4832 S. 24th Street, Omaha, NE Office:
402-502-1819
Fax: 402-502-2057
www.OmahaIntegratedRehab.com

New Patient Information

Date: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Social Security Number: _____-_____-_____ Marital Status (circle one): Single Married Divorced Widowed

Date of Birth: _____ Preferred Language: English Spanish Other: _____

Race (circle one): White Black or African American Hispanic or Latino Asian Decline to Answer Other: _____

Ethnicity (circle one): Hispanic or Latino Not Hispanic or Latino Decline to Answer

Home Phone: (_____) _____-_____ Work Phone: (_____) _____-_____ Cell Phone: (_____) _____-_____

Cell Carrier (circle one): Sprint Verizon AT&T US Cellular Boost Other: _____

Email address: _____

Contact Preference (circle one): Home Phone Work Phone Cell Phone Text Message Email

Spouse Data

First Name: _____ Middle Initial: _____ Last Name: _____

Cell Phone: (_____) _____-_____ Work Phone: (_____) _____-_____

Please use my spouse as my Emergency Contact (circle one): Yes No

Emergency Contact Data:

Contact Name: _____Home Phone: (_____) _____-_____

Primary Doctor: _____ City: _____ State: _____

Patient Employer Data:

Employment Status: Employed: FT or PT Student: FT or PT Retired Unemployed Other _____

Employer Name: _____ Job Title/Position _____

Employer Address: _____ City: _____ State: _____ Zip Code: _____

Whom may we thank for referring you to our office? _____

Medical Insurance:

Are you the policy holder (circle one)? Yes No If no, who is the policy holder (circle one)? Spouse Parent Employer Other

Policy Holder First Name: _____ Middle Initial: _____ Last Name: _____

Policy Holder's Date of Birth: _____ Policy Holder's Employer: _____

Insurance Carrier: _____ Policy Number: _____

*Is your visit related to an auto accident or work related injury (circle one)? Yes No Please Specify, if applicable: Auto Work

Auto Accident Data:

(If your visit is related to an auto accident, complete the following information.)

Date of Accident: _____ Claim Number: _____

Auto Insurance Carrier: _____ Is this your auto insurance carrier (circle one)? Yes No

Claims Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Adjuster Name: _____ Adjuster Phone Number: _____

Attorney Name: _____ Attorney Phone Number: _____

Worker's Compensation Data:

(If your visit is related to a worker's compensation claim, complete the following information.)

Date of Accident: _____ Claim Number: _____

Worker's Compensation Insurance Company: _____

Claims Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Case Manager Name: _____ Case Manager Phone Number: _____

Attorney Name: _____ Attorney Phone Number: _____

Insurance Assignment and Release:

I would like for Integrated Rehab to bill the above medical/liability insurance for all services rendered to me after each visit. In the event that the above liability insurance does not pay; Integrated Rehab has the right to bill the above medical insurance for payment on my account. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all co-pays, deductibles, co-insurances, and any other subscriber liabilities at the time that services are rendered, as are allowable.

Signature of Patient or Parent/Guardian of Minor Patient Date

INFORMED CONSENT FOR CARE

_____, in coming to Integrated Rehab, gives the practitioners permission and authority to care for the patient in accordance with the tests, diagnosis, and analysis. The treatments or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The practitioner, of course, will not give any treatment or health care if he is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through health care procedures whatever he is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the practitioner. Our practitioners provide a specialized, non-duplicating health care service. Your Doctor of Physical Therapy and/or your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

I understand that if I am accepted as a patient by a practitioner at Integrated Rehab, I am authorizing them to proceed with any treatment that may be necessary. Furthermore, any risk involved, regarding physical therapy treatment or chiropractic treatment will be explained to me upon my request.

Signature of Patient or Parent/Guardian of Minor Patient Date

Patient Health Information Consent Form and Acknowledgment of Privacy Practices

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Please refer to Notice of Privacy Practices of Integrated Rehab, LLC for a complete description of such uses and disclosures. I acknowledge that a copy of said Notice of Privacy Practices was offered to me.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example, the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physical therapist and/or chiropractic physician has the right to refuse to give care.

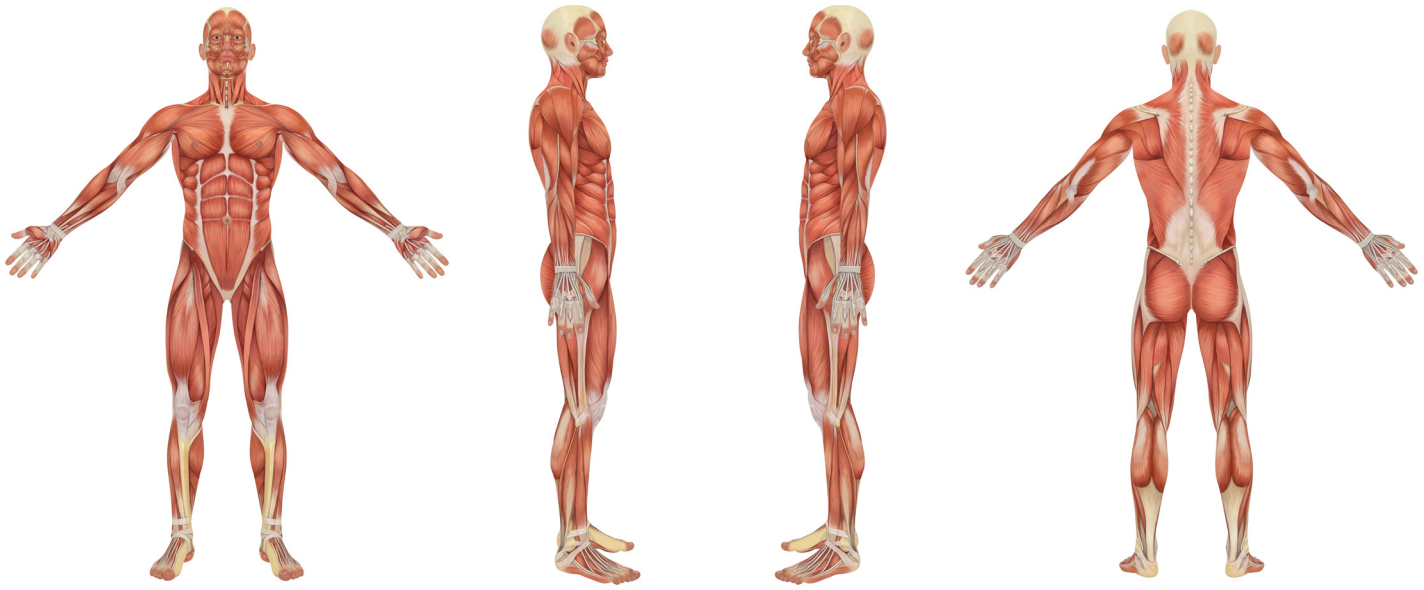
I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient or Parent/Guardian of Minor Patient Date

Current Complaints:_____

Patient Name: _____ Date: _____

Please mark where your pain/symptoms are:



Grade your pain on a scale of 0-10: [0= No Pain, 10= Extreme Pain] Choose how frequent the pain is presently:

Neck:	0	1	2	3	4	5	6	7	8	9	10	Seldom	Intermittent	Frequent	Constant
Upper Back:	0	1	2	3	4	5	6	7	8	9	10	Seldom	Intermittent	Frequent	Constant
Lower Back:	0	1	2	3	4	5	6	7	8	9	10	Seldom	Intermittent	Frequent	Constant
_____	0	1	2	3	4	5	6	7	8	9	10	Seldom	Intermittent	Frequent	Constant

Area(s) of complaint?

1. _____
2. _____
3. _____
4. _____

Describe the nature of your symptoms: (Deep, Burning, Numbness, Aching, Stiff, etc...)

1. _____
2. _____
3. _____
4. _____

When did this episode begin or start getting worse?

_____

Can you go to sleep without problems? Yes or No

Do you awaken because of the pain? Yes or No If yes, where is the pain that wakes you up? _____

Any prior history of current complaints? Yes or No

If yes, please describe episodes with dates: _____

_____

Have you had prior treatment by a Physical Therapist or Chiropractor for your current complaints? Yes or No

If yes, please list who and when: _____

_____

Have you seen a medical doctor for your current complaints? Yes or No

If yes, did you see your Primary Care Physician? Yes or No

If you saw a different doctor, please provide his or her name and specialty:

Doctor Name: _____ Specialty: _____

Current Medical History:

Has any doctor diagnosed you with High Blood Pressure? Yes or No

Has any doctor diagnosed you with Diabetes? Yes or No If yes, what kind? Type 1 or Type 2

Are you pregnant? Yes or No

Any other current health problems? (ex. Heart Disease, Allergies, etc...) _____

_____

Current Medications: _____

_____

Past Medical History:

Injuries to Head, Neck or Back: _____

_____

Surgeries (Date & Type): _____

_____

Fractures (Date & Type): _____

_____