Patient Information

_____(___)_____-_____(___)_____-_____
Patient Last Name First Name Middle Initial Home Phone number Cell Phone Number

_____
Street Address City State Zip

____/___/_____-___-_____
Date of Birth Age Sex Social Security Number Marital Status

If you would like to receive a reminder by email, text or voice call for your visits, provide the info below: (Circle one)

E-mail Address:_____ Phone (_____)_____-_____

_____(___)_____-_____
Employer's Name Employer's Phone

_____(___)_____-_____
Name of Primary Care Physician Primary Care Physicians Phone Number

_____(___)_____-_____
Referring Doctor Referring Doctor Phone Number

_____
How did you hear about our facility?

SPOUSE/ PARENT *(IF NOT MARRIED)* **INFORMATION**

_____
Last Name First Name Initial Date of Birth

_____(___)_____-_____
Their Employer's Name Employer's Phone

WHO CAN WE CALL IN CASE OF AN EMERGENCY

_____(___)_____-_____
Their Name Relation to Patient Phone Number

***** Is my referral due to a Workers Comp, Motor Vehicle Accident, or Slip and Fall Personal Injury?**
Yes No Circle one if Yes

PRC
Physical Rehab Center

Patient Information

Please present your insurance card to the receptionist when you hand in your paper work. Thank you.

Primary Insurance Company Name | Policy Number | Group Number

Policy Holder's Name (from card) | Social Security Number | Date of Birth

Secondary Insurance Company Name | Policy Number | Group Number

Policy Holder's Name (from card) | Social Security Number | Date of Birth

RESPONSIBILITY STATEMENT & RELEASE OF INFORMATION

I understand that I am responsible for paying for all medical services not covered by an authorization/agreement between Physical Rehabilitation Center of Tulsa and my insurance carrier or attorney. I authorize the release of any or all of the patient's medical records for this period of care to any person/corporation liable for any part of the physician charges and the patient's attorney. Oklahoma state law requires that we advise "The information authorized for release may include information which may be considered a communicable or venereal disease including but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS)."

Print Patient or Legal Guardian Name

Patient or Legal Guardian Signature | Date

Notice of Receipt of Privacy Notice of Physical Rehabilitation Center of Tulsa

By signing below, I acknowledge that I have received and reviewed the Privacy notice of Physical Rehabilitation Center of Tulsa, in force as of April 14, 2003 and all of my questions have been answered to my satisfaction in language that I can understand.

_____	_____
Name of Individual (Printed)	Signature of individual
_____	_____
Signature of Legal Representative (e.g., Attorney-In-Fact, Guardian, Parent if a minor):	Relationship
Date Signed ____/____/____	Witness: _____

5577 S. Lewis Avenue Tulsa OK 74105 Phone 918-749-0003 Fax 918-289-0450

PRC
Physical Rehab Center

AUTHORIZATION & ASSIGNMENT FORM

In consideration of Physical Rehabilitation Center of Tulsa (PRC) undertaking to care for me, I agree to the following:

1. PRC is authorized to release any information they deem appropriate concerning my physical condition to any insurance company, attorney or adjuster in order to process any claim for reimbursement of charges incurred.

2. I authorize the direct payment in full to PRC of any sum I now or hereafter owe PRC, by my attorney, out of the proceeds of any settlement of my case, and/or by any insurance company obligated to make payment to me or based in whole or in part upon the charges made for your services.

3. In the event any insurance company obligated by contractual agreement to make payment to me or to PRC for the charges made for the services refuses to make such payment upon demand by PRC, I hereby assign and transfer to PRC the cause of action that exists in my favor against any such company (the name(s) of which is believed to be correctly set forth under pertinent data) and authorize PRC to prosecute said action in my name as you see fit. I understand that whatever amounts PRC does not collect from the insurance companies proceeds, whether it be all or part of what is due, I personally owe and agree to pay to PRC. I also agree that PRC may elect, in its sole discretions, to seek payment in full from any and all applicable insurance sources and shall not be obligated to accept adjusted payment amounts from my health insurer as payment in full if other insurance coverage also applies or provides coverage for the charges incurred.

4. In addition to the above, I hereby waive the statute of limitations on collection and/or recovery in this State of Oklahoma.

5. I further agree that this Authorization and Assignment is irrevocable and ongoing until all monies owed are paid in full.

6. This Authorization and assignment will be in continual effect until revoked by both parties in writing.

_____ _____

Patient or Legal Guardian Signature Date

_____

Patient Printed Name

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PATIENT AUTHORIZIATION USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, hereby authorize Physical Rehabilitation Center of Tulsa disclose protected health information that pertains to me to the following person(s):

_____

_____

I expressly acknowledge that this authorization is voluntary. The following are other criteria or limitations that I make regarding this authorization:

_____

_____

I understand that I may revoke this authorization at any time by signing the revocation section of this form. I also understand that the revocation of this authorization will not have any effect on disclosures occurring prior to the execution of any revocation. I understand that the information used or disclosed pursuant to this authorization may be subject to being disclosed again by the recipient and that this information will no longer be protected by federal privacy regulations.

_____ _____

Signature Date

REVOCATION SECTION

I hereby revoke this authorization to disclose protected health information to the above stated person(s).

_____ _____

Signature Date

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PRC
Physical Rehab Center

Patient Health Questionnaire

Name: _____ Nickname: _____ Date:_____

Age: _____ Date of Birth: _____Height: _____ Weight: _____

Occupation:_____ Employer:_____

How did you hear about our facility? [ ] Physician Referral [ ] Past Patient [ ] Internet

[ ] Signage [ ] Friend or Family [ ] Other_____

How did problem occur? _____ [ ] Unknown

When did symptoms begin? Month _____ Day_____ Year_____

[ ] Within the past month [ ] Within the past year [ ] Ongoing for over a year

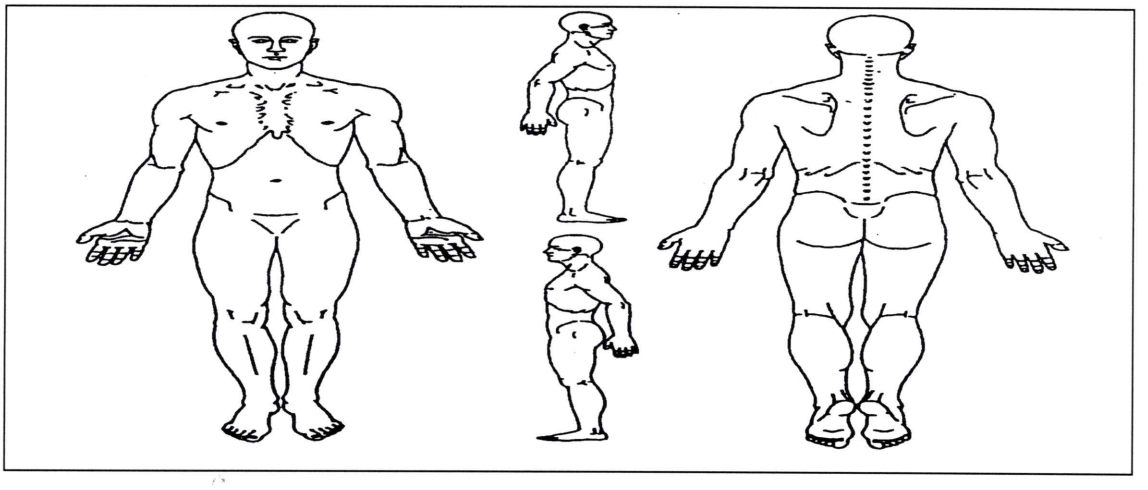
Have you had a MRI of your injury? [ ] Yes, [ ] No

Which body part(s) _____,What MRI Facility_____

Did you have surgery for this condition? [ ] Yes, [ ] No Surgeon Name _____

Date of surgery: Month _____ Day_____ Year_____

***On below chart please mark (X) location of your injury that you were referred for treatment:**



Please rate your pain on a scale of 0 – 10 with (0) being no pain and (10) being the worst.

At Worst:	0	1	2	3	4	5	6	7	8	9	10
Current:	0	1	2	3	4	5	6	7	8	9	10

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At Best: 0 1 2 3 4 5 6 7 8 9 10

Describe your pain: (Mark only the **one** that best describes)

[ ] Sharp, [ ] Dull / Achy, [ ] Burning, [ ] Shooting, [ ] Numbness/Tingling, [ ] Constant,

[ ] Intermittent [ ] Worse in am, [ ] Worse in pm

Aggravating Factors: [ ] Sitting, [ ] Standing, [ ] Walking, [ ] Stairs, [ ] Sit to stand, [ ] Bending,

[ ] Lifting, [ ] Sleeping, [ ] Squatting, [ ] Carrying, [ ] Reaching Overhead, [ ] Handling objects,

[ ] Pushing, [ ] Pulling, [ ] Running, [ ] Jumping, [ ] Exercise

Alleviating Factors: [ ] Sitting, [ ] Standing [ ] Walking, [ ] Lying Down, [ ] On the move,

[ ] When still, [ ] As the day progresses

What other treatment are you receiving for this condition? [ ] Medication [ ] Injections

[ ] Chiropractic [ ] Other : Doctor Name: _____ and Specialty _____

Medications related to your injury: [ ] Prescription pain, [ ] Over the counter pain,

[ ] Anti-inflammatory, [ ] Other _____

Check if you have, or have ever had any of the following conditions:

[ ] Abdominal Aneurysm, [ ] Pacemaker, [ ] Diabetes Type 1, [ ] Diabetes Type 2 [ ] Stroke

[ ] High Blood Pressure, [ ] HIV (+), [ ] Heart Attack, [ ] Fibromyalgia, [ ] Rheumatoid Arthritis,

[ ] Osteo Arthritis [ ] Currently Pregnant [ ] Cancer, What type_____ [ ] Are you in remission

Please list other pertinent medical conditions that might affect your treatment:

_____

What is your primary goal in Physical Therapy:_____

_____

Patient Name:_____

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