Siskin Hospital Outpatient Therapy Services

Name: First MI Last Date of Birth

Address: Street City State Zip

Primary Means of Contact: ( ) _____ _____

Phone: ☐cellular, ☐land line

_____

Alternate: ☐cellular phone, ☐land line

Emergency Contact

Name:_____ Phone: (____)_____

Email Address: _____

Insurance Information

Insurance Company (primary): _____ Phone Number: (____)_____.

Group #: _____ ID#:_____

Full Name of Subscriber: _____Subscriber's date of birth:_____

Relationship to subscriber: ☐patient, ☐spouse, ☐child, ☐other _____

Patient/Patient Agent Signature_____ Date_____

Consent for Treatment

I know that I have a condition which requires diagnosis and medical treatment. I understand my right to choose my healthcare provider. I choose, authorize and give my consent for Siskin Hospital to furnish the rehabilitative therapy services that are deemed necessary or advisable in the treatment of my condition.

I understand and am informed that, as in the practice of medicine, rehabilitative therapies may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform the staff of any health problems or allergies I have, as well as medications I am taking. I further understand that no guarantees have been made to me as to the outcome of treatment.

_____ _____

Patient/Patient Agent Signature Date

Privacy Notice and Release of Medical Information

Siskin Hospital's Notice of Privacy Practices describes how medical information about you may be used, disclosed and how you can get access to this information.
Siskin Hospital may use or disclose my personal health information for the purposes of carrying out treatment and/or obtaining payment for services provided. I understand that records will be released in workers compensation claims or when there is a court order. Siskin Hospital's Notice of Privacy Practices is posted and copies are present and available for you in the Outpatient Registration area, as well as on our website at www.siskinrehab.org/about-siskin-hospital/privacypractices

I acknowledge that I have been provided access to Siskin Hospital's Notice of Privacy Practices and choose to access it: (please initial your choice) _____Electronically _____Paper copy.

I authorize Siskin Hospital to share any and all of my medical/billing information with the following people:

Full Name: _____ Relationship: _____

Full Name: _____ Relationship: _____

_____ _____ _____ _____

Patient/Patient Agent Signature Date Siskin Hospital Representative Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign payment directly to Siskin Hospital of, and authorize Siskin Hospital to collect, all insurance benefits payable to me for evaluation and treatment. My guarantor and I understand that Siskin Hospital may waive any and all rights granted herein and elect to proceed solely against me personally, for the services rendered on my behalf or at my request. I authorize and direct said insurance company to furnish Siskin Hospital with all information regarding my benefits, claims status, reasons for nonpayment and other information deemed necessary by Siskin Hospital.

I understand that any balance remaining on my patient account after payment is made by any insurance provider is my responsibility as the patient and is to be paid by me. Should the account be referred to a collection agency or an attorney for collection, the undersigned shall pay reasonable attorney fees and/or collection agency fees, and the other costs of collection, including court costs. The undersigned further authorizes the transfer of any overpayment on this account to be applied to any accounts on which the undersigned is patient, guarantor, or otherwise legally responsible.

We verify benefits as a *courtesy.* Actual plan benefits are determined upon processing of the claim by the insurance company. Benefits are subject to change without notification from the insurance company. It is the patient's responsibility to understand the requirements of their health insurance coverage, including but not limited to network participation by Siskin Hospital in their specific plan and the patient's financial responsibility for services provided by Siskin Hospital. If, during the course of treatment, any insurance information changes, the patient is responsible for notifying the Outpatient Business Office immediately in order for insurance authorization to be obtained and to insure claims for services are filed to the appropriate insurance carrier in a timely manner. Should patient not advise Siskin Hospital of changes in insurance coverage, patient will be fully responsible for payment of services provided.

We have verified your insurance coverage and benefits as of _____. This information is being provided to you exactly as it was told to us. Please be aware that your benefits and/or coverage information may be subject to errors. Therefore, we strongly recommend you contact your insurance directly if you have any questions or concerns regarding this benefit.

PATIENT FINANCIAL REPONSIBILITY

You are responsibly for the copay if applicable at the time that services are rendered.
We accept Cash, Personal Checks, and Credit Cards (MASTERCARD, VISA, AND DISCOVER)
I understand the terms of my insurance benefits and financial responsibilities as described above.

_____	_____	_____	_____
Patient/Patient Agent	Date	Siskin Hospital Representative	Date

HOME CARE/HOSPICE QUESTIONNAIRE

Are you currently receiving Home Care or Hospice services such as nursing, speech therapy, physical therapy or occupational therapy?

YES **NO**

If you answered **Yes**, please notify the front desk and your therapist. Outpatient Therapy is **NOT** covered while receiving Home Care services and you will be responsible for payment prior to your visit.

Patient Signature:_____
Date:_____

Printed Name:_____

Legally Authorized Representative:_____
Date:_____

Printed Name:_____

MEDICAL HISTORY

To ensure you receive a complete and thorough evaluation, please provide us with the important background information. If you do not understand a question, leave it blank and your therapist will assist you. Thank you.

Are you latex sensitive? ☐ Yes ☐ No *List any other allergies we should know about:* _____

Have you ever been diagnosed with any of the following conditions? (Please check all that apply)

☐ Abdominal Pain
☐ Anemia
☐ Ankylosing Spondylosis
☐ Baclofen Pump
☐ Bladder infection
☐ Bone/Joint problems
☐ Blood Clots
☐ Cancer. What kind?_____
☐ Chemical Dependency (Alcoholism, etc.)
☐ Circulation Problems
☐ COPD: Asthma/Chronic Bronchitis/Emphysema
☐ Chronic Fatigue Syndrome
☐ Chronic Traumatic Encephalopathy (CTE)
☐ Congenital Abnormalities
☐ Congestive Heart Failure
☐ Concussion
☐ Constipation
☐ CURRENTLY PREGNANT
☐ Defibrillator
☐ Depression
☐ Diabetes
☐ DISH (Diffuse Idiopathic Skeletal Hyperostosis)
☐ Endometriosis
☐ Traumatic Brain Injury
☐ Shunt
☐ Fibromyalgia
☐ Fibroids/Cysts
☐ Guillian-Barre/CIDP
☐ Glaucoma
☐ Heart Disease/CAD
☐ HIV/AIDS
☐ Hepatitis
☐ High Cholesterol
☐ High Blood Pressure
☐ Irritable Bowel Syndrome (IBS)
☐ Kidney Disease. What kind? _____
☐ Kidney Stones
☐ Low Back Pain (LBP)
☐ Lyme's Disease
☐ Marphan Syndrome
☐ Menopause (peri or post)
☐ Migraines
☐ Multiple Sclerosis
☐ Osteo-Arthritis
☐ Osteopenia
☐ Osteoporosis
☐ Pacemaker
☐ Macular Degeneration
☐ Painful Intercourse
☐ Pelvic Inflammatory Disease
☐ Pelvic Pain
☐ Prolapse (Bladder, Uterus, etc.)
☐ Prostatitis
☐ Psychological Disorders
☐ Psoriatic Arthritis
☐ Rheumatoid Arthritis
☐ Reiter's Syndrome
☐ Seizures
☐ Sexually Transmitted Dis. (STD)
☐ Sleep Apnea
☐ Spinal Stenosis
☐ Stent(s): Heart __ Leg __ Other: ___
☐ Stroke
☐ Thyroid Problems
☐ Traumatic/Frequent Falls
☐ Tuberculosis
☐ Ulcerative Colitis
☐ Urinary Tract Infection (UTI)
☐ Pain Pump
☐ Parkinson's Disease
☐ Dementia
☐ Other:_____

Have you ever had any of the following Surgeries? (Please check all that apply)

☐ Appendix Removed ☐ Rotator Cuff surgery ☐ Total Hip ☐ Total Shoulder Replacement
☐ CABG (Coronary Artery Bypass Graft) ☐ Hernia Repair: If so check type of repair: ☐ Hiatal ☐ Umbilical ☐ Inguinal

During the past month, have you been feeling down, depressed or hopeless? ☐ Yes ☐ No
During the past month, have you been bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? ☐ Yes ☐ No

Please list any OTHER significant surgeries or procedures for which you have been <u>treated</u> or hospitalized.

Other Procedures/Surgeries: _____

Recent Hospitalizations: _____

_____

Please check any of the following that are <u>NEW or UNUSUAL</u> of you.

- ☐ Weight loss or gain (circle one)
- ☐ Easy bruising
- ☐ Fatigue
- ☐ Regular cough
- ☐ Arm/ leg swelling
- ☐ Seizures
- ☐ Double Vision
- ☐ Loss of vision
- ☐ Post menopause
- ☐ Urinary incontinence
- ☐ Pregnant or think you may be pregnant
- ☐ Pain that wakes you at night
- ☐ Joint/ muscle swelling
- ☐ Dizziness/ lightheadedness
- ☐ Weakness
- ☐ Fever/ chills/ sweats
- ☐ Tremors
- ☐ Heart racing in your chest
- ☐ Blood in stools
- ☐ Eye redness
- ☐ Problem sleeping
- ☐ Sexual difficulties
- ☐ Hearing problems
- ☐ Problems urinating
- ☐ Nausea/ Vomiting
- ☐ Excessive bleeding
- ☐ Difficulty breathing
- ☐ Numbness or tingling
- ☐ Difficulty swallowing
- ☐ Heartburn/ indigestion
- ☐ Constipation/ diarrhea
- ☐ Skin rash
- ☐ Blood in urine
- ☐ Night sweats
- ☐ Stress at home

Where do you currently live (or intend to live) at the conclusion of this outpatient therapy episode?

☐ Residential Home ☐ Apartment ☐ Assisted Living ☐ Group Home ☐ Other _____

Number of steps to enter home: _____ *Number of steps inside home:* _____

Handrails ☐ Yes ☐ No. If yes, Handrail on ☐Right ☐ Left going up

Who do you currently live with?

☐ Alone ☐ Spouse/significant other ☐ Child(ren) ☐ Other Relative ☐ Unrelated person(s)

Is this the same living environment as you resided prior to the current illness/injury? ☐Yes ☐ No

What medical equipment do you have? Check all that apply:

☐ Rolling Walker with two wheels ☐ Rolling Walker with four wheels and seat ☐ Straight Cane ☐ Quad Cane
☐ Power Wheelchair ☐ Manual Wheelchair ☐ Bedside commode (3-N-1) ☐ Shower Chair ☐ Shower Bench
☐ Reacher ☐ Sock aid ☐ Hip Kit ☐ Other: _____

Prior to your current illness/injury, were you able to:

Successfully complete dressing, toileting, bathing and self-feeding? ☐ Yes ☐ No
Successfully complete cooking, cleaning and other homemaking tasks? ☐ Yes ☐ No
Engage in activities outside the house? ☐ Yes ☐ No If yes, check all that apply:
☐ Work: Occupation: _____ ☐ Volunteer work ☐ Shopping ☐ Church ☐ Recreational sports
☐ Gardening ☐ Yard work ☐ Other: _____

Prescription Medications

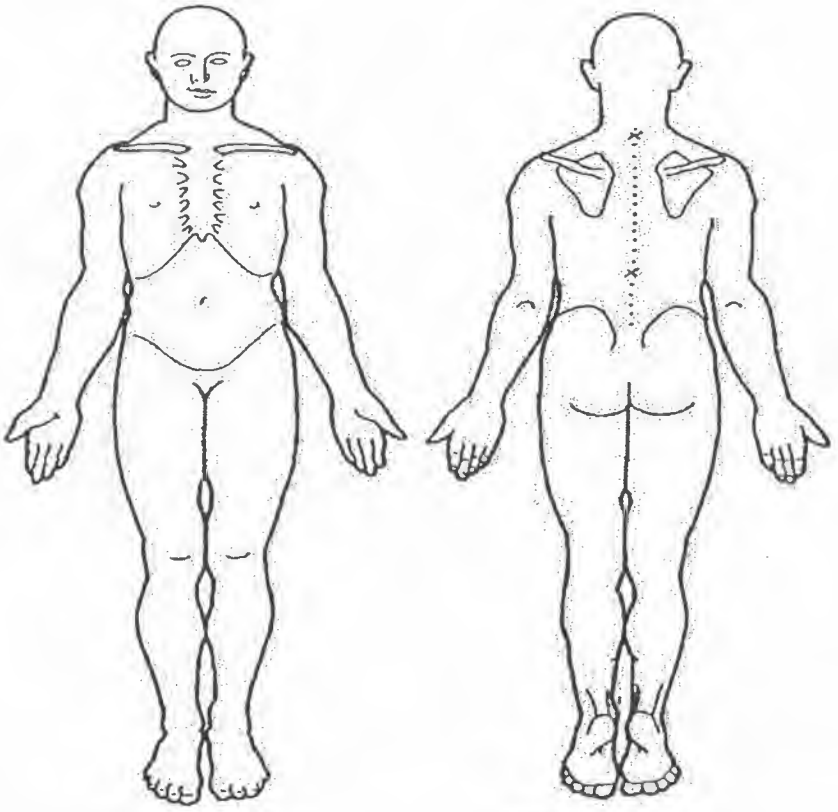
Patient name:	*Date of birth:*
☐ *See Attached List* *Do not use this form if you have a written current medication list.*	
If you do not have a written list, please use this form and list any prescribed medications.	
Medication	*How often taken?*

Changes in Medications

Date	*Medication*	*Change*

PAIN

Please mark an "X" on the location of your pain ☐ *N/A*



Rate your pain on a 0-10 scale; 0 being none and 10 being worst

Best ____/ 10
Worst ____/ 10
Average ____/ 10
Current ____/ 10

Description of pain: (Circle all that apply OR describe in your own words)
Sharp/Dull/Aching/Burning/Shooting/Catching/Clicking/Diffuse/ Stabbing/Throbbing/Radiating

_____

_____

_____

What makes your pain worse?
What makes your pain better?
Please check one:

- ☐ My pain is always there (continuous)
- ☐ My pain comes and goes (intermittent)

Siskin Outpatient Therapy

Notice of Cancellation Policy

Thank you choosing Siskin Outpatient Therapy! We look forward to working with you on your rehabilitation journey and are committed to providing you with highly skilled and compassionate care.

In order for you to receive the maximize benefit from your rehabilitation program, it is very important that you attend all of your therapy appointments, **which are reserved especially for you.** We understand that sometimes schedule adjustments are necessary and therefore request a minimum 24-hour notice for cancellations or rescheduling of appointments. If an appointment is missed or cancelled without a 24-hour notice, it will result in a **$15 cancellation fee.**

Please note: The $15 fee is your responsibility and is not covered by insurance. Payment will be due at your next scheduled appointment. After the 4th cancelled/missed appointment, you will be discharged from Siskin Outpatient Therapy and able to return after 30 days.

The 24-hour cancellation policy gives us time to inform our wait-list clients of any availability, thus better serving everyone. Thank you in advance for your support!

To reschedule or cancel your appointment:
Downtown: (423) 634-1400
East Brainerd: (423) 634-4260
Cleveland: (423) 339-1492

I have read the above guidelines and understand my responsibilities.

_____ _____

Patient **Date**