MOBILE REHAB
REGISTRATION FORM

Today's Date: ___________________

PATIENT INFORMATION				
Patient's Name First:	M.I.:	Last:		
Address:	City:	State:	Zip:	
Home Phone: ( )	Cell Phone: ( )	Email:		
Preferred Method of Appt Reminders: [ ] Home Phone [ ] Cell Phone [ ] Text [ ] Email [ ] Check Here For No Appt Reminder				
Date of Birth (mm/dd/yyyy):	# of Children:	Age:	Gender:	
Social Security #:	Date of Injury:	Place (State) of Injury:		
Height:	Weight:	How did you hear about us:		
Emergency Contact:				
Relationship:	Phone: ( )			
WORK INFORMATION				
Current Employer:				
Occupation/Job Title:	Employment Status (circle one): Full time Part time Retired Unemployed			
CARE PROVIDER INFORMATION				
PCP:	Name of Practice:			
PATIENT INSURANCE INFORMATION – PLEASE BRING YOUR INSURANCE CARD				
Primary Insurance Company:	ID #:			
Name of Subscriber:	Date of Birth:	Group/Policy #:		
Relationship to Subscriber: (Circle One) Self Spouse Minor Other				
Employer:	Work Phone: ( )			
Secondary Insurance Company (If applicable):	ID #:			
Name of Subscriber:	Date of Birth:	Group/Policy #:		
Relationship to Subscriber: (Circle One) Self Spouse Minor Other				
Employer:	Work Phone: ( )			
AUTO/WORK INJURY CLAIM (please provide private insurance info)				
Insurance Name: □ Auto:	□ Worker's Comp:			
Adjuster/Claim Manager:	Phone:	Extension:		
Address:	City:	State:	Zip:	
Claim #:	Accident Date:	Cause:		
Body part covered on claim:	Remaining PIP Benefits:			
ATTORNEY INFORMATION				
Name:	Law Firm:	Phone:		
Address:	City:	State:	Zip:	
GUARDIAN INFORMATION (IF UNDER 18 YEARS OLD)				
Name Last:	First:	M.I.:	SSN:	
Address:	City:	State:	Zip:	
Relationship to Subscriber: (Circle One) Self Spouse Other	Date of Birth:			
Employer:	Work Phone: ( )			

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Have you received any therapy during the current calendar year? Y / N			
If yes, please provide details:	◻ PT ◻ SLT ◻ OT		Date:
Location:		Number of treatments/visits:	

I understand and agree to pay all debts and outstanding balances for services rendered to the above designated patient, and that payment for these services, whether reimbursed by my insurance plan or not, or made at the time of service or at a later date, are my responsibility. While Mobile Rehab Inc. may assist me in verifying my insurance coverage, I realize that I am responsible to know my insurance benefits and coverage and am liable for all copayments, coinsurance, and deductibles. If applicable, I acknowledge that I am responsible to endorse and surrender to Mobile Rehab Inc. all insurance checks made out to me from my insurance company for physical therapy services. Further, if applicable, I grant this office permission to endorse checks made out to me, to be credited to my account.	
Signature of patient or person responsible for payment	Date:
Informed Consent: *I grant permission to Mobile Rehab Inc. for treatment in correspondence with either a medical prescription or a physical therapy plan of care, which may include, but is not limited to, therapeutic exercises, manual therapies and modalities. If treatment is rendered under direct access, I understand that I am required to see a medical doctor, DPM, or DDM, to continue treatment beyond the initial 30 days. In granting permission for treatment, I release Mobile Rehab Inc. from any liability. I authorize payment of physical therapy benefits to Mobile Rehab Inc. for services rendered by Mobile Rehab Inc. I authorize release of medical records upon request for settlement of a claim or for application of insurance benefits. I request payment of authorized benefits to be made on my behalf. I certify that information given by me in applying for insurance payment is correct.*	
Signature of patient or person responsible for payment	Date:
I understand that Mobile Rehab Inc. operates in an open environment and from time to time other clients may hear myself and the staff talking about my case. I give my permission for this communication to occur in an open environment. If at any time I prefer to have such conversations in private only, I will immediately inform the staff at Mobile Rehab Inc and they will refrain from public conversation and discuss my care with me in a private treatment room.	
Signature of patient or person responsible for payment	Date:

Past Medical History

Name:				Date:		
BLOOD PRESSURE	**YES**	**NO**		**OTHER CONDITIONS**	**YES**	**NO**
Hypertension				Rheumatoid Arthritis		
Low Blood Pressure				Multiple Sclerosis		
Irregular Heart Beat				Epilepsy		
HEART DISEASE	**YES**	**NO**		Gout		
Heart Attack				Diabetes		
Atherosclerotic Disease				Hearing Loss		
Myocardial Infarction				Fainting		
Rheumatic Heart Disease				Polio		
Heart Murmur				Osteoporosis		
MUSCLE CONDITION	**YES**	**NO**		Loss of balance		
Carpal Tunnel R/L				Unusual bleeding/discharge		
Tennis Elbow R/L				Wound that won't heal		
Back/Neck Problems				Change in bowel or bladder habits		
Limited Limb Movement				Lumps in body parts		
LUNGS	**YES**	**NO**		Unexpected weight loss		
Asthma				Nagging cough >3months		
Emphysema				Difficulty swallowing		
Shortness of Breath				Increased pain at night		
JOINT CONDITIONS	**YES**	**NO**		Anemia		
Upper Extremity Dislocation				Cancer (type/location)		
Lower Extremity Dislocation						

Other Medical History (please explain):

Surgical history (other than current condition)

EXERCISE	WORK ACTIVITY	STRESS LEVEL	HABITS
☐ None	☐ Sitting	☐ Low	☐ Smoking How much: ________
☐ 1-2x/week	☐ Standing	☐ Medium	☐ Alcohol How much: ________
☐ 3-4x/week	☐ Light labor	☐ High	
☐ 5+x/week	☐ Heavy labor		

Are you pregnant? YES NO If yes, which week:

Is this injury related to work? YES NO If yes, which body part and date:

Is this injury related to an auto accident? YES NO If yes, which body part and date:

Do you feel depressed? YES NO

Have you felt physically, mentally, or emotionally abused in the last 6 months? YES NO

List any allergies you currently have:

____
____
____
____
____
____
____
____

Current Medications List – PQRS #130

Name: _________________________________ Date: ____________________

Prescription/Medication Name	Ordering Physician	Dosage

Over-the counter, herbal, vitamin, mineral, or dietary supplements	Dosage

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer by protected by federal privacy regulations, and that it may be re-disclosed by the recipient.

Patient name: ______________________________________ DOB: ________________________________
Organization Providing the Information: ____
Organization Receiving the Information: Mobile Rehab Inc.
2435 E Plaza Blvd.
National City, CA 91950

Description of Information requested/disclosed:

DIAGNOSTIC TESTING REPORTS:

- ◻ Plain Film X-ray
- ◻ MRI
- ◻ CT Scan
- ◻ Bone Scan

Date of testing: ____________________

- ◻ Operative Report

Date of Surgery: ___________________

Purpose of Disclosure: For physical therapy treatments

I understand that I may revoke this authorization at any time by notifiying Mobile Rehab Inc in writing, but if I do, it will not have any effect on any actions Mobile Rehab Inc took before they received the recovation. This authorization expires one year from the signature date.

Initials:

Signature of patient or representative: ____
Relationship to patient: __________________________________ Date: ____________________

You may refuse to sign this authorization.
We cannot condition treatment on your signing this authorization.

Patient Acknowledgement of Receipt of the Notice of Privacy Practices

Mobile Rehab Inc.
2435 E Plaza Blvd.
National City, CA 91950

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

By signing this document, I acknowledge that you have provided me with a copy of your *Notice of Privacy Practices*. The *Notice of Privacy Practices* contains a more complete description of the uses and disclosures of my health information.

I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound by such restrictions.

Name of patient or responsible party: ____________________________________

Signature: ___________________________________

Relationship to Patient: __________________________________

Date: _______________

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