REVIVE
THERAPY + PERFORMANCE

WE CARE Mercy Therapy
Part of Mercy Hospital, Inc

Last Name: _____**First:** _____**MI:** _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Phone Number (_____)_____-_____ **Email:** _____
Date of Birth: ____/_____/_____ **Social Security #**_____-_____-_____ **Gender at birth:** M / F
Marital Status: ☐Married ☐Single ☐Divorced ☐Widowed **Current Gender:** _____
Race: ☐African American ☐Pacific Islander ☐Caucasian ☐Hispanic ☐Native American ☐ Other
Ethnicity: ☐Hispanic ☐Non-Hispanic **Preferred Language:** ☐English ☐Spanish ☐Other

Emergency Contact

Name:_____ **Phone:** (_____)_____-_____
Relationship to patient:_____ **Date of Birth:**____/_____/_____

Guarantor

☐Self ☐Spouse ☐Parent ☐Child ☐Guardian ☐Other_____
Last Name: _____**First:** _____**MI:** _____
Guarantor's address: _____ **Date of Birth:**____/_____/_____
City: _____ **State:** _____ **Zip:** _____
Phone Number (_____)_____-_____ **Email:** _____

Primary Insurance

Plan Name: _____ **Insured's Name:**_____
Insured's Date of Birth: ____/_____/_____ **Insured's Relationship to patient:** _____

Secondary Insurance

Plan Name: _____ **Insured's Name:**_____
Insured's Date of Birth: ____/_____/_____ **Insured's Relationship to patient:** _____
Is this because of an auto accident or work injury? ☐YES ☐NO
-If auto accident - **Date of accident:** ____/_____/_____ **Claim#**_____
-*If work injury -* **Date of injury:** ____/_____/_____ **Employers Name:** _____
Employers Address:_____

I understand that this office will submit claims to the listed insurance company, but that I am ultimately responsible for this account. I also authorize the release of any medical information necessary to process my claim.

Signature:_____ **Date:**____/_____/_____

Reviewed:_____ **Date:**____/_____/_____
Patient Signature

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Patient Information Consent Form

Consent to Physical Therapy Evaluation and Treatment
I hereby consent to the evaluation and treatment of my condition by a licensed physical or occupational therapist employed by Revive Therapy and Performance. The therapists will explain the nature and purposes of these procedures, evaluation, and course of treatment. The therapists will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Assignment of Benefits and Insurance Proceeds
I authorize payment of medical benefits to Revive Therapy and Performance for services rendered. Revive Therapy and Performance works with Mercy Therapy for billing services. Mercy Therapy will make reasonable effort to collect insurance proceeds by completing insurance forms and sending the forms to the insurance company. Completion of such forms and/or the acceptance of assignment of insurance benefits does not relieve the undersigned of the obligation to pay the amount owed for physical therapy.

Patient Information Consent Form (HIPAA)
I have read and fully understand Revive Therapy and Performance's Notice of Information Practices. I understand that Revive Therapy and Performance may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluating the quality of service provided, and any administrative operations related to treatment or payment. I understand that I have the right to request restrictions, in writing, regarding how my personal health information is used and disclosed for treatment, payment, and administrative operations. I also understand that Revive Therapy and Performance will consider requests for restrictions on a case-by-case basis, but is not required to oblige to such requests. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Revive Therapy and Performance's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time, at which point Revive Therapy and Performance has 30 days to respond to my request.

Release of Information
I hereby authorize the release of information necessary to file claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Patient Name (Include parent's name if minor) _____, authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties will be verified by photo ID before the release of any information. **If none, please print "none" below.**

Authorized Designees:

Name:_____Relationship: _____

Name:_____Relationship:_____

Name:_____Relationship:_____

LATE CANCEL / NO SHOW POLICY

Please provide a 24-hour notice to our office if you cannot attend a scheduled appointment. Failure to provide at least a 24-hour notice on 3 occasions will result in your case being discharged. Exceptions may be made at the discretion of the therapist on a case-by-case basis.

I have read and understand the above consents, assignment of benefits, release of information, and designate individuals' authorization above.

Patient (or Parent) Signature _____ **Date**_____

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Occupational Therapy Patient History

Vitals (Done by Therapist)

Temperature:_____Age:_____

Blood Pressure:_____mmHg

Pulse:_____bpm

Patient Name:_____
DOB:_____/_____/_____ **Phone Number:** (_____)_____-_____
Referring Physician:_____

What brings you to physical therapy today (primary condition or complaint):

_____

When did this first occur?_____

What caused it? _____

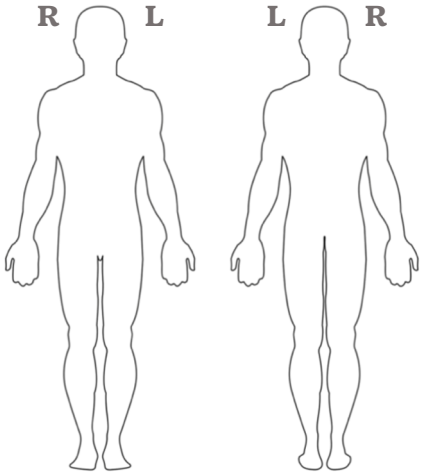
Have you had surgery for this problem? ☐Yes ☐No
If so, when? _____

What is your current level of pain? (0 being no pain at all and 10 being the worst pain imaginable)

0 1 2 3 4 5 6 7 8 9 10

Mark pain symptoms you've had or are currently experiencing:

☐Sharp ☐Radiating
☐Numbness/Tingling ☐Burning
☐Aching



front back

Circle the area most affected by this condition on the diagram.

Does anything make your condition worse?

_____

Does anything make your condition better?

_____

What are a few goals that you would like to accomplish by coming to Physical Therapy?

_____
_____
_____

Occupational History

Occupation: _____ ☐**Full** ☐**Part Time**

Do you do any heavy lifting with your job?

_____

Are there any special requirements for you to do your job?

_____

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What other activities are your routinely involved in?

_____

Do you smoke? ☐Yes ☐No

Medical History

Have you ever had surgery? ☐Yes ☐No
If yes, when and what? _____

Please mark all that apply

Diagnoses:	***Symptoms:***	***Medications:***
☐Allergies	☐Bowel Problems	☐Advil/Ibuprofen
☐Arthritis	☐Chest Pains	☐Aleve/Naproxen
☐Blood Disorders	☐Coordination Problems	☐Antacids
☐Cancer	☐Difficulty Sleeping	☐Antihistamines
☐Depression	☐Difficulty Swallowing	☐Aspirin
☐Head Injury	☐Difficulty Walking	☐Decongestants
☐Heart Problems	☐Dizziness/Blackouts	☐Herbal Supplements
☐High Blood Sugar	☐Headaches	☐Tylenol/Acetaminophen
☐High/Low Blood Pressure	☐Heart Problems	☐Other: _____
☐Infectious Disease	☐Heart Palpitations	
☐Kidney Problems	☐Joint Pain or Swelling	
☐Low Blood Sugar	☐Loss of Appetite	
☐Lung Problems	☐Loss of Balance	
☐Multiple Sclerosis	☐Nausea/Vomiting	
☐Osteoporosis	☐Pain at Night	
☐Pacemaker	☐Shortness of Breath	
☐Parkinson's	☐Vision Problems	
☐Seizure/Epilepsy	☐Weakness in Arms/Legs	
☐Skin Disease	☐Other: _____	
☐Stroke		
☐Thyroid Problems		
☐Ulcers		
☐Other: _____		

Reviewed: _____ Date:_____
Patient Signature

Do you have any questions or concerns that you would like to address with the Therapy team?

Thank you for choosing your local physical therapy department to address your needs