PHOENIX
Rehabilitation and Health Services, Inc.

Account Number _____

PATIENT INFORMATION

Patient Name: _____ _____ ____ _____
Last First MI Salutation

SSN: _____ DOB: _____/_____/_____ Sex: □ M □ F

Address: _____ Marital Status: □ S □ M □ D □ W

City: _____ State: _____ ZIP: _____

Home Phone: (_____) _____-_____ Cellular: (_____) _____-_____

Email (optional): _____

□ Yes, I wish to receive PRHS's exclusive monthly newsletter and future news announcements via email. I understand I can unsubscribe at any time.

Employer: _____ Work Phone (_____) _____-_____

Address: _____ Occupation/Position: _____

City: _____ State: _____ ZIP: _____

Responsible Party: Relation to Patient (Check one): □ Self □ Spouse □ Child □ Parent □ Other

Name: _____ Phone: (_____) _____-_____

SSN: _____ DOB: _____/_____/_____ Sex: □ M □ F

Employer: _____ Work Phone: (_____) _____-_____

INSURANCE INFORMATION

Primary Insurance: _____ **Secondary Insurance:** _____
(Personal Insurance if Primary is Worker's Comp or Auto)

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Is the patient the subscriber to this policy?
□ YES □ NO (If NO, please complete below)

Subscriber's Name: _____
Subscriber's DOB: _____
Relation to patient: _____

Is the patient the subscriber to this policy?
□ YES □ NO (If NO, please complete below)

Subscriber's Name: _____
Subscriber's DOB: _____
Relation to patient: _____

INJURY INFORMATION

My condition is related to (Check one): □ Work □ Auto □ Sports □ Other □ None

Date of Injury/Accident/Onset: _____/_____/_____ Injury Area: _____

Referring Doctor: _____ Primary Doctor: _____

Diagnosis: _____

EMERGENCY CONTACT:

Name: _____ Phone: (_____) _____-_____ Relation: _____

PHOENIX
Rehabilitation and Health Services, Inc.

Today's Date: _____

Name: _____

Occupation: _____

Date of Birth: _____ Age: _____

What is the condition for which you are seeking treatment and how did it occur? If you had recent surgery please list date and type of surgery?_____

_____

_____

What are the chief complaints that you are experiencing due to your injury and the severity?
Check all that are appropriate

	None	Minimal	Moderate	Severe
Awakened by pain	☐	☐	☐	☐
Current pain level	☐	☐	☐	☐
Difficulty Falling Asleep	☐	☐	☐	☐
Difficulty finding a comfortable position	☐	☐	☐	☐
Difficulty walking	☐	☐	☐	☐
Loss of Function	☐	☐	☐	☐
Loss of motion (stiffness)	☐	☐	☐	☐
Pain with work activities	☐	☐	☐	☐
Weakness	☐	☐	☐	☐
Other_____	☐	☐	☐	☐

	Yes	No
Are you experiencing pain?	☐	☐

Please rate your pain today on a scale of 0 to 10? 0 = no pain, 10 = worst possible pain? _____

Where is your pain located and how would you describe it?_____

_____

Please list any contraindications to treatment or precautions that we should know: _____

_____

Prior to the onset of your current symptoms and since your symptoms began, what percentage of the following activities were you able to complete?

Activities of Daily Living _____% prior to onset _____% since symptoms began

Recreation/Sports activities _____% prior to onset _____% since symptoms began

Work Activities _____% prior to onset _____% since symptoms began

PAST MEDICAL HISTORY

Patient Name: _____

Previous Surgeries	
When (if not sure, list approximate date)	**Type of Surgery**

History of Fractures	
When (if not sure, list approximate date)	**Area of Fracture**

Diagnostic Testing		
Type	**Date**	**Details/Findings**
Blood Work		
Bone Density		
CT scan		
EEG		
EMG		
MRI		
Nerve Conduction Test		
X ray		
Other		

Have you seen any specialist for your current condition: ☐ Yes ☐ No If so please list below:

Type	Date	Name

Medical Conditions – Please check all that you have or have had in the past

☐ Allergies	☐ Dizziness	☐ High Blood Pressure	☐ Current Nausea/Vomiting	☐ Rheumatoid Arthritis
☐ Asthma	☐ Epilepsy	☐ Joint Replacement	☐ Osteoarthritis	☐ Shortness of Breath
☐ Bowel Dysfunction	☐ Headaches	☐ Malaise/Fatigue	☐ Osteoporosis	☐ Substance Abuse
☐ Cancer	☐ Heart Condition	☐ Mental/Cognitive Disorder	☐ Pacemaker	☐ Syncope/Fainting
☐ Diabetes	☐ History of Smoking	☐ Metal Implants	☐ Pregnancy	☐ Weight Change
Other: _____				

Medications – Please select all medications that you are currently taking

☐ Acetaminophen (Tylenol)	☐ Allergy Medications	☐ Antibiotics	☐ Antidepressants
☐ Aspirin/Anti-Coagulants	☐ Cardiac(Heart) Medication	☐ Cholesterol Medication	☐ Diabetic Medication
☐ GI Medications	☐ Blood Pressure Medication	☐ Ibuprofen (Advil, Motrin)	☐ Muscle Relaxer
☐ Anti-inflammatories	☐ Osteoporosis Medication	☐ Pain Medication	☐ Steroids
Other: _____			

Hospitalization and Prior Care		
Type	**Name of Facility**	**Discharge Date**
Recent Hospitalization		
Recent Skilled Nursing Care		
Recent Home Health Care		
Recent Outpatient Physical Therapy		
***If you have received outpatient physical therapy or Chiropractic care this year, how many visits did you attend?** _____		

Social History

Current Smoker ☐ Yes ☐No Packs/day _____ Years Smoking _____

Previous Smoker ☐ Yes ☐No Years Smoke Free ____ Years Smoked _____

Alcohol ☐ Often ☐ Occasionally ☐ Never

Recreational Drugs ☐ Often ☐ Occasionally ☐ Never

Living Situation ☐ House ☐ Apartment ☐ Stairs in Home ☐ Alone ☐ Family/Roommate

Are you currently working? ☐ Yes ☐No

If so is it? ☐ Full Time ☐Part Time ☐ Full Duty ☐ Restricted Duty

What are your goals and what do you expect to achieve from treatment?_____

_____

_____

Patient Name: _____ **Account #:** _____

PHOENIX REHABILITATION AND HEALTH SERVICES, INC. FINANCIAL POLICY

We would like to **THANK YOU** for choosing PHOENIX Rehabilitation and Health Services, Inc. PHOENIX Rehabilitation and Health Services, Inc. accepts third party payments and will submit your bills for treatment to the address provided as a courtesy to you. In order for us to bill your insurance company on a regular basis, we request that you sign this release of information and assignment of benefits (if applicable). Typically, insurances pay a predetermined amount of our treatment charges; however it is your responsibility to call your insurance company to check on the coverage provided by your individual policy. As a courtesy to you, we will perform an insurance verification with your insurance company; however we will not take responsibility for any misinformation that we are given during this process. Therefore, it is within your best interest to verify your outpatient benefits with your individual insurance plan and to confirm them with our office prior to initiating treatment

CONSENT FOR CARE AND TREATMENT

I hereby give written consent for the provision of treatment. I authorize PHOENIX Rehabilitation and Health Services, Inc. to furnish treatment which is considered necessary and proper in diagnosing or treating my physical condition

INITIALS _____

FINANCIAL RESPONSIBILITY

I understand that in some instances the applicable insurance may not cover all treatment charges incurred. I agree to be financially responsible to PHOENIX Rehabilitation and Health Services, Inc. for any medically necessary therapeutic services that are deemed uncovered by my insurance policy.

INITIALS _____

ASSIGNMENT OF BENEFITS

I hereby authorize payment directly to PHOENIX Rehabilitation and Health Services, Inc. any benefits payable to me and/or my qualified dependents under the insurance coverage or Major Medical provisions of insurance coverage identified on bills submitted by PHOENIX Rehabilitation and Health Services, Inc. for treatment.

INITIALS _____

CO-PAYMENTS

I understand that if my insurance plan requires a co-payment for treatment, my co-payment will be collected at the time of my visit. A surcharge may be applied in order to collect late co-payments. This surcharge will cover expenses incurred by PHOENIX Rehabilitation and Health Services, Inc. to generate additional bills and/or utilize collection services.

INITIALS _____

LITIGATION ACCOUNTS

I understand that PHOENIX Rehabilitation and Health Services, Inc. will directly bill my appropriate insurance; however I am responsible for the payment of my treatment, not the entity being sued. Liability action against someone else will not enable me to refuse payment to PHOENIX Rehabilitation and Health Services, Inc.

INITIALS _____

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & AUTHORIZATION

I hereby acknowledge that I have received a copy of PHOENIX Rehabilitation and Health Services, Inc.'s Notice of Privacy Practices. I also understand that additional copies of this Notice are available for my review upon request. By way of my signature below, I provide PHOENIX Rehabilitation and Health Services, Inc. with my authorization and consent to use and disclose my protected health information for the purposes of treatment, payment and health care operations as described in the Notice of Privacy Practices

INITIALS _____

CERTIFICATION OF IDENTITY

I certify that I am in fact the individual I claim to be. I understand that the knowing and willful use of another individual's personal identifying information under false pretenses is a criminal offense.

INITIALS _____

I ACKNOWLEDGE THAT I READ AND UNDERSTAND ALL COMPONENTS OF THE PHOENIX REHABILITATION AND HEATLH SERVICES INC. FINANCIAL POLICY AS STATED ABOVE.

_____ _____

Signature of Patient or Guardian (if patient is a minor) **Date**

FOR PHOENIX REHABILITATION AND HEALTH SERVICES INC. OFFICE USE ONLY
PHOENIX REHABILITATION AND HEALTH SERVICES INC. VERIFICATION OF IDENTITY

I certify that I have verified the identity of the above named party; verification of identity was made by:

☐ Health Insurance Card that is current ☐ Driver's License or other Photo ID that is current

☐ Utility bill or other correspondence showing current residence if the Photo ID does not display the patient's current address

_____ _____

Signature of PHOENIX Rehabilitation and Health Services Inc. Representative **Date**

Welcome Patient Survey

Thank you for choosing PHOENIX for your rehabilitation. We're glad you're here!
To help us reach others in our communities, please tell us…

Email Address (optional): _____

☐ Yes, I wish to receive PHOENIX's exclusive monthly e-newsletter and future news announcements via email. I understand I can unsubscribe at any time.

Do you have a medical prescription (or referral) for therapy? YES or NO

Which of these applies or may have influenced your decision to choose PHOENIX?

Please check all that apply.

☐ **PHOENIX was recommended by my medical provider.**
- My doctor said specifically I should go to PHOENIX.
- My doctor's staff (physician assistant, nurse, front office) recommended I go to PHOENIX.
- I chose from list of therapy providers given to me by my doctor or staff personnel.

☐ **PHOENIX was recommended by my employer.**
- PHOENIX is listed on our Medical Panel of Providers.
- I was referred by an Occupational Health doctor.
- I was directed by a rehab nurse or case manager assigned to my work injury claim.

Please list employer or person overseeing your care: _____

☐ **I found PHOENIX on-line on via the web.**

A. I did an internet search for physical or occupational therapy providers in my area. (i.e. Google, Yahoo, Bing, etc.)

B. I visited the PHOENIX website (www.phoenixrehab.com)

C. I searched for a therapist on the APTA or AOTA website.

D. I found PHOENIX via a social networking site or online community (i.e. Facebook, Twitter, LinkedIn, etc.)

Please list the web/internet method(s) you used (mark A, B, C or D): _____

☐ **I came to PHOENIX because of a public relations opportunity.**
- I attended a social or business-related function at PHOENIX (i.e. open house, chamber mixer, etc.)
- I visited a PHOENIX exhibit/booth during a trade show (i.e. health fair, business expo)

☐ **I came to PHOENIX on recommendation made by another person.**
- PHOENIX was recommended to me by a friend or family member.

☐ **I am a former patient.**
- I came back because I am a former patient of PHOENIX (this location or other.)

☐ **I came to PHOENIX because of convenience.**
- This PHOENIX office is conveniently located to my home or place of work.
- This PHOENIX office offers convenient appointment hours.

☐ **I came to PHOENIX because of an advertisement.**

A. I saw an advertisement or listing in the yellow pages or telephone directory.

B. I saw an advertisement in the newspaper or other print publication.

C. I received a promotional piece in the mail or by email.

D. I read about PHOENIX on a brochure or flyer displayed in my community.

Please list the advertisement(s) you saw (mark A, B, C or D): _____

☐ **I came to PHOENIX simply because—**

A. I noticed the PHOENIX sign(s) outside the office.

B. PHOENIX offered a specialty service (i.e. aquatic therapy, vestibular rehab, certified hand therapy, etc.)

C. I was directed by my insurance carrier.

D. I was directed by my attorney.

E. I am an acquaintance of a PHOENIX staff member.

Please list the specific reason(s) (mark A, B, C, D or E): _____

Acknowledgement of Receipt of Privacy Notice

Purpose of this Acknowledgement

This Acknowledgement, which allows the Practice to use and/or disclosure personally identifiable health information for treatment, payment or healthcare operations, is made pursuant to the requirements of 45 CFR §164.520(c)(2)(ii), part of the federal privacy regulations for the Health Insurance Privacy and Accountability Act of 1996 (the "Privacy Regulations").

Please read the following information carefully:

1. I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by PHOENIX Rehabilitation and Health Services, Inc. (the "Practice") for the purposes of treating me, obtaining payment for treatment of me, and as necessary in order to carry out any healthcare operations that are permitted in the Privacy Regulations.

2. I am aware that the Practice maintains a Privacy Notice which sets forth the types of uses and disclosures that the Practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the Practice will make such use or disclosure. By signing this Acknowledgement, I understand and acknowledge that I have received a copy of the Privacy Notice.

3. I understand and acknowledge that in its Privacy Notice, the Practice has reserved the right to change its Privacy Notice as it sees fit from time to time. If I wish to obtain a revised Privacy Notice, I need to send a written request for a revised Privacy Notice to the office of the Practice at the following address: 520 Philadelphia St., Indiana PA 15701, Attention: Compliance Officer

4. I understand and acknowledge that I have the right to request that the Practice restrict how my information is used or disclosed to carry out treatment, payment or healthcare operations. I understand and acknowledge that the Practice is not required to agree to restrictions requested by me except in very limited circumstances as described in the Privacy Notice, but if the Practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing.

   I request the following restrictions be placed on the Practice's use and/or disclosure of my health information (leave blank if no restrictions):

   _____

   _____

I understand the foregoing provisions, and I wish to sign this Acknowledgement authorizing the use of my personally identifiable health information for the purposes of treatment, payment for treatment and healthcare operations.

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I HAVE REVIEWED AN EXECUTED COPY OF THIS ACKNOWLEDGEMENT AND A COPY OF THE PRACTICE'S POLICY NOTICE AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

_____ _____
Signature of Patient or Representative Date

_____
Patient's Name

_____
Date of Birth

_____ _____
Name of Personal Representative (if applicable) Relationship to Patient

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To Be Completed by the Practice

The requested restrictions on the use and/or disclosure of the patient's health information set forth above are:

_____ Accepted _____ Denied _____ Not Applicable

_____Other (explain) _____

_____ _____
Signature of Authorized Practice Representative Date

PHOENIX
Rehabilitation and Health Services, Inc.

Medicare Secondary Payer Questionnaire

Patient Name: _____ _____ ____ **HICN:** _____
Last First MI

YES	NO	QUESTION?
		1. Are you receiving Black Lung Benefits? If NO, proceed to Question #2. If YES, BL is primary only for claims related to BL.
		2. Are the services to be paid by a government program such as research grant? If NO, proceed to Question #3. If YES, Government program will pay primary benefits for these services.
		3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this facility? If NO, proceed to Question #4. If YES, DVA is primary for these services.
		4. Was the illness /injury due to a work related accident/condition? If NO, proceed to Question #5. If YES, complete blanks below: Date of injury/accident _____/_____/_____ Name/Address of WC plan_____ Policy Number _____ Name/Address of Employer _____ _____ (WC is primary for claims related to work related injuries or illness)
		5. Was the illness/injury due to a non-work related accident? If NO, proceed to Question #6. If YES, complete blanks below: Date of accident _____/_____/_____ Cause: Auto _____ Non-auto _____ Other Party Responsible_____ Name/Address of Auto or Liability Insurer _____ _____ Insurance claim # _____ (Auto/Liability Insurer is primary payer for claims related to the accident)
		6. Are you entitled to Medicare based on Age? (Age 65 or over) If NO, proceed to Question #7. If YES, go to AGE QUESTIONS (On Page 2).
		7. Are you entitled to Medicare based on Disability? If NO, proceed to Question #8. If YES, go to DISABILITY QUESTIONS (On Page 2).
		8. Are you entitled to Medicare based on ESRD (End Stage Renal Disease)? If YES, go to ESRD QUESTION #3 (On Page 2).

YES	NO	QUESTION?
		1. Are you currently employed? If NO, Retirement Date _____/_____/_____ If YES, Name/Address of Employer _____
		2. Is your spouse or family member currently employed? If NO, Retirement Date _____/_____/_____ If YES, Name/Address of Employer _____
		3. Do you have Group Health Plan (GHP) coverage based on your own or your family member's current employment? If NO, Medicare is primary. (STOP QUESTIONNAIRE HERE!) If YES, For AGE …GO TO 4a. For DISABILITY…GO TO 4b. For ESRD…GO TO 4c.
		4a. AGE: Does the employer that sponsors your GHP employ 20 or more employees? **4b. DISABILITY: Does the employer that sponsors your GHP employ 100 or more employees?** **4c. ESRD: Date of kidney transplant? ____/____/____** **Date dialysis began? ____/____/____** **(GHP is primary for 30 month coordination period…complete info below)** If NO, Medicare is primary. If YES, GHP is primary. Complete the information below: Name/Address of GHP _____ _____ ID # _____ Group # _____ Policy Holder _____ Relation to patient _____

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM (Check Yes or No)

Have you received any medical care (Ex. PT, ST, OT, Nursing, Aide) from a Home Health Agency in the past 60 days? **YES _____ NO _____**

MEDICARE PAYMENT AUTHORIZATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request that payment of authorized benefits be made on my behalf to PHOENIX Rehabilitation and Health Services, Inc. This authorization is valid for a period of 2 years from the date which I have signed.

_____ _____ / /

Patient or Authorized Signature Date

Patient Name: _____

Account #: _____

PHOENIX Rehabilitation and Health Services, Inc.

PATIENT INFORMATION BROCHURE

Welcome to PHOENIX Rehabilitation and Health Services, Inc. We are anxious to rise to your physical, occupational, and/or speech therapy needs. Please review this informational brochure thoroughly and keep it on hand for the duration of your care with us. Please allow the information below to help make your PHOENIX rehabilitation experience a smooth and successful journey!

CLINIC LOCATION & OFFICE HOURS

ADDRESS	
CITY, STATE, ZIP	
OFFICE PHONE	
FAX	
THERAPIST	
OFFICE HOURS	

TIMELINESS

All patients are expected to arrive to their scheduled therapy appointments on time.

CANCELLATION NOTICE

Please contact our office at least 24 hours in advance if you need to cancel a scheduled appointment.

NO-SHOWS

If you fail to show up for 3 scheduled appointments or cancel an excessive number of times, your treatment may be discontinued and your referring physician will be notified.

PROPER ATTIRE FOR PHYSICAL THERAPY

Please wear appropriate and comfortable clothing to your physical therapy sessions. Proper attire should enable your therapist to view and access the involved area as well as allow you to maneuver in the gym without restriction. For your safety, athletic shoes are recommended, unless your medical condition interferes with your ability to wear this type of footwear.

HOME EXERCISE PROGRAM COMPLIANCE

Your therapist will design & educate you on an appropriate home exercise program for your physical condition. In order to obtain maximal benefits from your therapy experience, you are expected to comply with your therapist's recommendations for your home program. You should inform your therapist immediately of any activities which seem helpful or detrimental to your condition or any changes in your symptoms.

DOCTOR'S APPOINTMENTS

Please remind us of the date of your next doctor's appointment so that we can prepare the necessary communication for your physician.

BILLING QUESTIONS/CONCERNS

At any point during or after your care with PHOENIX, if you have Billing questions or concerns you can contact the clinic in which you were seen at or our PHOENIX Business Office directly @ (888)644-PRHS.

YOUR INSURANCE BENEFITS

As a courtesy to you, we have verified your individual insurance benefits for outpatient physical, occupational, and/or speech therapy to be:

INSURANCE COMPANY	
CONTACT PERSON	
INSURANCE COVERAGE	
CO-INSURANCE	
DEDUCTIBLE	
CO-PAYMENT	
MAX or LIMITS TO COVERAGE	
OTHER DETAILS	

It is within your best interest to confirm the above benefits with your insurance company prior to beginning therapy; the insurance verification listed above does not guarantee the accuracy of the information.

PHOENIX Rehabilitation and Health Services, Inc. ensures quality care for all of its patients. We want you to have an optimal healthcare experience at our clinic. Should you have any questions or concerns, please call our office immediately. My signature below acknowledges receipt of the above listed information.

Patient Signature	Date	PRHS Representative Signature

RISING TO OUR PATIENTS' NEEDS…