Endeavor Rehab Center

Patient Information

Last Name: _____ First: _____ MI: _____

Address: _____ City, ST, Zip: _____

**D.O.B: _____ SSN: _____ Sex: _____ Height: _____ Weight: _____

Home Ph: _____ Cell Ph: _____ Work Ph: _____

E-Mail Address: _____

Emergency Contact: _____ Ph: ( )_____

(Please fill out all of the above information correctly)

******If patient is a minor, guardian or parent must fill out:**

1. Primary Ins. Co. _____ Policy #: _____

Policy Holder: _____ SSN/DOB: _____

2. Secondary Ins._____ Policy #: _____

If this is a work related injury, please fill out:

Employer: _____ Phone: _____

Address: _____

City, State, Zip: _____

If this is an auto related injury, please state the agency/law firm representing you:

_____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits. I hereby authorize Endeavor Rehab Center permission to release AND/OR Receive information to and FROM any entities involved in my care.

_____ _____

Signature Date

Endeavor Rehab Center

Confidential Medical Information

Name: _____ Date: _____

Please state reason for therapy: _____

Was this related to: □ Surgery □ Auto Accident □ Work Related Injury □ Other:
Please explain : _____Date of injury: __/___/___

Recent X-rays/MRI for this complaint date: _____

Referring MD for diagnostics: _____

Are you experiencing any symptoms, problems or pain with the following? If so, check which body part.

□ Neck: ___ Left ___ Right
□ Shoulder: ___ Left ___ Right ___ Both
□ Hand/Wrist: ___ Left ___ Right ___ Both
□ Elbow/Forearm: ___Left ___Right ___Both
□ Knee/Hip: ___Left ___ Right ___ Both
□ Foot/Ankle: ___ Left ___ Right ___ Both
□ Back: __Upper __ Lower __ Mid

Functionally, what are you having the most problem with ? _____

Pain levels today 0-10 (10= highest/crying/ER) _____Pain levels : over week 0-10 _____

Major surgeries and dates:
_____

List current medications and dosage :
_____

Allergies: _____

Check if you currently have or had previously:

□ Arthritis
□ High Blood Pressure
□ Asthma
□ Cancer
□ Seizures
□ Stroke
□ Diabetes
□ Brain Injury
□ Heart Problems/Pacemaker

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of the medical benefits for myself or the party who accepts assignment of benefits on my behalf to include law offices and any medical professional assigned to my case.

Signature:_____ Date:_____

Endeavor Rehab Center

Consent to Treat

I, _____, do hereby agree and give my consent for Endeavor Rehab Center to furnish medical care and treatment which is considered necessary and proper in the diagnosing or treating of my (their) care.

Signature: _____ Date: _____

Benefit Assignment/Release of Information

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of the medical benefits for myself or the party who accepts assignment of benefits on my behalf. I authorize Endeavor Rehab Center to release all medical information and records to any entities involved in my care. A photocopy of this assignment is to be considered as valid as the original.

Signature: _____ Date: _____

Financial Policy Statement

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you. Although you are responsible for any co-payments and/or co-insurances and are required as payment at time of services rendered. All co-insurance percentages paid at time of services are **ESTIMATED**. Your actual liability may be more or less depending on insurance contracted rate.

If any payments are made directly to you for the services rendered by Endeavor Rehab Center, you must promptly remit such payment directly to Endeavor Rehab Center or be solely responsible for the entire bill.

If you fail to make timely payments for any amounts that are due for services rendered, you will be responsible for any/all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

_____ _____

Signature: Date:

Late and Cancellation Policy

We try to accommodate patient schedules as much as possible. If you know you will be sick or late, please call us prior to your scheduled appointment. We appreciate at least 24-hour notice to cancel or reschedule. If you are more than 15 mins late, we reserve the right to reschedule your appointment. **If there are 2 no call/no shows, we reserve the right to cancel future scheduled appointments. If there are 3 no call/no shows we reserve the right to discharge your chart and refer you back to your physician**. Thank you in advance for understanding.

We offer appointment reminders.

How would you like to be reminded? TEXT / EMAIL/ PHONE

_____

Per Therapy Providers

We assume you are here to get better. It is our job to assist you in your recovery. This includes forming goals with you to have milestones in your progression. This also includes a home program that should be treated like a medicine prescription. We encourage dedicating a certain time each day to perform these home exercises. For the most part, exercises should make you feel better and speed recovery. If there is increased residual pain, we need to discuss this. As professional Physical and Occupational therapists, we have devised these specifically for you.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for any payments on my account.

Signature: _____ Date:_____