Rue &
Primavera

Occupational, Physical & Hand Therapy

Patient Intake Packet Occupational and Physical Therapy

Date: ____________________________Email Address: ____
Patient Name: ____SSN:____________________
Occupation Title:____Company Name:__________________________
Last First Middle
Date of Birth: ____/____/____Age:____ Gender: M______F_____ Cell: (____)________________Home: (_____)________
Mailing Address: ____
Street City Zip
In case of an emergency, whom should we contact? ____
Phone: _(_____)___________________ Relationship to patient: ____

Primary Insurance Information

Insurance Name: ____Phone: (_____)______________________
Policy ID#:________________________Group#:______________________ Sponsors Name:________________________
Sponsors DOB:_________________________ Sponsor SSN (Tricare patients only):____________________________________

Secondary Insurance Information

Insurance Name: ____Phone: (_____)______________________
Policy ID#:________________________Group#:______________________ Sponsors Name:________________________
Sponsors DOB:_________________________ Sponsor SSN (Tricare patients only):____________________________________

Work Related Incident

DOI: ____/____/_____Company Name:__________________________Company Phone:(_____)_________________
Company Address: ____
Street City Zip

Auto/PIP Related Incident

Insurance Name:____ID #:______________________________
Claim #:____Is PIP available?:______________________________

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Informed Consent to treat for Physical/Occupational Therapy

Response to physical and occupational therapy intervention varies from person to person; hence, it is not possible to accurately predict your response to a specific modality, procedure, or exercise protocol. Rue and Primavera does not guarantee what your reaction will be to a specific treatment, nor does it guarantee that the treatment will help resolve the condition that you are seeking treatment for. Furthermore, there is a possibility that the physical and/or occupational therapy treatment may result in aggravation of existing symptoms and may cause pain or injury.

It is your right to decline any part of your treatment at any time before or during treatment, should you feel any discomfort or pain or have other unresolved concerns. It is your right to ask your physical therapist about the treatment they have planned based on your individual history, physical therapy diagnosis, symptoms, and examination results. Consequently, it is your right to discuss the potential risks and benefits involved in your treatment.

I have read this consent form and understand the risks involved in physical therapy and agree to fully cooperate, participate in all physical therapy procedures, and comply with the established plan of care. I authorize the release of my medical information to appropriate third parties.

I, the undersigned patient or patient's representative, request admission to Rue and Primavera Rehabilitation for care and treatment. I certify that the information given is correct. I am aware that the practice of Rue and Primavera Rehabilitation is not an exact science and acknowledge that no guarantees or promises have been made as to the result of treatment of examination.

Signature____Date________________________

Joint Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provided you. You may ask to see and copy that record. You may ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

____	____
Patient or legally authorized individual signature	Date
____	____
Printed Name	Relationship to patient (parent, legal/personal representative)

Release of Medical Information

Please include the names of persons with whom we are allowed to discuss your medical and billing information (please include other medical facilities that you may need us to send information to other than your referring provider):

____	____
Name	Relationship
____	____
Name	Relationship

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No Show and Cancellation Policy

Thank you for choosing Rue and Primavera for your injury needs. We are happy to be of service to you. Rue and Primavera reserves treatment time exclusively for your benefit. In order for us to help you with your condition it is important that you keep your scheduled appointments. It is not our intention to cause undue financial hardship for you as the patient, however we cannot absorb a loss in revenue due to lack of compliancy.

- Late Cancelations: Appointments must be cancelled **24 hours PRIOR** to your scheduled appointment or there will be a **$50.00** fee not covered by your insurance company. If we are able to reschedule you in the same week (keeping the same number of scheduled appointments) we will waive this fee. **We must hear from you during business hours 9-5pm** to cancel. If you leave a voicemail after hours the fee will be billed to you, as we do not have the chance to fill your cancelled appointment.

- No Shows: If you do not show up for your scheduled appointment and do not call to notify us of your absence, you will be charged a fee of **$110.00**. This fee will not be waived under any circumstances.

All fees are due at the time of the next scheduled appointment.

***PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISHCARGED.**

RELEASE OF MEDICAL INFORMATION/ FINANCIAL AGREEMENT/ ASSIGNMENT OF BENEFITS/ MEDICARE CERTIFICATION/ PERSONAL VALUABLES: I authorize Rue and Primavera Rehabilitation to release any information necessary to facilitate the processing of health care claims, and audit of payments relative to this care. I consent to the release of any information as needed to my referring and primary physician and to other health facilities or agencies as I direct or as required by law.

Please read and print name below:

I,___________________________ understand Rue and Primavera's no show and cancelation policy. I am responsible to know when I scheduled my appointments and be there on those times and days.

Signature:____Date:_____________________________________

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Past Medical History

Patient Name: ____ Todays Date:_____/_____/_____

Date of Injury/Onset:___/______/______ Date of Next Doctors appointment:___/______/______

Have you ever had these symptoms before? Yes ☐ No ☐

Check which apply to your current condition:

☐Work-related injury ☐recurrence of previous injury ☐Athletic /recreational injury ☐Motor vehicle accident
☐injury related to lifting ☐injury related to falling ☐Cause unknown ☐other: ___________________________

Have you had a related surgery? Yes☐ No☐

Any allergies? Yes ☐ No☐ If yes please list all known allergies:____

Have you fallen two or more times in the past 12 months? Yes ☐ No ☐

Are you here today because of a fall? Yes☐ No☐

Do you have any problems with walking or balance? Yes☐ No☐

Do you have any stressors in your life at the moment? Yes ☐ No ☐

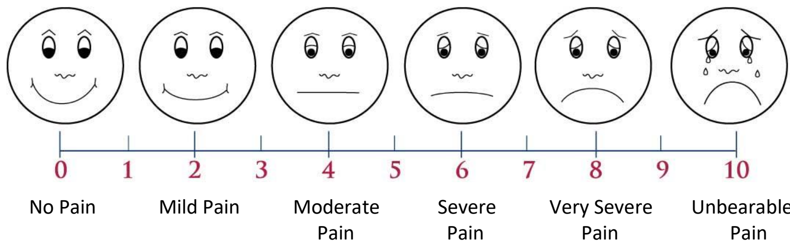
Do you suffer from PTSD or depression? Yes☐ No☐

Do you have, or have you had any of the following:	Yes	No		Yes	No
Diabetes (Type 1 or Type2)			Alzheimer's/Dementia		
Chest Pain/Angina			Osteoarthritis		
High Blood Pressure			Osteoporosis		
Heart Disease			Rheumatic Arthritis		
Asthma/ Breathing Difficulties			Seizures		
Stroke			Metal Implants		
Pacemaker			Dizziness/ Fainting		
Cancer			Fracture		
Urine Leakage			Surgeries		
Bowel/ Bladder Abnormalities			Smoking		
Ringing in the ears			Other		

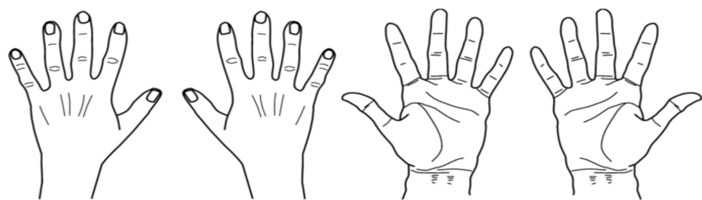
If you answered yes to any of the items on the right please explain and provide dates below. Include any other pertinent information regarding your medical history.

____
____
____
____
____
____
____
____
____
____
____

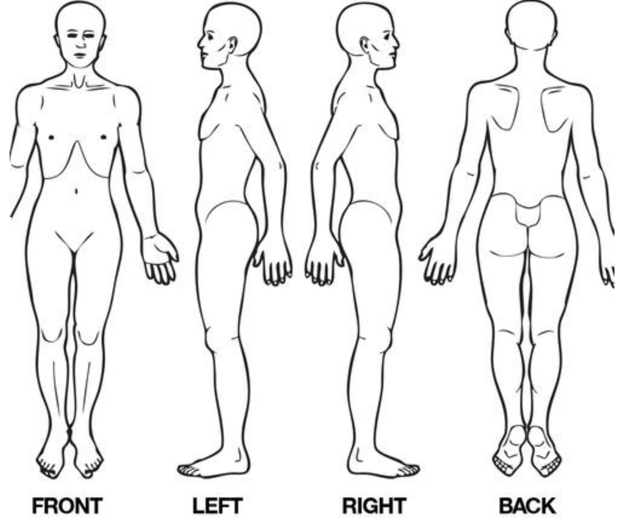
First: Please shade in any areas of pain, discomfort or concern.
Second: Using the Scale Below, rate each area of pain and mark the appropriate pain number next to the shaded area.



Occupational Therapy Patients Only:



Physical Therapy Patients Only:



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Current Medication List

(This includes prescriptions, over-the- counter, Herbals, vitamins, mineral/dietary and nutritional supplements.)

If you are not currently taking any medications or supplements please write that you are not taking any.

Current Medication / Supplement	Dosage	Frequency	Start Date	Stop Date
1.				
2				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				
11.				
12.				

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