6000 Meadowbrook Mall Court ◆ Suite 22 ◆ Clemmons, NC 27012
Phone (336) 778-0292 Fax (336) 778-0242

NOTE: Are you currently participating in any other therapy (PT/OT, Pulmonary, etc.) or are you receiving any Home Health Care, nursing, or do other health care service agencies come to your home to deliver any services at this time?

☐ **Yes** ☐ **No**

➔ **If yes, please let us know before proceeding.**

PERSONAL INFORMATION

Name: ______________________ (FIRST) ______ (MI) ______________________ (LAST) ______ (SUFIX) ______________________ (PREFERRED NAME)

Date of birth: ______________ (00/00/0000) Age: _____ Height: _________ Weight: ________

Home Phone: ________________ ((000) 000-0000) Cell Phone: __________________ ((000) 000-0000) Work Phone: ____________________ ((000) 000-0000)

Home Address: ______________________________ (STREET INFORMATION) Email: ____

______________________________ (CITY, STATE, ZIP)

EMPLOYMENT

Occupation: _______________________________ (CURRENT OR PAST) Employer: ____

Still Working? ☐ **Y** ☐ **N** Retired? ☐ **Y** ☐ **N**

EMERGENCY CONTACT *(ONLY 1 IS REQUIRED)*

Name: ______________________________ Phone: ____________________ Relation: _________________

Name: ______________________________ Phone: ____________________ Relation: _________________

PRIMARY CARE PHYSICIAN

Facility Name: ______________________________

Doctor or PA Name: _________________________

Address: _________________________________ (STREET INFORMATION)

_________________________________ (CITY, STATE, ZIP)

Phone #: _____________ ((000) 000-0000) Fax #: ______________ ((000) 000-0000)

REFERRING PHYSICIAN (ONLY IF REFERRED BY A PHYSICIAN)

Facility Name: __________________________________

Doctor or PA Name: ____________________________

Address: _____________________________________ (STREET INFORMATION)

_____________________________________ (CITY, STATE, ZIP)

Phone #: _______________ ((000) 000-0000) Fax #: ________________ ((000) 000-0000)

PRIMARY INSURANCE

Insurance Provider: ____

Plan Name: ____________________ Plan #: __________ Plan Letter: ________

Member/Subscriber ID #: ______________ Group #: __________

CARDHOLDER

Name: ____________________
AS IT APPEARS ON THE CARD

DOB: ____________ Gender: ______
00/00/0000

Relation: __________

Address: ____________________
AS IT IS LISTED WITH THE INSURANCE COMPANY

____
CITY STATE, ZIP

POLICY HOLDER

Name: ____________________
AS IT APPEARS ON THE CARD

DOB: ____________ Gender: ______
00/00/0000

Relation: __________

Address: ____________________
AS IT IS LISTED WITH THE INSURANCE COMPANY

____
CITY STATE, ZIP

SECONDARY INSURANCE

Insurance Provider: ____

Plan Name: ____________________ Plan #: __________ Plan Letter: ________

Member/Subscriber ID #: ______________ Group #: __________

CARDHOLDER

Name: ____________________
AS IT APPEARS ON THE CARD

DOB: __________ Gender: ______
00/00/0000

Relation: ________

Address: ____________________
AS IT IS LISTED WITH THE INSURANCE COMPANY

____
CITY STATE, ZIP

POLICY HOLDER

Name: ____________________
AS IT APPEARS ON THE CARD

DOB: __________ Gender: ______
00/00/0000

Relation: ________

Address: ____________________
AS IT IS LISTED WITH THE INSURANCE COMPANY

____
CITY STATE, ZIP

MEDICAL INFORMATION

1) When did your problems begin? ______________________________

2) Briefly describe what occurred: ______________________________

____

3) PAIN SCALE: Now: *(CIRCLE ONE)* 0 1 2 3 4 5 6 7 8 9 10

4) PAIN SCALE: At Worst: *(CIRCLE ONE)* 0 1 2 3 4 5 6 7 8 9 10

5) PAIN SCALE: At Best: *(CIRCLE ONE)* 0 1 2 3 4 5 6 7 8 9 10

6) When do you have your symptoms or pain? *(CHECK ONLY ONE)*

☐ Constant ☐ Intermittent (come and go) ☐ Only at night ☐ Other times

7) How long do your symptoms last? ______________________________

8) When are your symptoms or pain worst? ______________________________

9) Do your symptoms or pain move from one place to another? ☐ **Y** ☐ **N**

If yes, where does it travel? ______________________________

10) What makes your symptoms or pain worse? ______________________________

____

11) What makes your symptoms or pain better or ease off? ______________________________

____

12) Check the words that describe your symptoms or pain: *(CHECK ALL THAT APPLY)*

☐ Aching	☐ Cramping	☐ Heavy	☐ Pins and Needles	☐ Tender
☐ Burning	☐ Deep	☐ Itching	☐ Sharp	☐ Throbbing
☐ Cold	☐ Dull	☐ Numbness	☐ Shooting	☐ Tingling
☐ Constant	☐ Hot	☐ Penetrating	☐ Stabbing	☐ Weakness

13) Balance issues:

a. Do you have any difficulty with your gait or maintaining your balance? ☐ **Y** ☐ **N**

b. Can you stand from a sitting position without using your hands? ☐ **Y** ☐ **N**

c. Have you fallen with in the last year? ☐ **Y** ☐ **N**

If yes, did you suffer any injury? ______________________________

d. Do you use a: *(CHECK ALL THAT APPLY)* ☐ Cane ☐ Walker ☐ Wheelchair ☐ Rollator ☐ Other: __________________

14) Do your symptoms or pain interrupt your sleep? ☐ **Y** ☐ **N**

15) Do you wake up at night or in the morning with the pain/symptoms? ☐ **Y** ☐ **N**

16) What do your symptoms or pain prevent you from doing? ______________________________

17) What is your primary goal for therapy? ______________________________

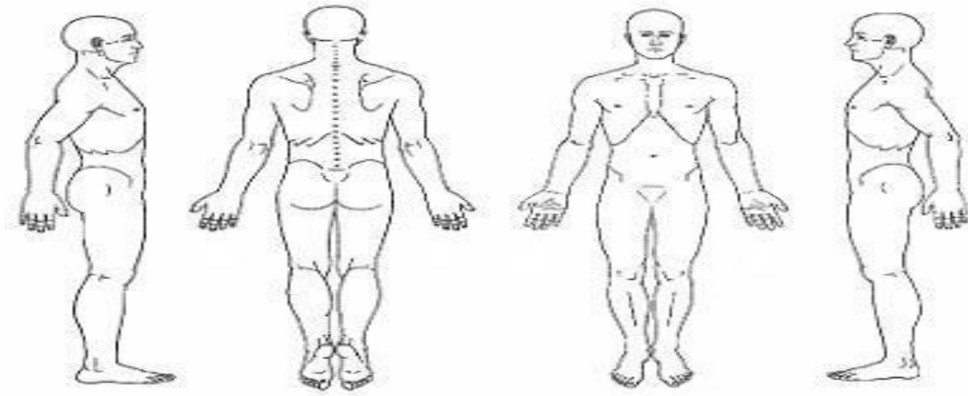
18) What do you feel caused your diagnosis? *(CHECK ONLY ONE)*

☐ Chemo/Rx induced ☐ HIV/AIDs ☐ Toxic agent ☐ Unknown

☐ Diabetes ☐ Idiopathic (Unknown) ☐ Other ______________________

19) Have you ever seen a Neurologist? ☐ **Y** ☐ **N** If yes when? ______________________________

WHERE ARE YOUR SYMPTOMS?



MEDICAL HISTORY (PUT YEAR DIAGNOSED OR YEAR STARTED BESIDE)

- ☐ Anemia ____
- ☐ Angina ____
- ☐ Arthritis ____
- ☐ Asthma ____
- ☐ Atrial Fibrillation ____
- ☐ Auto Immune Disorder ____
- ☐ Back Pain ____
- ☐ Blood Clots ____
- ☐ Bowel/Bladder Problems ____
- ☐ Bronchitis ____
- ☐ Cancer ____
- ☐ Circulation Issues ____
- ☐ COPD ____
- ☐ Do you use CPAP? ____
- ☐ Depression ____
- ☐ Diabetes ____
- ☐ DVT ____
- ☐ Epilepsy ____
- ☐ Fibromyalgia ____
- ☐ GI Ulcers ____
- ☐ Gout ____
- ☐ Heart Attack ____
- ☐ Heart Disease ____
- ☐ Heart Murmur ____
- ☐ Hepatitis ____
- ☐ Hernia ____
- ☐ High Blood Pressure ____
- ☐ High Cholesterol ____
- ☐ Incontinent ____
- ☐ Infectious Disease ____
- ☐ Kidney Disease ____
- ☐ Liver Disease ____
- ☐ Migraines ____
- ☐ Neuropathy ____
- ☐ Parkinson's Disease____
- ☐ Pulmonary Embolism ____
- ☐ Loss/Gain ____
- ☐ Restless Leg ____
- ☐ Raynaud's Disease ____
- ☐ Rheumatic Fever ____
- ☐ Seasonal Allergies ____
- ☐ STD's ____
- ☐ Stroke (CVA) ____
- ☐ Thyroid Disease ____
- ☐ TIA ____
- ☐ Varicose Veins ____
- ☐ Drink Alcohol? ____
- ☐ Do you Smoke? ____

OTHER SIGNIFICANT MEDICAL HISTORY

Do you have any trouble with the following? (*CHECK ALL THAT APPLY*)

- ☐ Balancing
- ☐ Bending/Stooping
- ☐ Carrying
- ☐ Dressing
- ☐ Driving
- ☐ Getting up from floor
- ☐ Grasping
- ☐ Grooming
- ☐ Hopping
- ☐ Jumping
- ☐ Kneeling
- ☐ Lifting
- ☐ Lying Flat
- ☐ Moving lying to sitting
- ☐ Moving sitting to standing
- ☐ Pulling
- ☐ Pushing
- ☐ Raising arms above head
- ☐ Reaching
- ☐ Rolling over
- ☐ Running
- ☐ Sitting
- ☐ Squatting
- ☐ Stairs
- ☐ Walking long distance
- ☐ Walking outdoors
- ☐ Walking short distance

Of the above list what is the worst: ____

SURGERIES

(PROCEDURE)	(DATE)	(FACILITY)

MEDICATIONS

(PLEASE LIST BELOW OR BRING A COPY OF YOUR MEDICATION LIST)

(MEDICATION NAME)	(QUANTITY)	(FORM / UNIT)	(WAY TAKEN)	(HOW MANY TIMES)

HOW DID YOU HEAR ABOUT US

- ☐ Doctor
- ☐ Family/Friend ___________
- ☐ Facebook
- ☐ Magazine _____________
- ☐ Newspaper ____________
- ☐ Phonebook
- ☐ Radio _________________
- ☐ www.crtherapy.com
- ☐ Search Engine

Appointment Cancelation and Scheduling Policy Agreement

Complete Rehab's goal is to provide quality individualized medical care in a timely manner. No-shows, late shows, and cancellations inconvenience those individuals who need access to medical care. We would like to remind you of our policy regarding missed appointments.

Cancellation of an Appointment

In order to be respectful of the medical needs of other patients, please be courteous and contact Complete Rehab's office promptly if you are unable to show up for an appointment. This time may be reallocated to someone who needs treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 24 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely medical care.

How to Cancel Your Appointment

To cancel your appointment, please call 336-778-0292. If you do not reach the receptionist, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name, and phone number. We will return your call promptly.

Late Cancellations:

A cancellation is considered late when the appointment is cancelled without a 24-hour advance notice (barring emergencies).

No Show Policy:

A "no-show" is a patient who misses an appointment without cancelling it. A failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show".

The first time there is a "no-show", late cancellation, or cancellation without a reasonable excuse there will be no charge to the patient. A 2nd occurrence may result in a fee of the visit. The 3rd occurrence will be the fee of the visit and the patient may be discharged from Complete Rehab.

Appointment Times:

It is important that you arrive to your appointment at your scheduled time. We prefer you not to come more than 15 minutes early. If you do your treatment may not start until your scheduled time.

For courtesy, please give us notice if you will be arriving later than 15 minutes from your scheduled time.

__________________________________ __________________________________

Patient Name Date

____

Patient Signature/Guardian

Notice of Privacy Practices

This *Notice of Privacy Practices* describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Healthy Information: Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician’s practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include:

Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglects: Food and Drug Administration requirement: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: research: Criminal Activity: Military Activity and National Security: Workers’ Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirement of Sections 164.500.

We will share your protected health information with third party “business associates” that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associated involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may use or disclose your protected health information as necessary to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you.

______________________________ ______________________________

Patient Name Date

____

Patient Signature/Guardian

Payment and Insurance Policies

We are pleased to assist you with your rehab needs. If you have Medical Insurance, please be aware that insurance quotes are an estimate only.

Co-Pays: I understand that I am responsible to pay all co-payments at the time of service, prior to leaving.

Deductible: If my insurance determines that I have not met my deductible I understand that I will be fully responsible for payment in a timely manner, no more than thirty days after I have been notified by insurance and/or provider.

I acknowledge that I assume full financial responsibility for services rendered to me if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of insurance coverage.

______________________________ ______________________________

Patient Name Date

____

Patient Signature/Guardian

Medical Information Release Form
(HIPPA Release Form)

RELEASE INFORMATION

I ____ authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to.

- ☐ Spouse ______________________________
- ☐ Child(ren) ______________________________ ______________________________
- ☐ Physician ______________________________ ______________________________
- ☐ Other: ______________________________ ______________________________

☐ Information is not to be released to anyone.

This release of Information will remain in effect for one year after discharge or until terminated by me in.

MESSAGES

Please Call: ☐ My home ☐ My work ☐ My cell

If unable to reach me:

- ☐ You may leave a detailed message
- ☐ Please leave a message asking for a return phone call

Best telephone # to reach me is: __________________________
(000-000-0000)

The best time to reach me is:

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Time: _______

If available, I would like to receive automated appointment reminders: ☐ **Y** ☐ **N**

____________________________________ ____________________________________

Patient Name DOB

____________________________________ ____________________________________

Patient Signature/Guardian Date