Reliant

Patient Information

Patient's Name: _____ **Gender:** ☐ M ☐ F
First Middle Last

Birthdate: ____/____/____ **Social Security #:** _____-____-_____ **eMail:** _____

Mailing Address: _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

- ***Would you like an email or text message reminder about your appointments?*** ☐ No ☐ Yes: ☐ eMail ☐ Text
- ***Would you like us to sign you up for our monthly Newsletter?*** ☐ No ☐ Yes

Responsible Party/Guarantor: ☐ *Same as Patient*

Name: _____ **Gender:** ☐ M ☐ F
First Middle Last

Relationship: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other: _____

Date of Birth: ____/____/_____ **Social Security #:** _____-_____-_____ **Phone:** _____

Mailing Address: _____
Street City State Zip

Insurance Information

Primary Insurance: _____ **Policy Number:** _____

Insured Party: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other _____

Insured Party Information: ☐ Patient ☐ Same as Guarantor Above

- **Name:** _____ **Birthdate:** ____/____/_____
First Middle Last
- **Phone:** _____ **Mailing Address:** _____
Street City State Zip

Secondary Insurance: _____ **Policy Number:** _____

Insured Party: ☐ Self ☐ Child ☐ Spouse ☐ Guardian ☐ Other _____

Insured Party Information: ☐ Patient ☐ Same as Guarantor Above

- **Name:** _____ **Birthdate:** ____/____/_____
First Middle Last
- **Phone:** _____ **Mailing Address:** _____
Street City State Zip

Is this claim a result of ☐ **Worker's Compensation** ☐ **Litigation?** (*if so, please complete this section*)

Case Worker: _____ **Claim #:** _____ **Phone:** _____

Emergency Contact:

Emergency Contact 1: _____ **Phone:** _____

Emergency Contact 2: _____ **Phone:** _____

By signing below, I certify that I have provided correct information to the best of my knowledge. I hereby authorize payment directly to Reliant, Inc. for medical services rendered. I authorize the release of my medical information deemed necessary in the processing of my medical claims.

Patient/Guardian Signature: _____ **Date:** _____

Name: _____ **Date:** _____

Basic Info

What part of the body part are we treating today? _____ □ Left □ Right □ NA
Date of Injury or When Pain Began: _____ _____
Is this injury due to a Motor Vehicle Accident? □ No □ Yes; What State was the MVA in? _____
Briefly Describe your symptoms: _____
How did your symptoms start? _____
What is your biggest complaint? _____
How often do you experience your symptoms?
□ Constantly (76-100% of the time) □ Frequently (51-75% of the time)
□ Occasionally (26-50% of the time) □ Intermittently (0-25% of the time)
Did you have surgery? □ No □Yes; Date of Surgery: _____ Procedure: _____
Rate your overall health right now: □ Excellent □ Very Good □ Good □ Fair □ Poor
Home Layout:
□ 1 Story □ 2 Story □ Condo/Apt □ Stairs/Steps □ Shower Stall □ Combo Tub/Shower
Living Situation: □ Live with Family □ Live Alone □ Live with Caregiver
Marital Status: □ Married □ Single □ Other: _____
Are you a Smoker? □ No □ Yes; Packs per day: _____ Years you have smoked: _____
Do you have a history of falling? □ No □ Yes; How many falls in the past year: _____
Have you had prior Physical Therapy, Occupational Therapy or Chiropractic treatment this year? □ Yes □ No

Current Functional Limitations

Please choose any activity that your injury has interfered with.
How much have your symptoms interfered with your usual daily activities?
□ Not at All □ A little bit □ Moderately □ Quite a bit □ Extremely

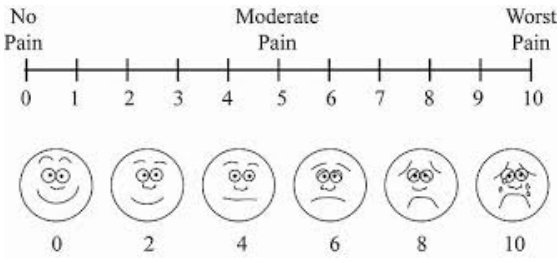
□ **Self Care:**
□ Hygiene □ Sleeping □ Bathing □ Dressing □ Toileting □ Eating
□ Chores □ Driving □ Caregiving □ Other: _____

□ **Mobility: Walking & Moving Around:**
□ Walking at Home □ Use of walking aid (walker, crutches, cane…) □ Food Prep
□ Housekeeping □ Laundry □ Transportation □ Negotiating Obstacles □ Shopping

□ **Changing and Moving Body Positions**
□ Prolonged Sitting □ Prolonged Standing □ Kneeling □ Squatting
□ Transferring from Bed to Chair □ Housekeeping □ Laundry □ Transportation

□ **Carrying, Moving & Handling Objects:**
□ Hand & Arm Use □ Fine Hand Use □ Work/Vocation/Occupation □ Recreation
□ Kicking/Pushing with Legs □ Pulling/Pushing Objects

Pain



Using the scale to the left please rate your pain (past week):
I. Location of Pain: _____
- At Worst my pain is: ____/10
- Currently my pain is: ____/10
- At Best my pain is: ____/10

II. Other Locations of Pain: _____
_____
_____

Pain Description: (Check All that Apply)
□ Burning □ Sharp □ Dull/Achy □ Throbbing □ Shooting □ Numbness/Tingling
□ Constant □ Intermittent □ Worse in AM □ Worse in PM □ Worse at Night (Sleeping)
What makes your pain worse?
□ Sitting □ Standing □ Walking □ Up Stairs □ Down Stairs □ Standing □ Bending
□ Using the Bathroom □ Lying Down □ Coughing/Sneezing □ Other: _____
What makes your pain better? _____

Employment

Are you employed? □ No □ Yes

- **Employer:** _____
- **Name of Occupation:** _____ □ Full Time □ Part Time
- **Duty Level:** □ Sedentary □ Light □ Medium □ Heavy □ Very Heavy
- **Currently Working?** □ Yes □ No; Off Work Since: _____
  - **Do you have job restrictions?** _____

Are you disabled or on disability? □ No □ Yes

- When did you become disabled or on disability? _____
- What is the reason? _____

Medical History

Do you have any of the following medical conditions? (Check all that apply)

□ No Significant History □ Alzheimer's □ History of Cancer □ Cardiovascular Issues
□ Huntington's □ Cauda Equina □ Immunosuppression □ Stroke
□ Lupus □ Current Infection □ Muscular Dystrophy □ Diabetes Type 1
□ Diabetes Type 2 □ Obesity □ Osteoarthritis □ Parkinson's
□ Fibromyalgia □ Fracture □ Rheumatoid Arthritis □ High Blood Pressure
□ Traumatic Brain Injury □ HIV/AIDS □ Bleeding Disorder □ Seizures
□ Fainting Spells □ Pacemaker □ Currently Pregnant; Weeks: _____
□ Other: _____

Have you had any diagnostic imaging studies for this injury?

□ X-Ray □ MRI □ CT Scan □ Other: _____

Have you had any recent or unexplained weight loss? □ Yes □ No

Please list any medications you are currently taking:

□ Not Currently taking any Medications.
□ Prescription: _____
□ Over the Counter: _____
□ Herbal: _____
□ Vitamin/Mineral/Dietary Supplements: _____
□ Other: _____

Please list any allergies: _____

Previous surgeries: _____

_____

What are your goals from physical therapy? _____

_____

Patient Specific Functional Scale:

List three specific activities and circle the difficulty level in performing this task

0 = Unable to Perform 10 = No Problem

Activity No. 1:_____ 0 1 2 3 4 5 6 7 8 9 10

Activity No. 2:_____ 0 1 2 3 4 5 6 7 8 9 10

Activity No. 3:_____ 0 1 2 3 4 5 6 7 8 9 10

Are you currently receiving home health services? □ No □ Yes

How did you find out about us?

□ Phone Book □ Internet Search □ Saw Building/Sign □ Other:_____

Patient/Guardian Signature: _____ **Date:** _____

Reliant

Consent for Treatment: I, the patient/guardian, acknowledge that I am of a sound mind and physically/mentally able to give consent for my care. I hereby give consent to receive outpatient physical therapy services as deemed necessary by the therapist(s) on duty at Reliant, Inc. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made regarding my treatments, results or outcomes. I understand that in some cases, treatment techniques may actually increase my pain. I understand that proper evaluation and treatment may require bodily contact, touching and/or direct contact by the therapists. I also acknowledge that as the patient/guardian I have the right to decline and/or refuse any portion of my treatment that I decide not to participate in.

Waiver and Release: I hereby release, discharge, and acquit this facility, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

Authorization of Payment: I request that payment of services be made by Medicare, third party insurance plan/payor(s), or other source as listed in my admission paperwork on my behalf to Reliant, Inc. I hereby assign all insurance and similar benefits directly to Reliant, Inc. and authorize release of any medical records necessary to process medical claims. I understand that in the event my insurance company or financial responsible party does not pay for services or products, I will be financially responsible.

Financial Responsibility: In consideration for services to be provided, I consent to pay Reliant, Inc. all amounts that are due or owing for services provided and not paid by Medicare, a third party insurance plan or payor, or other source on my behalf for services so rendered.

Notice of Privacy Practices: I hereby acknowledge that I have been offered or received a copy of Reliant, Inc.'s Notice of Privacy Practices. I understand that I may also view a copy of this document online at *www.ReliantPT.com* or request a hard copy at any time in writing to Reliant, Inc., ATTN: Privacy Director; 3825 Highway 80 East; Pearl, MS 39208.

No Show/Cancellation Fee: In an effort to enhance each of your therapy visits, we strongly encourage regular attendance. A $30 fee may be charged for all patients who do not show for their appointment.

Release of Information: According to office policy, medical information will be released to the patient only. Please request and complete a separate Request to Release Medical Information form to specify any third party or individual to whom information may be release to other than yourself. This information would include but not limited to medical information, billing, and other protected health information. (Example: your spouse, son, daughter, sibling, caretaker, friend)

Information Usage: We respect your privacy and do not tolerate spam. We will never sell, rent, lease or give away your information (name, address, email, etc.) to any third party with the exception of: the payor(s) you have provided for us to send your claims to for processing, court subpoena, in compliance with relevant laws or per your written request.

Electronic Monthly Newsletter: In an ongoing effort to provide our patients with continued education and the latest healthcare information you may choose to receive monthly emails from our company. You may opt-out at any time, if you prefer to receive our monthly newsletter please sign up on the first page of our admission paperwork.

By signing below, I certify that I have read and understand the statements and policies that have been stated above.

Patient Name: _____

Guardian Name (If patient under 18): _____

Patient/Guardian Signature: _____ **Date:** _____

Witness: _____ **Date:** _____