

PATIENT INTAKE AND CONSENT FORM

Attachment B1.003A
Attachment M7.005C

Internal Use Only: A/C# Name A/C Type Office#

First Name _____ MI _____ Date of Injury/Onset _____ Today's Date _____

Last Name _____ Date of Birth _____ Age _____

Address _____ Sex M F Marital Status S M D W

Home Phone _____

City _____ State _____ Zip _____ Work Phone _____

Responsible Party _____ Cell Phone _____

Address _____ E-mail _____

City _____ Injury Area _____

Phone Number _____ Accident Related: Yes No

Relationship to Responsible Party _____ If Accident: Auto Work Other

Nature of Accident _____

Employer _____ SS# _____

Address _____ Occupation _____

City _____ State _____ Zip _____ Contact at Employer _____

Referring Physician _____ Phone Number _____

Primary Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Second Insurance _____ Insured Name _____

Group # _____ ID # _____ Address _____ City _____

Insured Employer _____ State _____ Zip _____ Phone _____

Relationship to Insured _____ Insured Date of Birth _____ Insured Sex: M F

Emergency Contact _____ Daytime Phone Number _____

Are you receiving or have you received home health services? Yes No

Are you receiving or have you received other therapy services? Yes No

(Continued on next page)

PATIENT INTAKE AND CONSENT FORM

Please Initial Each as Applicable:

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CONSENT TO TREATMENT: I consent to rehabilitation and related services at Star Therapy Services. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of sensitive nature.

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 any such treatment, and waive any claim I may have resulting from failure to do so.

LIABILITY: I know and agree that Star Therapy Services is not responsible for loss or damage to personal valuables.

WAIVER AND RELEASE: I hereby release, discharge and acquit Star Therapy Services, its representatives, affiliates, employees, or assigns, of and from any and all liability, claim, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept or allow emergency and or medical services, including but not limited to ambulance, Medical Technician, physician or urgent care services.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment.

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices.

I certify that all of the information provided herein is true and correct.

Patient/Guardian Signature _____ Witness Signature _____

This form constitutes proprietary information and cannot be used, reproduced or duplicated, in whole or in part, absent written consent of Star Therapy Services. This form must be completed in its entirety and be provided to Star Therapy Services prior to initiation of therapy services.

STAR THERAPY SERVICES MEDICAL HISTORY FORM

PATIENT NAME: _____ TODAY'S DATE: _____

REFERRING PHYSICIAN'S NAME: _____ DATE OF INJURY OR ONSET: _____

CAUSE OF INJURY OR ONSET: _____ ARE YOU PRESENTLY WORKING? Y N

PRIMARY CARE PHYSICIAN'S NAME: _____ DATE OF NEXT MD APPT: _____

WHAT IS YOUR REASON FOR ATTENDING THERAPY: _____

BECAUSE OF YOUR PROBLEM, WHAT SPECIFIC ACTIVITIES ARE YOU HAVING DIFFICULTY WITH?

1. _____
2. _____
3. _____

WHAT ARE YOUR PERSONAL GOALS/OUTCOMES YOU HOPE TO ACHIEVE FROM THERAPY?

1. _____
2. _____
3. _____

DESCRIBE YOUR GENERAL HEALTH: (circle one) EXCELLENT GOOD FAIR POOR
DO YOU USE TOBACCO? (circle one) YES NO IF YES, HOW MUCH? _____

HAVE YOU RECENTLY BEEN HOSPITALIZED OR HAD SURGERY? YES NO IF YES, WHEN _____ AND WHY _____

HAVE YOU HAD PRIOR PHYSICAL/OCCUPATIONAL THERAPY FOR THIS CONDITION? (circle one) YES NO
WHAT WAS DONE / WHAT WERE THE RESULTS: _____

HAVE YOU HAD PRIOR PHYSICAL THERAPY THIS CALENDAR YEAR? (circle one) YES NO
WAS IT RECEIVED AT: (circle one) HOSPITAL OUT PATIENT CENTER HOME HEALTH
FOR HOW LONG? _____

CURRENT MEDICATIONS: _____

ALLERGIES: Medication _____ Reaction _____ Medication _____ Reaction _____

ARE YOU ALLERGIC TO LATEX? (circle one) YES NO If yes what is the Reaction _____
Are you Allergic to Dexamethasone? YES NO If yes what is the Reaction _____

DO YOU NOW OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS? (check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> RESPIRATORY PROBLEMS |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> ASTHMA <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> COPD <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> CARDIOVASCULAR PROBLEMS | <input type="checkbox"/> FRACTURES | <input type="checkbox"/> Other |
| <input type="checkbox"/> HOLTER MONITOR - currently wearing? | <input type="checkbox"/> HEADACHES | <input type="checkbox"/> SEIZURES <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> HEPATITIS/HIV | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE <input type="checkbox"/> controlled <input type="checkbox"/> uncontrolled | <input type="checkbox"/> KIDNEY PROBLEMS | |
| <input type="checkbox"/> LOW BLOOD PRESSURE | <input type="checkbox"/> MRSA (Methicillin Resistant Staphylococcus Aureus) | |
| <input type="checkbox"/> CURRENTLY PREGNANT | <input type="checkbox"/> OSTEOPOROSIS | |

If checked any above, explain: _____

ANY OTHER MEDICAL PROBLEMS: _____

SIGNATURE OF PATIENT: _____ REVIEWED BY Therapist: _____ Date _____