Rue &
Primavera

Occupational, Physical & Hand Therapy

Patient Intake Aquatic Therapy

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

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 an **$80.00** fee not covered by your insurance company. **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 **$80.00**. 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)**

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

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			Ringing 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. _____

_____

_____

_____

_____

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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