LAKE CENTRE for REHAB

NEW PATIENT INFORMATION SHEET

HOW DID YOU HEAR ABOUT US? ☐ PHYSICIAN ☐ WEBSITE ☐ FACEBOOK
☐ SEMINAR ☐ NEWSPAPER AD ☐ FRIEND ☐ RETURNING PATIENT ☐ OTHER_____

Name (First)_____(Middle)_____(Last)_____(Suffix)_____

Mailing Address_____

(City)_____(State)_____(ZIP)_____

Phone: Home_____Cell_____Work_____

Primary Phone _____Email Address_____

Date of Birth_____Age_____Marital Status: ☐Married ☐Divorced ☐Single ☐Other ☐ Unknown

☐Widowed ☐Separated Gender: ☐Male ☐Female Social Security #_____

Driver License #_____

Employment Status: ☐Full Time ☐Part Time ☐Not Employed ☐Self-Employed ☐Retired ☐Active Military
☐Unknown ☐Full Time Student

In case of emergency, please notify_____Phone_____

Attorney involvement? ☐Yes ☐No Attorney name_____Phone_____

Name of Employer, Parent or Guarantor_____

Street Address of Employer or Parent_____

City, State and ZIP of Employer or Parent_____

Name of Spouse_____Spouse Date of Birth_____

Spouse's Employer_____Phone_____

Have you received any therapy this year? ☐Yes ☐No

Have you been seen for nursing or physical therapy services in your home by a Home Health Agency prior to requesting services through our organization? ☐Yes ☐No If yes, name of home health agency_____

_____

Primary Care Provider/Family Doctor_____Phone_____

****

The two documents listed below are available for review at the Lake Centre for Rehab front office. Your signature below indicates agreement with the two forms listed below.

1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident Information.
2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

The listed individuals may have access to my PHI (Protected Health Information): _____

_____

_____ _____

Patient/Representative Signature Date Witness Date

_____ _____

Guardian Signature if patient is a minor Date Relationship to Patient

LAKE CENTRE for REHAB

NEW PATIENT INFORMATION SHEET & AUTHORIZATION
FOR PEDIATRIC PATIENTS

Facility: ☐LB ☐MD ☐HL ☐SP ☐MG ☐LSL ☐COL

Name (First)_____(Middle)_____(Last)_____Age_____

Date of Birth_____Social Security Number_____ Gender: ☐Male ☐Female

Father's Name_____Mother's Name_____

Mailing Address_____

(City)_____(State)_____(ZIP)_____

Phone: Home_____Cell_____Work_____

Primary Phone _____Email Address_____

Father's Employer_____

Employer's Name, Address and Phone_____

Father's Date of Birth_____Social Security Number_____DL Number_____

Mother's Employer_____

Employer's Name, Address and Phone_____

Mother's Date of Birth_____Social Security Number_____DL Number_____

Patient was referred by_____

****

- I, the undersigned, give permission for Lake Centre for Rehab to treat _____ for any and all physical, occupational or speech therapy treatments which may be deemed advisable by my child's attending physician, and grant authority to Lake Centre for Rehab to administer therapy in accordance with my child's physician's Plan of Care.

- I hereby authorize payment directly to Lake Centre for Rehab for medical benefits, if any, otherwise payable to me under the terms of my insurance. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR SERVICES NOT COVERED BY THIS AUTHORIZATION.

- I hereby authorize Lake Centre for Rehab to release any and all information concerning my child's medical condition to my insurance company, attorney or to the physician referring my child.

- I have had the opportunity to review the below-listed documents and agree to the contents of each:

  1. Authorization for Treatment, Assignment of Benefits, Payment Responsibility and Disclosure of ALF Resident Information.
  2. Acknowledgement of Receipt of Privacy Notice in combination with Voluntary Consent.

_____ _____

Patient Signature Date Witness Date

_____ _____

Parent Signature Date Relationship to Patient

LAKE CENTRE for REHAB

AUTHORIZATION
FOR
TREATMENT, ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILITY
AND DISCLOSURE OF ALF RESIDENT INFORMATION

1. I hereby consent to treatment by Lake Centre for Rehabilitation ("LCR") as outlined in the treatment Plan of Care developed in collaboration with my attending physician.
2. MEDICARE: Patients who are covered by Medicare are responsible for their annual deductible and the 20% portion of the Medicare allowed benefit amount for covered services. I understand Medicare does not pay for all of my therapy costs. Medicare only pays for 80% of the covered benefit. My covered outpatient therapy benefit is as stated in the federal guidelines, unless I qualify for an exception to the benefit limit. If I receive therapy service that is not a Medicare covered benefit, I am responsible for payment, personally or through any other insurance I may have. The purpose of this notification is to help me make an informed choice about whether or not I want to receive therapy services, knowing I may have to pay for the services myself. I understand that LCR will bill my secondary insurance carrier. I authorize LCR to furnish my insurance company any information needed to process the claim. I assign to LCR all money paid for the rehabilitation services furnished. I agree to pay all deductibles, co-insurance and non-covered items not paid for by my secondary insurance carrier. I will notify LCR if I am eligible for coverage with Tricare for Life Health Care System. I certify that the information given me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the holder of any medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf to LCR.
3. PRIVATE: I understand that every effort will be made by LCR to bill my insurance carrier for services rendered. I authorize LCR to furnish my insurance company any information needed to process the claim. I assign to LCR all money paid for the rehabilitation services furnished. LCR DOES NOT accept assignment on non-contracted claims. Any amount not paid by my insurance company is my direct responsibility. I also understand that it is my responsibility to see that all claims are paid within 30 days of receipt. If claims are not paid by 60 days, I will be responsible for payment of the claim (IN FULL) at that time. Any balance due after 60 days may be subject to a delinquency fee of 1% per month. I understand that health and accident insurance policies are an arrangement between my insurance company and myself, that all services rendered me are charged directly to me, and that I am personally responsible for payment.
4. WORKERS' COMPENSATION: Patients who are covered under Workers' Compensation are not financially responsible for services rendered unless their claim is controverted/denied. If this occurs, I understand that I am immediately responsible for all controverted/denied charges regardless of pending litigation.
5. MANAGED CARE PLANS: Patients who are covered under a participating Managed Care Plan are responsible for any applicable deductibles and/or co-payments required under their plan. I understand that I am responsible for payment of any applicable deductibles and/or co-payments under my plan at the time services are rendered.
6. I, and Patient if applicable, agree to execute any documents and perform any acts that Provider may reasonably request. <u>The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable Powers of Attorney, Health Care Surrogate forms or Court Orders appointing the undersigned as the legal guardian of the Patient</u>.
7. I UNDERSTAND THAT IF I FAIL TO MAKE MY APPOINTMENT AT THE TIME RESERVED FOR ME, WITHOUT A 24-HOUR PRIOR NOTICE, I WILL BE SUBJECT TO A $25.00 FEE. If I do not show up for three (3) appointments, I may forfeit all subsequent appointments and be discharged or placed on a call list for open appointment times if available.
8. I agree that the provisions hereof shall continue in full force and effect until Provider has received written notice of termination signed by the undersigned; provided, however, that the provisions of Paragraphs 2, 3, 4, 5, 6, 7 and 8 shall survive any such termination.
9. **Your signature at the bottom of the New Patient Information Sheet indicates your agreement with the above terms.**

LAKE CENTRE for REHAB

SCREENING FORM

Patient Name _____ Facility _____

Effective January 1, 2020, the Medicare "Cap" starts at $2,080 for physical and speech therapy services combined, and $2,080 for occupational therapy services, billed by an outpatient provider. Each provider is required to track the entire therapy episode, regardless of setting. When the Cap exceeds $3,000, there may be additional scrutiny of the claim by Medicare for medical necessity. Services can only be denied for medical necessity reasons.

Previous Therapy

1. Since the first of the year, have you received Part B therapy services in a skilled nursing facility?
   □ Yes □ No If yes, by whom and how much?_____
   _____
2. Since the first of the year, have you received Part B therapy services in a physician's office?
   □ Yes □ No If yes, by whom and how much?_____
   _____
3. Since the first of the year, have you received Part B therapy services in an outpatient clinic?
   □ Yes □ No If yes, by whom and how much?_____
   _____
4. Since the first of the year, have you received Part B therapy services in your home? □ Yes □ No
   If yes, by whom and how much?_____
   _____

Previous Home Health

Are you currently receiving home health services for nursing, or physical, occupational or speech therapy, from a home health agency? □ Yes □ No

Signing below indicates that the answers above are true and correct, and that the information is complete to the best of the signor's knowledge.

Patient Signature _____ Witness Signature _____

Date _____ Date _____

LAKE CENTRE for REHAB

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient_____

Medicare #_____ Admit/Eval Date_____

Facility_____ Provider #_____

1. Is the patient covered by Veterans Administration or Black Lung? ☐ Yes ☐ No

2. Was illness due to an injury? ☐ Yes ☐ No If yes,

   a. Date of accident_____
   b. What type of accident cause your illness/injury?_____
      _____
   c. Is the patient filing or intending to file a liability suite?_____
      If yes, please give name and address of attorney_____
      _____

3. Is the patient employed (Medicare disabled beneficiaries under the age of 65 or Medicare over the age of 65) and covered by a group health plan? ☐ Yes ☐ No

   a. Date of retirement_____
   b. Is the patient married?_____
   c. Is the spouse currently employed?_____
   d. Does the spouse have group coverage?_____
   e. Does the patient have coverage through a spouse, parent or guardian's employer group health plan?_____

4. Is the patient entitled to benefits solely on the basis of end stage renal disease? ☐ Yes ☐ No Has the patient been undergoing kidney dialysis for more than 12 months? ☐ Yes ☐ No

If you answered yes to any of the above questions, you will need to fill out the information requested below.

Insurance company_____

Address_____

Policy/certificate number_____

Group name_____

Group number_____

PATIENT SIGNATURE_____ DATE_____

RESPONSIBLE PARTY SIGNATURE_____ DATE_____

Relationship to patient_____

Signature of person completing this form_____ Date_____
(If other than the patient)

LAKE CENTRE for REHAB

Acknowledgement of Receipt of Privacy Notice
in Combination with Voluntary Consent

Acknowledgement:

As a patient of Lake Centre for Rehab, I have been provided with its **Notice of Privacy Practices** which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge that I have received the **Notice of Privacy Practices** and understand how medical information about me may be used, the duties of Lake Centre for Rehab, and my rights to privacy protection and access to my medical information. I understand that the office manager of Lake Centre for Rehab is available to answer any questions that I may have regarding issues of privacy.

Consent:

I give consent for medical information about me to be used and disclosed for purposes of treatment, payment or health care operations. I understand that the privacy regulations allow Lake Centre for Rehab to use or disclose my medical information for these purposes, and that my consent is not required. Lake Centre for Rehab is obtaining my consent to provide additional assurance regarding the privacy of my medical information.

I understand that I have the right to make a request to revoke this consent and instead request a restriction on the use of my medical information at any time. I further understand that Lake Centre for Rehab may choose not to agree to the request for a restriction on the uses or disclosures of my medical information for purposes of treatment, payment or health care operations.

To make a request to revoke my consent, I must complete and sign a "Request to Restrict Uses and Disclosures of Protected Health Information" form and return it to the office manager at Lake Centre for Rehab. I may obtain a copy of the form from the office manager at the Lake Centre for Rehab location at which I am being treated.

LAKE CENTRE for REHAB

Patient Name_____ Date_____

PAST MEDICAL HISTORY

Please check any of the following conditions you have, or have had -OR- ☐ No medical history to report

☐ Allergies
☐ Anemia
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Blood disorders
☐ Blood transfusion
☐ Cancer
☐ Congestive heart failure
☐ Nerve/muscle disease
☐ Lung disease
☐ Meningitis
☐ Depression
☐ HIV/AIDS
☐ Kidney disease
☐ Diabetes mellitus
☐ Clotting disorder (blood clot)
☐ High blood pressure
☐ Acid reflux
☐ Glaucoma
☐ Gout
☐ Heart attack
☐ High cholesterol
☐ Osteoporosis
☐ Seizures
☐ Sickle cell anemia
☐ Stroke
☐ Substance abuse
☐ Thyroid disease
☐ Tuberculosis
☐ Ulcers
☐ Cataracts
☐ Other_____
_____
_____

For men only: Have you been diagnosed with prostrate disease? ☐ Yes ☐ No

For women only: Have you ever been diagnosed with any of the following? (Check all that apply)
☐ Pelvic inflammatory disease
☐ Endometriosis
☐ Trouble with your period
☐ Complicated pregnancies or deliveries
☐ Pregnant or think you may be
☐ Other gynecological or obstetrical difficulties? If yes, please describe_____
_____
_____

PAST SURGICAL HISTORY

Please check any surgery you have had -OR- ☐ Never had surgery

☐ Breast surgery ..... Year_____
☐ Open heart or bypass surgery..... Year_____
☐ Gall bladder ..... Year_____
☐ Colon surgery..... Year_____
☐ Fracture surgery ..... Year_____
☐ Hernia repair ..... Year_____
☐ C-section ..... Year_____
☐ Pacemaker ..... Year_____
☐ Metal implants ..... Year_____
☐ Spine surgery ..... Year_____
☐ Tubes tied .....Year_____
☐ Hysterectomy.....Year_____
☐ Heart valve replacement.....Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Orthopaedic surgery_____...Year_____
☐ Orthopaedic surgery_____...Year_____
☐Other_____...Year_____
☐Other_____...Year_____
☐Other_____...Year_____

CURRENT MEDICATIONS

-OR- ☐ No medications

Medication	Strength	How Often?

ALLERGIES/SENSITIVITIES

-OR- ☐ No known allergies/sensitivities

Allergic/Sensitive To	Reaction		Allergic/Sensitive To	Reaction
Latex			Other:	
Adhesives/tapes			Other:	
Bees			Other:	
Lotions/creams			Other:	

LAKE CENTRE for REHAB

Patient Name_____ Date_____

REVIEW OF SYSTEMS

Please indicate if you are currently experiencing any of the following conditions:

Constitutional	**Y**	**N**
Fever	☐	☐
Chills	☐	☐
Unintentional weight loss	☐	☐
Fatigue	☐	☐
Profuse sweating	☐	☐

Skin	**Y**	**N**
Rash	☐	☐
Itching	☐	☐

Head, Ears, Nose & Throat	**Y**	**N**
Headaches	☐	☐
Hearing loss	☐	☐
Ringing in ears	☐	☐
Ear pain	☐	☐
Ear discharge	☐	☐
Nose bleeds	☐	☐
Congestion	☐	☐
Wheezing	☐	☐
Sore throat	☐	☐

Eyes	**Y**	**N**
Blurred vision	☐	☐
Double vision	☐	☐
Sensitive to light	☐	☐
Eye pain	☐	☐
Eye discharge	☐	☐
Eye redness	☐	☐

Cardiovascular	**Y**	**N**
Chest pain	☐	☐
Pounding heart	☐	☐
Shortness of breath relieved by sitting up	☐	☐
Shortness of breath during sleep/rest/activity	☐	☐
Calf pain with activity	☐	☐
Foot/ankle swelling	☐	☐

Respiratory	**Y**	**N**
Cough	☐	☐
Coughing up blood	☐	☐
Phlegm production	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐

Gastrointestinal	**Y**	**N**
Heartburn	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Stomach pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐
Dark tarry stools	☐	☐
Bladder incontinence	☐	☐
Bowel incontinence	☐	☐

Genitourinary	**Y**	**N**
Painful urination	☐	☐
Urgency	☐	☐
Frequency	☐	☐
Blood in urine	☐	☐
Side pain	☐	☐

Musculoskeletal	**Y**	**N**
Muscle pain	☐	☐
Neck pain	☐	☐
Back pain	☐	☐
Joint pain	☐	☐
Falls	☐	☐
Weakness in arms or legs	☐	☐
Lack of coordination	☐	☐
Difficulty walking	☐	☐
Night pain	☐	☐
Difficulty rising from low seat	☐	☐

Neurological	**Y**	**N**
Tingling/numbness	☐	☐
Tremors	☐	☐
Speech change	☐	☐
Hand, arm or leg weakness	☐	☐
Seizures	☐	☐
Loss of consciousness	☐	☐
Vertigo/spinning	☐	☐
Unbalanced/unsteady	☐	☐
Lightheadedness	☐	☐

Psychiatric	**Y**	**N**
Depression	☐	☐
Suicidal ideas	☐	☐
Substance abuse	☐	☐
Hallucinations	☐	☐
Nervous/anxious	☐	☐
Sleeping disorder	☐	☐
Memory loss	☐	☐

MISELLANEOUS

Living Environment

With whom do you live?

☐ Alone
☐ Spouse and /or other
☐ Child/children at home

Where do you live?

☐ Private home
☐ Assisted living

How do you rate your general health?

☐ Good ☐ Average ☐ Poor

Your current pain: Indicate where your pain is located on the diagram.
Do not indicate areas of pain that are not related to your current problem.

KEY: 0000 = Pins & Needles
xxxx = Burning
/ / / / = Stabbing
- - - - = Numbness

LAKE CENTRE for REHAB

Patient Name_____ Date_____

CURRENT PROBLEM

Reason for today's visit_____Date of onset_____

Is this visit due to injury or accident? ☐ Yes ☐ No Date of injury_____ Date of surgery_____

What treatment or tests have you had for this current problem?
☐ Surgery ☐ CT ☐ MRI
☐ X-Ray ☐ Injection ☐ Splint/brace

Are you self-medicating with any of the following?
☐ Anti-inflammatory (Ibuprofen/Motrin/Advil)
☐ Acetaminophen (Tylenol)
☐ Other pain medication_____

Have you received therapy for the current or other problem in the past year? ☐ Yes ☐ No If yes, indicate below:

	Date	# of Visits		Date	# of Visits
☐ Physical therapy			☐ Chiropractor		
☐ Occupational therapy			☐ Massage		
☐ Speech therapy			☐ Acupuncture		
☐ Skilled nursing facility					

What activities make your pain worse?_____
What activities make your pain better?_____
How far can you walk?_____What stops you?_____
What are you unable to do because of your current problem?_____
Have you had this problem before? ☐ Yes ☐ No If yes, when?_____
What did you do about it?_____

Pain rating, on a scale of 0 to 10: 0 = NO PAIN 10 = THE WORST PAIN IMAGINEABLE

How would you rate the intensity of your pain during the last 1 to 2 weeks?

Current:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Lowest:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Highest:	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

Since the problem began, has the problem become: ☐ Worse ☐ Better ☐ Unchanged

What are your goals for treatment?_____
_____
_____

Signature_____Date_____

Signature_____Date_____

Signature_____Date_____

LAKE CENTRE for REHAB

INSTRUCTIONS

Before your first visit, download the patient forms from our website at www.golcr.com/forms

On your first visit, please remember to bring the following:

1. Physician or NPP (Non-Physician Provider) order for therapy.
2. ***Bring the patient forms you filled out***
3. Insurance cards (primary and secondary).
4. Photo ID.
5. Current list of medicines and allergies.
6. Recent reports that you might have, including x-rays, MRI's, surgeries, etc.
7. Loose-fitting, comfortable clothing.
8. Supportive closed-toe shoes.
9. Bring in any adaptive devices currently used, such as braces, canes, walkers, etc.
10. Copy of home health discharge with name and phone number of home health agency if applicable.
11. Notify us of implants and pacemakers (defibrillators).

Due to allergies of staff members and patients, please refrain from strong fragrances.