LIBERTY
REHABILITATION SPECIALISTS
PHYSICAL AND OCCUPATIONAL THERAPY

# Patient Information Form

**Patient: (Full Legal Name or as shown on Insurance Card)**

Last: _____ First: _____ MI: _____ Sex: M F

Email: _____ Birthdate: ___/___/___ S.S #: _____--_____--_____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip: _____

Primary Phone #: (___) ___--_____ Alternate Phone #: (___) ___--_____

_____ _____ (___) ___--_____
Emergency Contact Name Relationship to Patient Phone

_____ _____ (___) ___--_____
Referring Dr. Last Name First Name MI MD, DO, DDS Other Phone

**Condition to be treated in Therapy:** _____ Date Condition Began/Injury Date ___/___/___

**Circle One:** **Auto Accident** **Work Injury** **Non-Work Related Accident** **Other**

Did this Condition Result in Surgery? Y N If Yes Date of Surgery: ___/___/___

Have you had therapy anywhere this year for this condition? Y N If Yes, where: _____ Dates: ___/___/___

Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you) Y N

If Yes, from who? _____

Whom may we thank for this referral: _____My doctor _____Friend/Family _____social media_____Workshop

_____ **Initials**

**Consent to Treatment**

**I consent to rehabilitation and related services at Liberty Rehabilitation Specialists, Inc. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve body contact, touching and/or direct contact with sensitive areas.**

_____ **Initials**

**Treatment of Minors**

**I, as a parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during such treatment, and waive any claim I may have resulting from failure to do so.**

_____ **Initials**

**Liability**

**I know and agree that Liberty Rehabilitation Specialists, Inc. is not responsible for loss or damage to personal valuables.**

_____ **Initials**

**Waiver and Release**

**I hereby release, discharge and acquit Liberty Rehabilitation Specialists, Inc., it's agents, affiliates, representatives, employees, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind, arising our of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, emergency medical technician, physician, or urgent care services.**

_____ **Initials**

**Notice of Privacy Practices**

**My signature below indicates that I have been given the Notice of Privacy Practices for Liberty Rehabilitation Specialists, Inc. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Liberty Rehabilitation Specialists, Inc. to release any of my protected healthcare information.**

_____ _____
**Patient or Legal Representative's Signature** **Today's Date**

# Cancellation and Missed Appointment Policy

*Attendance at your rehabilitation appointments is vital to your continued healing. Keeping your appointments allows us to help facilitate your rehabilitation in a timely manner, meets your physician's expectations, and returns you to your normal activities. This policy enables us to better utilize available appointments for our patients in need of our care.*

## Our appointment policy

Please arrive on-time to your scheduled appointment. Late arrivals( **more than 15 min**) may cause schedule delays for those patients who arrive promptly at their appointment time. We will do our best to accommodate late arrivals if time allows; however, late arrivals may have to be rescheduled for another date or time. If rescheduling an appointment is necessary, this will be recorded in your medical record as a "cancellation" and a cancellation fee of $25 will apply. Our office policy is firm in this regard. ****This charge is not covered by your insurance and will be your responsibility.****

## Cancellation of an Appointment

Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your visit at our office. We understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule.

In order to be respectful of the rehabilitation needs of other patients, please be courteous and call Liberty Rehab promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. You will be subject to a $25 charge for appointments cancelled fewer than 24 hours before your appointment time. ****This charge is not covered by your insurance and will be your responsibility.**** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care.

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## No Show Policy

A "no-show" is someone who misses an appointment. You will be subject to a $25 NO-SHOW charge for an appointment that is scheduled and not kept. ****This charge is not covered by your insurance and will be your responsibility.****

After 3 “cancellations” or “no-shows” OR a combination of the 2 we will be unable to schedule any further appointments for you. Your physician will be notified and your treatment at our facility will be discontinued. Your attendance becomes part of your permanent record.

- Worker’s Compensation patients: Documentation of missed appointments is forwarded to your case manager and primary physician. This could jeopardize your claim.

## How to Cancel Your Appointment

To cancel appointments, please call Liberty Rehabilitation Specialists. Our contact information is listed below. If you do not reach us, you may leave a detailed message on our voicemail. Please include your name and a phone number that we can reach you at. We check our voicemail regularly and will return your call and give you the next available appointment time.

**North Central** (210) 490-4738 | **Northeast** (210) 656-5848 | **Southside** (210) 922-6292

**I understand and will abide by this policy.**

_____ _____

**Patient Signature** **Date**

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# Medical History Screening Form

**DATE:**

**List any medications/ dietary supplements you are taking.**

_____

_____

_____

_____ ☐ See attached list

**List any drug or latex allergies.**

_____ ☐None

**Do you have difficulties with?** (Check all that apply)

☐Communication ☐Vision ☐None

☐Speech ☐ Hearing ☐Other_____

**How do you learn best?** (Check one)

☐ Seeing ☐ Doing ☐ Hearing

**Are you:** (Circle *Yes* or *No*)

| | | | |
|---|---|---|---|
| Pregnant / Potentially Pregnant / Nursing? | N/A | Yes | No |
| Often bothered by feeling down, depressed or hopeless? | | Yes | No |
| Often bothered by little interest or pleasure in doing things? | | Yes | No |

**Do you:** (Circle *Yes* or *No*)

| | | |
|---|---|---|
| Feel safe at home and in the workplace? | Yes | No |
| Use tobacco? If yes, _____packs per day, for_____years | Yes | No |
| Use alcohol? | Yes | No |

**Rate your HIGHEST/WORST pain level in the past 72 hrs.**

_____

0 1 2 3 4 5 6 7 8 9 10

**No pain** **Worst pain**

**Rate your LOWEST/BEST pain level in the past 72 hrs.**

0 1 2 3 4 5 6 7 8 9 10

No pain Worst Pain

_____

**Are your symptoms:**

☐Getting worse? ☐Not Changing? ☐Getting Better?

**Past Surgical History**: (list all procedures and dates):

_____

_____

_____

_____

**What would you like to be able to accomplish by coming to therapy?**

_____

**Have you ever been told you have:** (Circle *Yes* or *No*)

| | | | | | |
|---|---|---|---|---|---|
| Cancer | Yes | No | Asthma/Bronchitis | Yes | No |
| Diabetes | Yes | No | Emphysema | Yes | No |
| High Blood Pressure | Yes | No | HIV/AIDS | Yes | No |
| Heart Disease/Attack | Yes | No | Chest Pain/Angina | Yes | No |
| Stroke | Yes | No | Headaches | Yes | No |
| Rheumatoid Arthritis | Yes | No | Pacemaker | Yes | No |

| | | |
|---|---|---|
| Kidney Disease | Yes | No |
| Liver Disease | Yes | No |
| Neurologic Disease | Yes | No |
| Osteoarthritis | Yes | No |
| Osteoporosis | Yes | No |
| Pain with sexual intercourse | Yes | No |
| Pelvic Pain /abnormal menstruation | Yes | No |
| Bowel/Bladder problems | Yes | No |
| Sexually Transmitted Diseases | Yes | No |
| Seizures | Yes | No |
| Difficulty swallowing | Yes | No |
| Drug Abuse | Yes | No |
| Prior Surgeries | Yes | No |
| Head Trauma | Yes | No |
| Surgical Impants | Yes | No |
| Fibromyalgia | Yes | No |

OTHER:_____

**In the past 3 months have you experienced**: (Circle *Yes* or *No*)

| | | |
|---|---|---|
| A change in your general health | Yes | No |
| Nausea / Vomiting | Yes | No |
| Fever / Chills / Excessive Sweating | Yes | No |
| Unexplained weight change (>10lbs) | Yes | No |
| Abnormal sensations (e.g. numbness) | Yes | No |
| Changes in your appetite | Yes | No |
| Difficulty swallowing | Yes | No |
| Changes in cough/sputum | Yes | No |
| Shortness of breath | Yes | No |
| Abnormal Bowel / Bladder function | Yes | No |
| Infections of any sort | Yes | No |
| Difficulty sleeping due to pain | Yes | No |
| Sustained morning stiffness | Yes | No |
| Dizziness | Yes | No |

**PATIENT IDENTIFICATION:**

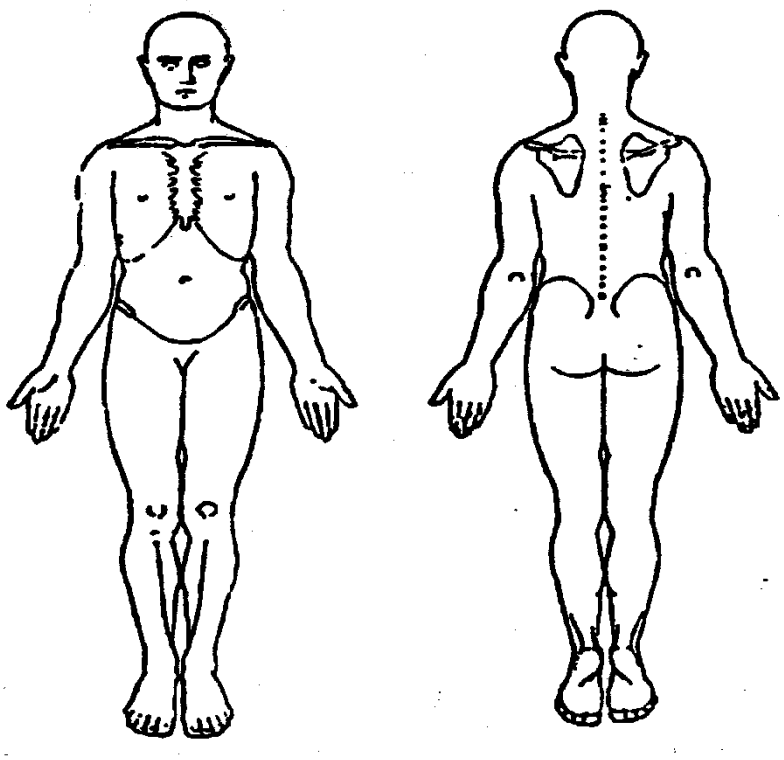
NAME (Last, First MI): _____ DOB: (dd-mm-yyyy)_____

ADDRESS: _____ PHONE:_____

(Form continued on back side)

## Medical History Screening Form

**Mark on the body chart below where your pain is located and then describe what it feels like to you.**



**Instructions:** Choose from the choices below to indicate where you are having pain, how often, and the description of your pain. You may have several different areas and descriptions of pain.

**Descriptors of Pain: ( check all that apply)**

| | | | |
|---|---|---|---|
| sharp | shooting | burning | dull |
| throbbing | ache | tingling | numbness |
| heavy | tight | pulling | stabbing |

**Behavior of your symptoms: (check all that apply)**

1.) constant (never goes away)
2.) intermittent (relieved by rest/position change)
3.) occasionally (daily or less freq)
4.) infrequent (once a week/month)
5.) previously (no longer present)
6.)variable (sometimes worse than other times)

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**List 3 activities you have difficulty doing because of your pain. Then mark on the scale from 0-10 how difficult the activity is to perform with 0 meaning unable to perform the activity. (Example: running 1 mile-2)**

**Activity #1:** _____

0 1 2 3 4 5 6 7 8 9 10

**Unable to perform activity** — **Able to perform activity at the same level as before my injury or problem began**

**Activity #2:** _____

0 1 2 3 4 5 6 7 8 9 10

**Unable to perform activity** — **Able to perform activity at the same level as before my injury or problem began**

**Activity #3:** _____

0 1 2 3 4 5 6 7 8 9 10

**Unable to perform activity** — **Able to perform activity at the same level as before my injury or problem began**

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# AUTHORIZATION FOR RELEASE OF INFORMATION

***Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules***

**(1) Patient's Printed Name**:_____
Last First Initial or Other

Date of Birth: ____/_____/___

**(2) Liberty Rehabilitation Specialists, Inc. will only disclose the protected health information you want disclosed.** (Check only one box.)

☐ Do NOT release any information other than for treatment or payment (skip # 3)

☐ ALL records regarding my care at Liberty Rehabilitation Specialists, Inc. to any requesting party

☐ **Other** _____

**(3) Liberty Rehabilitation Specialists, Inc. can use this authorization for the following period:**

beginning ___/___/_____ and ending ___/___/_____

**(4) Please initial all items below indicating that you have read and understand the rights/information below:**

_____ Initial — I understand that this authorization does not expire unless I have indicated an expiration date above

_____ Initial — I understand that I can refuse to give authorization without fear of retaliation or treatment limitations

_____ Initial — I understand that if I give authorization I may revoke it at any time by notifying this Liberty Rehabilitation Specialists, Inc. in writing

_____ Initial — I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession

_____ Initial — I understand that if Liberty Rehabilitation Specialists, Inc. requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to

_____ Initial — I understand that I will receive a copy of this authorization after I sign it, if I request it.

_____ **Signature of Patient** **Date**

**or**

_____ **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**