RISE REHAB

Patient's Name: _____Date_____

(First) (MI) (Last)

Responsible Party (if a minor):_____ Contact Phone #:_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Sex: ____ Female _____Male Birth Date: _____/_____/_____ SS# _____

Cell: _____ Work: _____ Home: _____

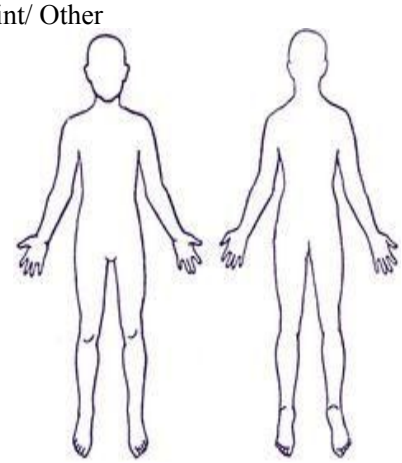
Email Address: _____

Emergency Contact: _____ Relationship: _____ Phone #:_____

Would you like to be notified by TEXT or EMAIL for a reminder of your upcoming appointments?

If text, who is your cell phone provider? Verizon/ T-Mobile/ AT & T/ Sprint/ Other

Please mark on the body diagram where you are Currently having pain/ symptoms →



History of High Blood Pressure - Yes____No____

History of Low Blood Pressure - Yes____No____

History of High Cholesterol - Yes____ No____

Latex Allergy - Yes____ No____

Surgical History

Body Region_____ Surgery Type _____Date:_____

Body Region_____ Surgery Type _____Date:_____

Current Medications

Drug: _____ Dosage: _____ Reason: _____

Drug: _____ Dosage: _____ Reason: _____

Medical History Continued on FOTO-Supervising PT Initials_____

Medical History and Foto Reviewed with Patient: Therapist Name_____Signature_____

Release of Medical Information: I authorize Rise Rehabilitation Specialists or any professional rendering care of treatment to release medical and supporting documentation of same as compiled in the medical records for purpose of benefit payments.

Medicare Patient Certification: I certify that this information given by me in applying for payment under Title XVII 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 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 payment of authorized benefits be made on my behalf.

Disclosure of Health Information: I understand that as part of my health care, Rise Rehabilitation Specialists originates and maintains paper or electronic records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that a copy of Notice of Privacy Practices is available upon request which provides a more comprehensive description of information use and disclosures. I understand my rights and privileges and that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.520 of the Code of Federal Regulations.

I understand that as part of this organization's treatment, payment or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

Teaching: This facility is a teaching facility. I consent and understand that treatment may be performed by a qualified intern from a certified physical therapy program under the guidance of our licensed therapists.

Cancellation/ No Show Policy: If you No Show or need to cancel your scheduled appointment, a 24 hour notice must be given or a fine of $25.00 will be charged and will be due upon your next visit. (Patient Initials _____)

May our office leave messages on your voicemail regarding your health care, including but not limited to appointments or other necessary treatment information at the stated numbers on this form? Yes___ No___

May our offices leave messages with family members, friends or other individuals that answer at the listed numbers on this form? Yes ___ No___

By signing below you acknowledge that you fully understand and accept the terms of this consent.

_____ _____

Patient Signature Date