Patient Information and ONE Rehab Authorizations and Service Terms

Account Number *(if known)*	Patient Name *(First, Middle, Last)*	Birth Date *(mm-dd-yyyy)*

Instructions:

1. Please complete all information on this form
2. If you have access to a scanner or a copy machine, please enclose copies of both sides of you insurance card(s).
3. If you are 18 years of age or older, sign and date on the last page of this form. If you are 17 years of age or younger, a parent or legal guardian must sign and date the last page.
4. Return all pages of this form to Scheduling or you may email to **info@onerehab.com** as well as fax to **(469) 458-2096**.
5. If you have questions or need assistance, please call Scheduling at **(972) 845-7875** between 7 a.m. and 7 p.m. (CST), Monday through Friday, and between 8 a.m. and 2 p.m. on Saturdays (CST).

Patient Demographic Information

Full Legal Name *(First, Middle, Last)*		
Patient Phone ☐ Mobile ☐ Work ☐ Other	Alternative Contact/Patient Email	Sex
Social Security Number	Religious Affiliation	What language do you feel most comfortable speaking with your provider? If not English, do you require an interpreter? ☐ Yes ☐ No
Address *(Street, City, State, and Zip)*		
Race ☐ Asian/Pacific Islander ☐ African American ☐ Caucasian ☐ Hispanic ☐ Multiracial ☐ American Indian/Eskimo ☐ Other:		Marital Status ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employment Information

Employer Name	Occupation	Employment Status ☐ Full-Time ☐ Part-Time ☐ Student ☐ Self-Employed ☐ Retired ☐ None
Address *(Street, City, State, and Zip)*		Work Phone

Emergency Contact *(i.e. spouse, life partner, parent, nearest relative, next of kin, friend, etc.)*

Name *(First, Middle, Last)*	Relationship to Patient	Phone

Physician/Referral Information

Referring Physician	Physician Phone Number	Date on Referral *(mm-dd-yyyy)* ☐ Patient Has Script

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Medical History

History of any of the following:	**Yes**	**No**	**Family Hx**
Diabetes	☐	☐	☐
Hypertension (High BP)	☐	☐	☐
Heart Attack	☐	☐	☐
Heart Disease	☐	☐	☐
High Cholesterol	☐	☐	☐
Smoking	☐	☐	☐
Chest Pain/Angina	☐	☐	☐
Light-Headedness/Dizziness/Fainting	☐	☐	☐
Hypotension (Low BP)	☐	☐	☐
Shortness of Breath	☐	☐	☐
Ankle Swelling	☐	☐	☐
Night Coughing	☐	☐	☐
Cancer/Tumors/Growths	☐	☐	☐
- Radiation/Chemo/Treatment	☐	☐	☐
Osteoporosis	☐	☐	☐
Osteoarthritis	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐
Rheumatic Disease	☐	☐	☐
Have you had/have a:			
Stroke	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Brain Injury	☐	☐	☐
Spinal Cord Injury	☐	☐	☐
Fracture(s)*:*			
Date & Area:			
Date & Area:			

In the past 3 months have you experienced:	**Yes**	**No**
Changes or difficulty with bowel	☐	☐
Changes or difficulty with bladder	☐	☐
Night Sweats	☐	☐
Fever	☐	☐
Diminished Sensation/Numbness	☐	☐
Skin Sensitivities:	☐	☐
☐ Latex ☐ Adhesives ☐ Temperature		
History of pressure sores	☐	☐
Pacemaker/Defibrillator	☐	☐
Bleeding/Bruising (recent history)	☐	☐
Hypoglycemia	☐	☐
Active seizure disorder	☐	☐
Dementia / Alzheimer's	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
- Always have inhaler with you?	☐	☐
Lung Disease/Emphysema/COPD	☐	☐
- Oxygen use	☐	☐
Are you pregnant?	☐	☐
In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	☐	☐
In the past month, have you frequently been bothered by having little interest in things or have you last pleasure in doing things?	☐	☐

Are you in Pain? Elaborate.	Location of Pain	Surgery(s) within the last 3 month (*Surgery & Date)*

If you answered yes to any of the above, are you under the care of a physician for these conditions? ☐ Yes ☐ No	Allergies

What are your rehabilitation goals?

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Fall Risk Assessment

	Yes	No
Have you fallen within the past year? If so, how many times _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐

	Yes	No
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory/cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

*Per CMS Fall Screening Criteria, patient is considered a fall risk if patient has fallen 2 or more times in the past year; patient is considered a fall risk if patient has fallen one time with resulting injury in the past year.

Fall Risk – Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgement indicates. Clinician should refer to the Fall Prevention Policy in the OP KRC P&P manual (PC OP 1018)

Nutritional Screening

	Yes	No
Unexplained weight loss? (>5% in last 30 days)	☐	☐
Recent loss of appetite/aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐

	Yes	No
Decrease in food intake? (<50% for 3 days or more)	☐	☐
Are you under the care of a physician for these conditions?	☐	☐

Current Medications ☐ I am currently NOT taking any OTC or prescribed medications ☐ I provided a separate list

Please inform your therapist of any changes in medications, medical conditions, or surgeries so this summary list can be updated as you progress in your treatment.

For therapist(s):

- **Has the patient been identified as a fall risk?** ☐ **Yes** ☐ **No**
- **If yes, has a fall prevention program been implemented?** ☐ **Yes** ☐ **No**
- **Has the patient been identified as a nutrition risk?** ☐ **Yes** ☐ **No** (If yes, notify MD)
- **Would the patient benefit from social services?** ☐ **Yes** ☐ **No** (If yes, coordinate with staff)

Signature *(Required)*	**Signature Date** *(Required) (mm-dd-yyyy)*
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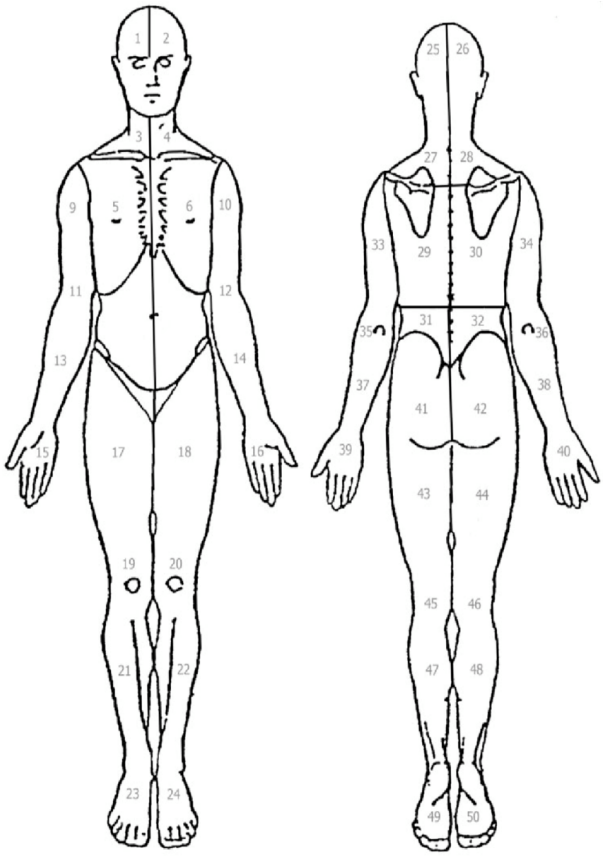
Medical Screening

Please shade the areas of your symptoms.

From 0-10 (0 being no pain, 10 being severe pain). Rate your current pain levels.
What makes your pain or symptoms worse?
What makes your pain or symptoms better?
Describe your pain or symptoms. *(ie is it burning, stabbing, aching, etc)*
Are your symptoms: ☐ Getting Worse ☐ The Same ☐ Improving
How are you able to sleep at night? ☐ Fine ☐ With moderate difficulty ☐ Only with medication
Do you have pain at night? ☐ Yes ☐ No
When (date) did your problem begin?
Have you been treated for this before? ☐ Yes – If yes, when & how? ☐ No



Patient Specific Functional Scale

Identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your medical condition. (0 being unable to perform, 10 being as able to perform as pre-injury)

Activity & Rating from 0-10
Activity & Rating from 0-10
Activity & Rating from 0-10

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Authorizations

Authorization to Release/Obtain Medical Information*

I authorize ONE Rehab**, its employees or agents, to release/obtain all medical information as necessary to:

- All insurance carriers, health-plan administrators, or any other payers, including the Centers for Medicare & Medicaid Services (CMS), their agents or review agencies for processing health care claims;
- The person(s) I designate as my Billing Addressee for handling the billing, payment, and health care coverage for my account;
- Accrediting and quality organizations, regulatory agencies, or other persons or entities for health care operations; and
- My other health care providers for treatment or payment purposes.

Authorization to Assign Benefits and Release Information to ONE Rehab

I authorize my insurance carrier, health-plan administrator or any other payer to pay directly to ONE Rehab any benefits due under the terms of my health care plan(s) for services provided by ONE Rehab. I understand that ONE Rehab reserves the right to refuse or accept assignment of medical benefits. If my health care plan will not allow direct payment to ONE Rehab or if ONE Rehab chooses not to accept assignment of medical benefits, I agree to immediately forward to ONE Rehab all health care payments I receive for services provided by ONE Rehab. I also authorize ONE Rehab, its employees or agents, to contact my insurance carrier, health-plan administrator or any other payer, their agents or review agencies, to obtain all pertinent financial information concerning coverage and payments made under my health care plan(s). I further authorize my insurance carrier, health-plan administrator or any other payer, their agents or review agencies, to release such information to ONE Rehab, its employees or agents.

Consent to Treatment

I hereby consent to the care (history, physical examination, treatment, etc.) provided by my providers and the care team at ONE Rehab. (Care team consists of physicians, therapists, techs, etc.)

Authorization to Photograph

I hereby grant ONE Rehab and its affiliated entities the right to photograph/video record me in connection with my participation in medical care. I authorize ONE Rehab, to copyright, use, and publish the same in print and/or electronically with or without my name and for any lawful purpose, including for example ads and web content and I waive any right to compensation therefore.

Service Terms

Statement of Financial Responsibility

I acknowledge I am responsible for all charges for services provided to me, including any amount not paid by my health care plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), a workers' compensation policy, or any other payer. I acknowledge that **no-show fees** of **$25** may be assessed for failing to give a 24-hour notice of the need to cancel routine follow-up appointments.

Dispute Resolution

I agree that any dispute (including personal injury claims) related to health care services rendered by ONE Rehab is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be venued in the county where the provider of the disputed services is physically located when the services are rendered. These agreements also apply to my legal representatives and next of kin.

Use of Cell Phone

I agree ONE Rehab may use an automated telephone dialing system/telephone/text to contact the cellular telephone number(s) that I provide to ONE Rehab for appointment and payment purposes.

Notice of Privacy Practices

By signing this form, you acknowledge that you have been offered a copy for review of our Notice of Privacy Practices. This Notice of Privacy Practices provides information about how we may use and disclose your protected health information. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice and if you have any questions about our Notice of Privacy Practices, please contact the clinic manager.

* Medical information includes, but is not limited to, information related to psychologic, psychiatric, sickle cell anemia, HIV/AIDS, communicable diseases, genetic testing, and alcohol and drug abuse diagnosis and treatment, if such information exists.

* I understand that I may revoke any authorizations in writing to the clinic manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my PHI that have already been made in reliance on this authorization.

- **If the patient is 18 years or older,** the patient must sign and date the form.
- **If the patient is 18 years of age or older and is incapable of signing,** a legally authorized representative may sign and date the form. Please indicate your legal authority. ☐ **Legal Guardian/Counselor**
  ☐ **Healthcare Agent (Healthcare Power of Attorney)** ☐ **Other Legal Representative**
- **If the patient is 17 years of age or younger,** the patient's parent or legal guardian must sign and date the form, unless an exception exists under state or federal law.
  Please indicate your relationship: ☐ **Parent** ☐ **Legal Guardian**

Signature *(Required)*	**Signature Date** *(Required) (mm-dd-yyyy)*

Printed Name of Person Signing *(If Not Patient)*