigation will be the responsibility of the patient. This includes past and/or current services provided.
- It is the responsibility of the patient to ensure referrals or authorizations have been obtained prior to the appointment.
- If your insurance requires a referral and you do not have one, you have the option of paying for the visit at the time of service or rescheduling the visit.
- Payment may be required for paperwork completion.
- I understand that the ultimate responsibility for payment is mine if my insurance does not reimburse Rehabilitation Physicians PC, RPPC Labs LLC or RPPCPT PLLC for services I have received.

PATIENT INTIALS: _____

Thank you in advance for your cooperation and understanding. A copy of this form is available upon request.

Patient or Representative's Signature	Date
_____	_____

Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information. Form must be signed and dated each year.

Patient Name: _____ **Date of Birth:** _____

Release Information From:
Specify Provider/Organization Name and Facility Address

Organization Name_____
Address_____
_____
_____

Release Information To:
Specify Provider/Organization Name and Facility Address

Organization Name_____
Address_____
_____
_____

Purpose of request (who will be authorized to release information)- I authorize **Rehabilitation Physicians, PC** to disclose or provide protected health information about me to following individual(s)/Entity:

Name:_____ Relationship To Patient_____
Name:_____ Relationship To Patient_____
Name:_____ Relationship To patient_____

Entity Name: _____
Address_____
Phone/Fax: _____

Description of Information to be disclosed- I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:
□ Entire patient record; **or**, check **only** those items of the record to be disclosed:
□ Office notes
□ Lab results, pathology reports
□ X-rays/MRI/CT Scan
□ Financial history report (previous 3 years only)
□ Only send the following: _____
Covering the period(s) of health care: From (Date)____/____/____ **To** (Date)____/____/____

Purpose of Disclosure (please record the purpose of the disclosure or check patient request):
□ Patient Request □ Other (please specify): _____

- This authorization will expire at the end of the calendar year of your last signature below, unless you specify an earlier termination. You must renew or submit a new authorization after the expiration date to continue the authorization. Please list the date of expiration if earlier than the end of the calendar year: _____
- You have the right to terminate this authorization at any time by submitting a written request to our Privacy Manager. Termination of this authorization will be effective upon written notice, except where a disclosure has already been made based on prior authorization.
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment.
- We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization may no longer be protected by the requirements of the Privacy Rule, and will no longer be the responsibility of the practice.

I wish to be contacted in the following manner for verbal communication:

Home Phone: _____
Cell Phone: _____
Work Phone: _____
□ Okay to leave a message with details
□ Leave practice name and call back

Patient or authorized representative signature: _____
Date: ____/____/____

You have the right to receive a copy of signed authorizations upon request.

Office phone: 248-893-3200 | Novi fax: 248-893-2950 | Livonia fax: 248-615-1125 | Howell fax: 248-893-2950