PATIENT IDENTIFICATION SHEET

Admission Information		Insurance Information			
Name		Social Security #			
Address		Primary Insurance:			
		Policy Number:			
State / Zip		Group Number:			
Home Phone		Subscriber Name:			
Alternate Phone		Address:			
E-Mail Address					
		State /Zip		DOB	
Emergency Contact Information		Second Insurance:			
Name:		Policy Number:			
Relation:		Group Number:			
Address:		Subscriber Name:			
		Address:			
State / Zip					
Phone:		State /Zip:		DOB	
General Information		Other Insurance:			
Date of Birth:		Policy Number:			
Citizenship:		Group Number:			
Occupation:		Subscriber Name:			
Injury Date:		Address:			
		State /Zip:		DOB	
Medical Information					
Physician					
Address:		**Type of Claim**			
State / Zip		Workmens Comp:		BCBS	
Phone:		Auto:		Private	
		Medicare		HMO	
		Medicaid		Other	
Workmans Compensation Claim Details					
Employer:		**Diagnosis and Treatment Site**			
Address:		Diagnosis:			
State / Zip					
Phone:		Treatment Site:			
Insurance Detail:					

Patient Signature: ______________________________

Date: ______________________________

MED REHAB SERVICES, INC

37463 Schoolcraft Rd.
Livonia, MI 48150
(734) 432-1700 fax (734) 266-7100

Patient Medical History

*Patient Name*_______________________________ *Date*_________________

*PLEASE MARK AN **"X"** ON THE APPROPRIATE LINE IF IT APPLIES TO YOU*

Condition	Yes	No	N/A	Unknown
Heart Attack, Chest Pains				
Pace Maker				
Seizures				
Neurological Conditions (stroke, M.S. M.D. Parkinson's Head Injury)				
Respiratory Conditions, (Shortness of Breath, Emphysema, Bronchitis, Asthma)				
Broken Bones				
Any Metal Implants (Pins, Screws, plates, IUD)				
Cancer (location)				
Allergies (Hay Fever, Medicine, Iodine)				
Diabetes				
Major Accident				
Past Surgeries (Location, Type)				

Pregnant now? Yes_______ No________ Number of past pregnancies__________

Any other conditions If yes please explain:________________________________
____

Please use this space to elaborate on any of the above statements:____________
____

Date of onset of present pain, illness or injury
____

Please describe how the incident or onset occurred_________________________
____

My pain is (please circle the appropriate response)

Constant
Variable
Worse in the morning
Worse with sitting
Sharp
Worse with activity
Dull Ache
Burning
Radiating
Stabbing

Does the pain decrease with: (Circle all that apply)

Standing Sitting Lying down Position changes

Do you have any numbness? Yes______ No______ Where_______________

Are you taking any medication now? _____________________________

If Yes please list all current Medications:

____
____

________________________________ _______________
Patient Signature Date

________________________________ _______________
Therapist Signature Date

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Name:____ SS#:_______________________

Insurance Name:________________________________ Insurance Number_______________

Secondary Insurance Name Address and ID # ____

____

CONSENT TO TREATMENT & PROVIDER PAYMENT AUTHORZATION

I hereby authorize the above named provider, through its appropriate personnel to perform or have performed upon me, or the above named patient, appropriate assessment and treatment procedures, for the therapy services established by the referring physician and the therapist.
I also authorize the provider to release to the appropriate agencies any information acquired in the course of my examination and treatment.

I also hereby authorize payment to the above provider for services rendered during my treatment. The provider is also authorized to invoice my primary and or secondary insurance company for the services rendered.

I also declare I am not under the care of any home care agency at this time and if I seek any other agencies services during my therapy certification period authorized by the doctor. I will promptly inform the therapist before signing their care. I also understand that I am responsible for the payment s of therapy services which I received in case of my insurance agencies denial based upon any other agencies involvement during my therapy certification period.

___________________________________ ______________________
Patient's Signature Date

____
Print Name

Nature of Authority
________________Self ____________Legal Guardian
________________ Durable Power of Attorney ____________Other (please Specify Below)

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PHYSICAL THERAPY CONSENT FORM

NOTICE

Dear Patient

This is to inform you that your Physical Therapy Program is one of your physician treatment regiments along with your other medications.

Your Frequency Duration Period for this program is ______X_______weeks.

Please try to attend all of your scheduled visits during the duration of the program Missing visits and not attending may cause Insurance benefit discrepancies due to non-achievement of the treatment goals.

If you are unable to attend your appointment(s) with your Physical Therapy please try to call and re-schedule your appointments so you will not be dropped from the program.

Thank-you, for selecting Med Rehab Inc.

___________________________________	____________________
Patient Signature	*Date*
___________________________________	____________________
Witness Signature	*Date*

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Patient Consent for use and Disclosure Of Protected Health Information

With the consent, Med Rehab Services, may use and disclose protected health information (PHI) about me or my children to carry out treatment, payment and healthcare operations (TPO). Please refer to Med Rehab Services Notice of Privacy for more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices Prior to signing this consent. Med Rehab Services reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ***Nancy Mathew, PT, Privacy Officer, Med Rehab Services, 37463 Schoolcraft Rd., Livonia, MI. 48150.***

With my consent Med Rehab Services may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical car, including laboratory results among others.

With my consent, Med Rehab Services may mail my home or other designated locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

With my consent, Med Rehab Services may e-mail to me my appointment reminder cards and patient statements. I have the right to request that Med Rehab Services restrict how it uses or discloses my PHI to carryout TPO. However, the practice is not required to agree to your request restrictions, but if it does it is bound by this agreement.

By signing this form, I am consenting to Med Rehab Services to use and disclose of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Med Rehab Services may decline to provide treatment to me or my children.

___________________________________	___________________________________
Patient's Name	*Signature of Parent or Legal Guardian*
___________________________________	___________________________________
Today's Date	*Print Name of Parent or Legal Guardian*