Patient Information

Patient Name:_____ Date:_____

Address:_____ Apt #_____ City/State_____ ZIP _____

DOB: _____ SSN: _____ Sex: M F

Daytime Phone #: _____ Evening Phone #:_____ Best time to call:_____

Email Address:_____ Language Spoken:_____ Marital Status: _____

Emergency Contact:_____ Relationship:_____ Phone #:_____

Referring doctor:_____ Date of next appointment to see this MD?_____

Primary Physician (if Different from above):_____

Functional Limitations:

- ☐ Amputation
- ☐ Blind
- ☐ Hearing
- ☐ Incontinence
- ☐ Other: _____

Does your job or daily activities involve the following?

- ☐ Carrying ☐ Walking
- ☐ Prolonged Sitting (Greater than 30 minutes)
- ☐ Prolonged Standing (Greater than 30 minutes)
- ☐ Lifting: Average Weight: _____ lbs.
- ☐ Other: _____

What tests have you had for this condition?		☐ Arthrogram	☐ Bone Scan
☐ X-Ray	☐ CT Scan	☐ Blood Test	☐ Other: _____
☐ MRI	☐ EMG/NCV	☐ Diagnostic arthroscopy	☐ Other: _____

Are you seeing any specialists for this condition other than your referring physician? If so, please list below:

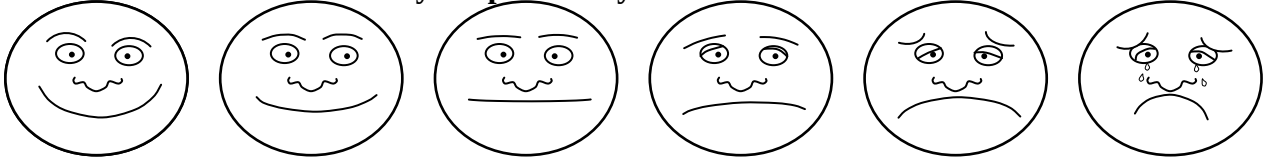
_____

_____

Medical History	**Yes**	**No**
Have you been hospitalized for this condition? If so, please give dates?		
Have you had previous problems with current involved body area? If so, when?		
Have you been treated by any other health care provider (i.e. Home Health or Chiropractor) for this diagnosis? If so, when?		
Is anyone or any company providing healthcare services to you, in your home?		

Referral Source: ☐ Internet ☐ Friend/Family ☐ Self ☐ Reavis Employee ☐ Physician ☐ Walk-In ☐ Yellow Pages ☐ Publication ☐ Daycare ☐ Health Fair ☐ Event ☐ Other/Source Name: _____

Circle the number that best describes your pain today:



No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst
0	**2**	**4**	**6**	**8**	**10**

Please fill out all four sections below	**Yes**	**No**
Have you had prior **PHYSICAL Therapy** services? **If Yes, Describe below**.		
Do you experience pain in your trunk, hips, legs and/or feet?		
Do you have difficulty with mobility for tasks such as work duties, housework, etc.?		
Do you experience frequent falls or balance problems?		
Do you have trouble performing tasks such as walking, driving, etc.?		

Have you had prior **OCCUPATIONAL Therapy** services? **If Yes, Describe below**.		
Do you experience pain in your shoulders, arms, wrists, and/or hands?		
Do you need assistance to dress yourself?		
Do you need assistance to fasten closures on clothes (buttons, snaps, etc.)?		
Do you have trouble manipulating small objects?		
Do you require assistance to prepare a meal?		
Do you need assistance to care for children (lifting, etc.)?		
Do you have difficulty performing normal activities at home?		
Do you have difficulty engaging in your favorite hobbies?		
Do you have difficulty performing on the job tasks?		

Have you had prior **SPEECH Therapy** services? **If Yes, Describe below**.		
Do you have a difficult time expressing yourself?		
Do other individuals have difficulty understanding what you say?		
Do you exhibit slurred speech?		
Do you have difficulty identifying objects?		
Do you have difficulty finding the correct word to say?		
Do you have difficulty remembering events, people, or activities?		
Do you have difficulty swallowing water or other liquids?		
Do you have difficulty swallowing different textured foods?		

Do you require assistance with transportation?		
Do you need assistance with shopping/errands?		
Do you need assistance with meals/personal care?		
Have you lost interest in things you used to enjoy?		
Have you been feeling sad or down in the dumps?		
Does the future look bleak and hopeless?		
Do you have trouble making decisions?		
Have you noticed a change in your eating or sleeping habits?		
Has your current injury or illness caused problems you have trouble dealing with?		

Describe your Previous Physical, Occupational or Speech Therapy (from questions above):

Area on body or Diagnosis:_____

When:_____

Name of Clinic:_____

Outcome or results:_____

_____

Referral made to (initial and date): _____**PT** _____**OT** _____**ST** _____**SW**

Patient Name: _____ **Date of Admission:** _____

YES	Check (✓) symptoms you currently have or have had in the past.
	AIDS
	Anemia
	Anxiety
	Arthritis/Osteoarthritis
	Bleeding Disorders
	Cancer
	Chest Pain
	Complex Region Pain Syndrome
	Convulsions/Seizures
	Depression
	Diabetes
	Dizziness
	DVT / Blood Clots
	Emphysema / COPD
	Epilepsy
	Fainting
	Fibromyalgia
	Gout
	Hardware/Implants
	Head Injury
	Headaches/Migraines
	Hearing Problems
	Heart Disease
	Heart Murmur
	Heartbeat Irregular

YES	Check (✓) symptoms you currently have or have had in the past.
	Hepatitis
	Hernia
	Herpes
	High Blood Pressure
	High Cholesterol
	HIV Positive
	Indwelling Circuitry/Pacemaker
	Infection
	Kidney Disease
	Lupus
	Multiple Sclerosis
	Osteoporosis
	Phlebitis
	Pregnant
	Psychological Disorder
	Rheumatic Fever
	Shortness of Breath
	Smoking / Alcohol / Drugs
	Stroke
	Swollen Ankles
	Throat Problems
	Thyroid Disease
	Tuberculosis
	Urinary Problems
	Visual Problems

List **MEDICATIONS** you are currently taking	Route (Oral, SQ, IV, etc.)	Dosage	Frequency

Therapist Signature: _____ Date Reviewed: _____

Patient Name: _____ Admission Date: _____

Cancellation and No-Show Policy

We regard this very seriously at Reavis Rehab & Wellness Center. Consistent treatment can make the difference in whether your therapy is successful or not. Your doctor and/or therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is one of your most important responsibilities.

Notification of missed appointments is sent to your Case Manager and Primary Physician. If you are non-compliant, this could jeopardize your request for further treatment especially for Medicaid, Worker's Compensation and Personal Injury patients.

Please understand that your symptoms or pain may increase or decrease through your treatment.

Either condition can seem to be a reason not to come in:

a) You're feeling worse and think the treatment is not working.
b) You're feeling better and it's a great day for wind-surfing.

Neither of these conditions is legitimate as a reason not to come:

a) If you're in pain, come in and get it fixed.
b) If you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and/or educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are injured: You, because you don't get the treatment you need as prescribed by the doctor and the therapist, who now has a space in their schedule since the time was reserved for you personally, and another patient, who could have been scheduled for treatment if you had given proper notice.

Please Read and Initial

_____ • If you must cancel an appointment, please do so by giving 24 hours notice. We do encourage rescheduling your appointment if possible. It is essential to keep your regular schedule for treatment to be successful. Understanding that emergencies do occur, it is our policy that any **cancellation with less than 3 hours notice will result in a charge of $30.00**. These charges are not reimbursable by your insurance company and must be paid at the time of your next scheduled therapy appointment.

_____ • If you must cancel or reschedule an appointment, please contact the **Front Desk** by phone: 512-310-7665. Voicemails may be left 24 hours a day. Please notify **ONLY** the front desk of any cancellations, *notifying your therapist and not the front desk will still result in a $50.00 no-show fee*. All emails and voicemails will be returned to confirm the cancellation. **If you do not receive a confirmation from the front office, your appointment has not been cancelled and you will be charged the $50.00 no-show fee.**

_____ • **If you do not show up or "NO-SHOW" for your appointment and do not give notice, you will be charged a fee of $50.00**, your scheduled appointment times will be "Cancelled" and you may be discharged from therapy.

_____ • If you Cancel for three (3) consecutive appointments, especially multi-discipline therapies, your appointment times may be "Cancelled" and you may be discharged.

_____ _____

Patient Signature Date

Reavis Rehab
& Wellness Center

Consent for Care and Treatment

I hereby authorize Reavis Rehab & Wellness Center, Inc., (Reavis), to provide care and treatment to me or my child, as prescribed by my physician. A representative of Reavis will explain my plan of care and/or treatment plan. I further understand that I and/or my family/Caregiver will receive instructions to assist with my care. I agree to notify my physician or others providing care of any adverse reactions or other significant events relating to my health.

Release of Information and Liability

I certify that the information given by me in applying for payment under TITLE XVII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release information needed for this or a related claim. I further authorize any holder of medical or other information about me to release such information as may be necessary for the completion of my claim for benefits under my group or individual insurance policy(s). We may disclose medical information to Third Party Providers as necessary for your care (DME, Prosthetists, etc.) This authorization shall release Reavis Rehab from all legal liability and shall stay in effect until revoked by me.

Liability for Payment

We bill your insurance as a courtesy. You will need to pay or make arrangements to pay your estimated co-pay or deductible today. If your insurance carrier does not remit within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund, you will be responsible for the amount of money refunded. I understand and agree that I am financially responsible for any deductible, co-pay, co-insurance or other amounts for services not covered by my insurance. I understand and agree that I am financially responsible for any amounts denied by my insurance for services or supplies provided to me.

I understand that my insurance coverage has been verified to the best of Reavis's ability. **A verification of eligibility, benefits, and/or authorizations is not a guarantee of payment** by my insurance carrier. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorneys' fees.

Assignment of Benefits

My Insurance Company is hereby authorized and directed to pay Reavis any and all benefits to which I am entitled, for services or supplies provided by Reavis. In the event that payment is made directly to me, I will promptly remit to Reavis. I understand a late charge of 18% APR will be charged on all past due accounts. I understand there is a $ 10.00 fee for billing co-pays/co-insurance not paid at time of appointments unless prior arrangements are made.

Medicare patients: I understand that Reavis accepts Medicare Assignment and I will not be responsible for any amounts over the Medicare allowable charges. I understand that, if applicable, my secondary insurance will be billed for any amounts not covered by Medicare. **I understand that Medicare will not pay for outpatient therapy services if I am receiving or begin receiving Medicare reimbursable Home Health services during the same period of time.** Medicaid or State reimbursed Homemaker/Home Health services are not affected.

Workers Comp. patients: The above liability does not apply to patients who are covered under Worker's Compensation. However, if benefits are subsequently denied, you will be held responsible for the total amount of charges for services rendered to you.

Third Party Claims: Patient will be responsible and billed for their claims if not settled one year after discharge.

I authorize Reavis Rehab & Wellness Center Inc. to be my representative and act on my behalf in any appeals with my insurance.

Photograph Release

Initial Here_____if you consent to visual/audio images of myself or my child for the purpose of treatment, education or promotional material, i.e. social networks, website, brochures/flyers and special events by Reavis employees, including, but not limited to photographs, digital images, drawing, renderings, voices, sound or video recordings, or audio clips.

☐ - I have been provided an opportunity to review the *Notice of Privacy Practices.*

☐ - I have reviewed and agree to follow the *Cancellation and No Show Policies*.

☐ - I have reviewed and agree to follow the *Pediatric Therapy Guidelines if applicable.*

☐ - I have reviewed and agree to follow the *Pool Rules/Guidelines*

_____ _____

Signature of Patient or Responsible Party **Patient's Name (Please Print)**

_____ _____

Staff Witness **Relationship** **Date**

Pool Rules/Guidelines

1. All patients receiving aquatic therapy **must sign in** at RRWC and **Ready Go Swim (RGS)**.
2. **DO NOT** enter pool without your designated/treating therapist in the Ready Go Swim pool area.
3. You must pay for Independent use of the pool if you are not having a session with one of our therapists. (You will be billed $ 10.00 for any sessions not with one of our therapists, unless you have paid RGS directly.)
4. Do not use lotions, oils or powders before entering the pool.
5. Pool participants must be independent in certain activities including dressing or provide a person to assist.
6. Smoking is prohibited on the premises.
7. Glass containers are prohibited in the pool area.
8. Pool participants are responsible for self-regulation to avoid over-exhaustion and prevent injury.
9. Reavis Rehab is not responsible for the loss of any personal items. Locks for lockers may be used during use of facility but must be removed when you leave the premises unless prior authorization from Ready Go Swim administration.
10. In case of emergency, full cooperation is requested and necessary.
11. Aquatic therapy patients and clients in swim lessons have first priority in use of equipment and space (class or independent participants have second priority).
12. The use of water shoes is strongly encouraged.
13. Infection Control guidelines/Precaution Guidelines prohibit the use of the pool by a member who is experiencing any of the following:
    a. Uncontrolled seizure disorder
    b. Vomiting
    c. Diarrhea
    d. Elevated Temperature (100°F or more)
    e. Active Infection (including skin, urinary, gastrointestinal, or respiratory)
    f. Incontinent of Bowel
    g. Open Sores, Pressure Sores, lesions, rashes or other forms of skin breakdown
    h. Uncontrolled Hypertension
    i. Exercise induced angina
    j. Impaired immune system
    k. Significant cardiovascular or respiratory disease

Failure to comply with these policies will result in loss of pool privileges.

I agree to abide by the above rules and guidelines:

_____ _____

Patient Signature Date