MOBILE REHAB REGISTRATION FORM



Today's Date: _____

Patient's Name First: Inst:	PATIENT INFORMATION											
Home Phone: [] Cell Phone: [] Home Phone [] Cell Phone [] Ernali: I Check Here For No Appt Reminder: Date of Birth (mn/ddy/yy): # of Children: Age: Gender: Remainset Social Sacurby #: Weight: # of Children: Age: Gender: Remainset Height: Weight: Weight: Base of Injury: Prone: [] Ernali I Check Here For No Appt Reminder: Social Sacurby #: Weight: Date of Injury: Restanding: Prone: [] Ernali I Check Here For No Appt Reminder: Belafonship: Weight: Base of Injury: Restanding: Prone: [] Ernali I Check Here For No Appt Reminder: Belafonship: Weight: Base of Injury: Restanding: Prone: [] Ernali I Check Here For No Appt Reminder: Courset temployer: Weight: Base of Injury: Restanding: Prone: [] Ernali I Ernali Decomptor/Lob Tride: Ernali I Ernali I Ernali I Ernali I Ernali Restand: Marce of Birth: Endle: Endle: I Ernali I Ernali Restand: Marce of Birth: I Ernali I Ernali I Ernali </td <td>Patient's Name First:</td> <td></td> <td></td> <td></td> <td>M.I</td> <td>.:</td> <td></td> <td>Last:</td> <td></td> <td></td> <td></td> <td></td>	Patient's Name First:				M.I	.:		Last:				
Preferred Method of Appt Reminder: Ionne Phone [Text [] Fmail Ichek Here For No Appt Reminder Date of Birth (mm/ddl/yyyy): # of Children: Age: Gender: Social Security it: Weight: Here of Injury: Here of Status Emergency Contact: Retarionship: Phone { _ } Fmail Prescentry Relationship: Prone { _ }	Address:		City	City:				State:		Zip:		
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Height: How did you hear about us: Emergency Contact: Prione: { > Relationship: Prione: { > Current Employer: Carrent Employment Status (circle one): Full time Part time Metrice Occurrent Employer: CARE PROVIDER INFORMATION PLEASE BRING YOUR INSURANCE CARD Metrice Unemployed PCP: Name of Practice: ID #: Secondary (Net organy: ID #: Name of Subscriber: Seque of Birth: Group/Policy #: Secondary (Secondary (Seco	Date of Birth (mm/dd/yyyy):			# of Ch	ildren:		Age:			Gender	r:	
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Current Employment Status (sircle one): Full time Retired Unemployed CARE PROVER INFORMATION PCP: ID #: Retired Unemployed PATIENT INSURANCE INFORMATION – PLEASE BRING YOUR INSURANCE CARD Primary Insurance Company: ID #: ID #: ID #: Secondary Insurance Company: ID #: ID #: Relationship to Subscriber: (Circle One) Set of Birth: ID #: ID #: Secondary Insurance Company (If applicable) Set of Birth: ID #: ID #: Secondary Insurance Company (If applicable) Set of Birth: ID #: ID #: Image of Subscriber: (Circle One) Set of Birth: ID #: ID #: ID #: Image of Subscriber: (Circle One) Set of Birth: ID #: ID #: Secondary Insurance Company (If applicable) Set of Birth: ID #: ID #: Set of Sifth: ID #:	Relationship:					Phone: ()					
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ATTORNEY INFORMATION Name: Law Firm: Phone: Address: City: State: Zip: OUARDIAN INFORMATION (IF UNDER 18 YEARS OLD) Name: Last: First: M.I.: SSN: Address: City: State: Zip: Address: City: State: Zip: Relationship to Subscriber: (Circle One) Self Spouse Other Date of Birth:	Claim #:		Accide	nt Date:					Cause:			
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	Employer:							Work Ph	ione: ()		

MOBILE REHAB REGISTRATION FORM



Have you received any therapy during the c	urrent calenda	ir year?	Y / N	
If yes, please provide details:	🗆 PT	🗆 SLT	D OT	Date:
Location:		Nu	mber of treatmen	ts/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.

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 environm		
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		
Limited Limb Movement			habits 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	Other Medical History (please explain):						
Surgical history (other	than current o	condition)					
EXERCISE	WORK	ACTIVITY		STRESS LEVEL		Н	ABITS
□ None □ 1-2x/week □ 3-4x/week □ 5+x/week	0	0		□ Low □ Medium □ High		Smoking Alcohol	How much: How much:
Are you pregnant?	YES NO	lf yes, whi	ch w	veek:			
Is this injury related to	work? YES	NO If y	es, ۱	which body part and date:			
Is this injury related to	o an auto accid	ent? YE	S	NO If yes, which body	/ part	and date:	
Do you feel depressed	I? YES	NO					
Have you felt physical	ly, mentally, or	emotional	ly ab	used 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: Organization Providing the Information:	DOB:
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	t
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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.

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: _		
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Relationship to Patient: _	
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Date: _____

These forms are provided as a service to subscribers to HIPPAps.com, LLC, and do not constitute legal advice. We try to provide quality information, but all forms should be reviewed by competent counsel to ensure that they apply correctly to the laws and regulations in your locale.