

No Pain Huge Gain!



Rue &  
Primavera

Occupational and Physical Therapy

### Patient Intake

Date: \_\_\_\_\_ Email Address: \_\_\_\_\_

Patient Name: \_\_\_\_\_  
Last First Middle SSN

Mailing Address: \_\_\_\_\_  
Street City Zip

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Occupation: \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ Gender M\_ F\_ Married \_\_\_ Single \_\_\_

In case of an emergency, whom should we contact? \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

### Work/Auto Related

Place of Employment: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Was this an injury? Y\_\_ N\_\_ Date of Injury \_\_\_/\_\_\_/\_\_\_ Job Related? Y\_\_ N\_\_

Referring Doctor: \_\_\_\_\_

Claim Number: \_\_\_\_\_ Claim Manager: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have medical insurance? Y\_ N\_ Primary Insurance Co. \_\_\_\_\_

### Insurance Information

Primary Insurance: \_\_\_\_\_ Phone # \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_ Phone # \_\_\_\_\_

Policy ID#: \_\_\_\_\_ Group#: \_\_\_\_\_

Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Guarantor Date of Birth: \_\_\_/\_\_\_/\_\_\_ SSN: \_\_\_\_\_

In order to bill your insurance, we must make a copy of your insurance card.



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. I consent to and authorize the following:

**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.

\_\_\_\_\_  
Patient or other legally responsible persons signature Date

\_\_\_\_\_  
Print Name if not Patient Relationship of legally responsible person to patient

### Informed Consent for Physical Therapy Services

Response to physical 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 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.

Signature \_\_\_\_\_ Date \_\_\_\_\_

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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 Cancellations: 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 8-5pm** 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.**

### 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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**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 you 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)



Please include the names of persons with whom we are allowed to discuss your medical and billing information:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship

I authorize Rue & Primavera Occupational & Physical Therapy to discuss my medical and billing information with the above named person(s).

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to patient (parent, legal/personal representative)

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### Past Medical History Form

Patient Name: \_\_\_\_\_ Todays Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Are you presently working?  Yes  No Date of Next Doctors appointment \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Injury/ Onset: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you ever had these symptoms before?  Yes  No

Check which apply to your current condition:  work-related injury  recurrence of previous injury  
 Motor vehicle accident  injury related to lifting  injury related to falling  Cause unknown  
 Athletic /recreational injury  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   |     |    | Hypoglycemia        |     |    |
| Chest Pain/Angina                                  |     |    | Osteoarthritis      |     |    |
| High Blood Pressure                                |     |    | Osteoporosis        |     |    |
| Heart Disease                                      |     |    | leukemia            |     |    |
| Heart Attack                                       |     |    | Seizures            |     |    |
| Heart Palpitations                                 |     |    | Metal Implants      |     |    |
| Pacemaker  |     |    | Dizziness/ Fainting |     |    |
| Headaches  |     |    | Fracture            |     |    |
| Kidney Problems                                    |     |    | Surgeries           |     |    |
| Cancer   |     |    | Skin Abnormalities  |     |    |
| Stroke   |     |    | Nausea/ Vomiting    |     |    |
| Bowel/ Bladder Abnormalities                       |     |    | Ringin in the ears  |     |    |
| Urine Leakage                                      |     |    | Rheumatic Arthritis |     |    |
| Liver /Gallbladder Problems                        |     |    | Smoking             |     |    |
| Asthma/ Breathing Difficulties                     |     |    | Other               |     |    |

In order to bill your insurance, we must make a copy of your insurance card.



Past Medical History continued...

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

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Date: \_\_\_\_\_



**Current Medication List with Dosage**

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

| Current Medication / Supplement | Dosage | Frequency | Start Date | Stop Date |
|---------------------------------|--------|-----------|------------|-----------|
| 1.                              |        |           |            |           |
| 2.                              |        |           |            |           |
| 3.                              |        |           |            |           |
| 4.                              |        |           |            |           |
| 5.                              |        |           |            |           |
| 6.                              |        |           |            |           |
| 7.                              |        |           |            |           |
| 8.                              |        |           |            |           |
| 9.                              |        |           |            |           |
| 10.                             |        |           |            |           |
| 11.                             |        |           |            |           |
| 12.                             |        |           |            |           |
| 13.                             |        |           |            |           |
| 14.                             |        |           |            |           |

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