

PROHAB PHYSICAL THERAPY EAST PATIENT INFORMATION FORM

Name		Gender	Date of Birth	
Address		PO Box	City	State Zip
Social Security Number	Home Phone		Work Phone	Cell Phone
E-mail address			Employer	
Emergency Contact			Phone	Relationship
Physician	Next Doctor Visit	Problem Area		Date of Injury
How did you learn about Prohab?				

INSURANCE INFORMATION

Primary Insurance	Name of Insured/ Date of Birth of Insured	Subscriber ID
Secondary Insurance	Name of Insured/ Date of Birth of Insured	Subscriber ID

MEDICAL INFORMATION				PAIN OR PROBLEMS				
		Yes	No			Yes	No	
High or low blood pressure				Convulsions/Epilepsy				
Cardiac pacemaker				Dizziness/Fainting				
Heart conditions (list)				Headaches/Migraines				
				Arthritis				
				Currently pregnant				
Stroke/TIA				Surgery (list)				
Cancer/malignancy								
Diabetes								
Blood disorder (anemia, etc.)								
Vision/Hearing Difficulties								
Respiratory Problems								
Infectious Disease (TB, HIV, etc)								
Allergy (list)								
					Other Medical Conditions (list)			

List Any/All Medications

Are you aware of your Diagnosis? YES _____ NO _____ Are you aware of your Prognosis? YES _____ NO _____

I understand that I am fully responsible for any balance incurred at Prohab Physical Therapy East, LLC. I request that Prohab submit all claims to the appropriate party for reimbursement. I also request that payment should be made to Prohab and authorize the release of any information necessary to process any medical claims.

I understand that the treatment as requested by the referring physician and rendered by Prohab Rehabilitation Services, Inc., may involve a variety of treatment methods. I understand that the primary goals of the rehabilitation program are to reduce the symptoms of my condition and to improve my ability to function on a daily basis, at work and/or at home. I understand in order to achieve these goals; the program will become progressively more extensive as my capacity and tolerance to therapeutic activities improve.

Although every precaution will be taken when the therapy is administered to avoid an adverse physical reaction, I realize that there are risks involved. I realize it is my responsibility to inform the therapist of any changes in the signs and symptoms I am experiencing, and that I have the right to refuse any treatment and/or test if I feel may be harmful.

Prohab Physical Therapy East, LLC, does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment. For further information about this policy, contact: Nicholas Encheff, 419-698-2500.

Patient/Parent/Guardian Signature _____ Date _____

A legal guardian must consent for a minor under the age of 18.

I acknowledge that I have received a copy of the "Notice of Privacy Practices" from Prohab Physical Therapy East, LLC. I understand that if I have any questions regarding this notice that I can contact the Privacy Manager at 419-698-2500.

Patient/Parent/Guardian Signature _____ Date _____

Would you be willing to participate in a Customer Satisfaction Survey at the end of your treatment? Yes _____ No _____