# *Total Rehabilitation Inc. - Patient Information Sheet*

## Patient Information

Name:

DOB Age: Sex: Marital Status:

Address

City, St Zip: Tel:

Alt Tel: Alt Tel Type: Email:

Soc Sec#: Drivers Lic #:

Employer: EmployerTel:

Employer Addr:

Spouse or Parent Name: Tel:

Friend or Rel. Not Living with You: Tel:

Primary Physician: Tel:

Referring Physician: Tel:

## Subscriber Information

☐ *Same as above*

Insured's Name: Relationship to Patient: ☐ Spouse: ☐ Parent: ☐ Other:

Address: Tel:

Insured's Employer Tel:

Employer Addr:

Soc Sec#: DOB: Sex: M / F

## Primary Insurance Information

Insurer: Tel:

Insurer Address

Group #: Ins. ID#:

## Secondary Insurance Information

Insurer: Tel:

Insurer Address

Group #: Ins. ID#:

I request that payment of authorized Medicare, Medicaid, or private insurance benefits be made to above Company for any services provided to me by above Company. I hereby assign, transfer, and set over to above Company all of my rights, title and interest of my medical reimbursement benefits under my insurance policy for services provided to me by above Company. I authorize any holder of medical information about me to be released to determine these benefits. I understand that I am financially responsible for all charges whether or not they are covered by my insurance. I have read the financial policy presented to me and agree to this financial policy.

Deductibles, copays, and co-insurance will be estimated according to the benefits quoted by your insurance company and due the day of service. Benefits quoted are not a guarantee of payment and I understand that I am responsible for any patient responsibility assigned to me by my insurance company.

The "Notice of Privacy Practices" is available in the office for my viewing. With my consent, above Company may use and disclose Protected Health Information (PHI) in order to carry out treatment, payment and health care operations. With my consent, this office may also call my home and leave a message, send reminders/requests for appointment by mail; speak to other members of my household by telephone.

Signature:_____ Date:_____

# )ICAL INFORMATION

Name: _____ Today's Date: _____

What is the problem for which you need therapy? _____

When did your symptoms start? _____

Is treatment the result of surgery? [ ] Yes [ ] No If yes, please give date: _____

Is treatment the result of injury? [ ] Yes [ ] No

If yes, was it on the job? [ ] Yes [ ] No

OR from an auto accident? [ ] Yes [ ] No

When do you go back to your referring doctor? _____

Previous Medical History (Please check all that apply)

| | | | |
|---|---|---|---|
| [ ] Arthritis | [ ] Hepatitis (Type___) | [ ] Heart problems | [ ] High blood pressure |
| [ ] Cancer | [ ] Blood disease | [ ] Mental illness | [ ] Depression |
| [ ] Diabetes | [ ] Degenerative joint disease | [ ] Stroke | [ ] Circulation |
| [ ] Tuberculosis | [ ] Respiratory / lung | [ ] Osteoporosis | [ ] Parkinson's disease |

[ ] Other _____

Please list any previous surgeries with dates

_____

_____

_____

_____

_____

Please list your current medications

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list allergies of any kind

_____

_____

_____

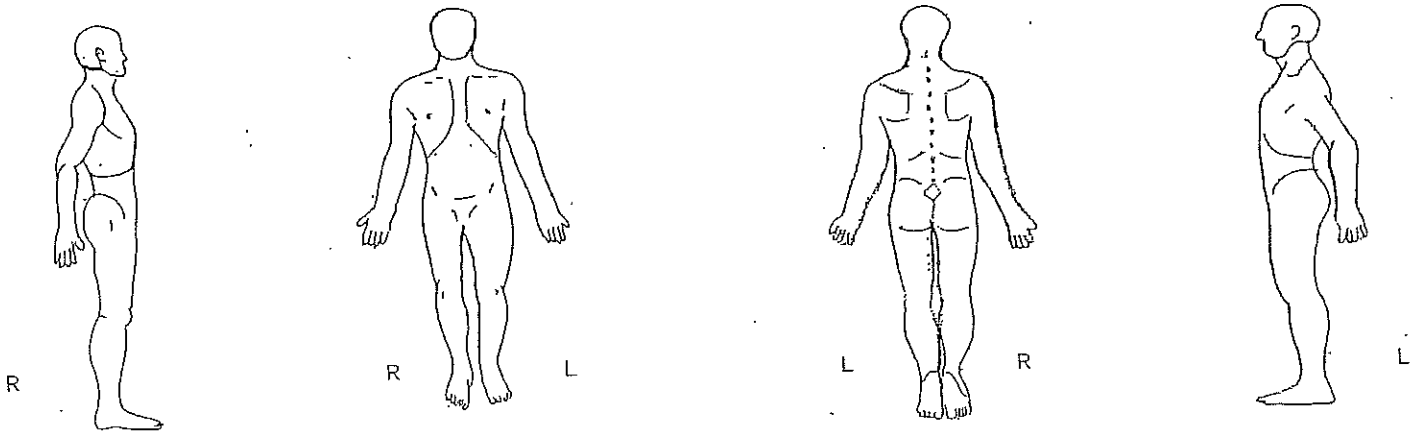
Please rate your pain

0 1 2 3 4 5 6 7 8 9 10

No pain — Worst possible pain

Using the symbols below, please mark the areas where you are having problems:

Aching: XXXXXXX Burning: /////// Numbness: 0000000



# APPOINTMENT CANCELLATION POLICY

Total Rehabilitation, Inc is committed to providing our patients with exceptional care. We understand unplanned issues may arise and you may need to cancel an appointment. If this happens, we respectfully ask for a **24-hour notice**. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging **$25 for appointments not cancelled within 24 hours**. There will be a **$75 charge for no-show appointments**. When a patient cancels without notice, they prevent us from scheduling another patient at that time. Furthermore, if a patient has multiple cancels/no shows, they may be discharged, and a note sent to the referring doctor.

If you need to cancel an appointment you may call or text our office at 479-452-7773. This option is available 24hrs a day, 7 days a week. If you call after business hours or on weekends, simply leave us a message.

Thank you for being a valued patient and for your understanding and cooperation as we institute this policy. This policy will enable us to open otherwise unused appointments to better serve the needs of our patients.

The Staff of Total Rehabilitation, Inc.

Your signature confirms your consent to this policy.

Signature:_____

Date:_____

Name_____

Date_____

Height____

Weight____

Do you smoke or use any other tobacco products_____

Occupation_____

Retired_____

Have you had any falls in the last year? ____ If so how many_____

Do you suffer from depression? _____

Are you having any memory issues? _____

Do you have normal energy for a person your age? _____

Living status: single___, divorced____, widowed or widower_____, married_____

Is anyone abusing you or trying to scam money from you? _____