PALOMA
WELLNESS & REHABILITATION

612 N. Resler Dr.
El Paso, TX 79912
Ph: 915-584-5683 Fax: 915-584-5657

PATIENT INFORMATION

Full Name: _____ **Date of Birth**: ____/____/_____

Primary Physician: _____ **Referring Physician**: _____

How did you hear about us? ☐ Physician ☐Website ☐Facebook ☐Google
☐Family/Friends ☐Other (Please Specify) _____

Preferred time to schedule your appointment (Morning,Afternoon,Evening):_____

Address: _____

City: _____**State:** _____ **Zip:** _____

Tel: Home: (____)_____ **Cell:** (____)_____ **Work:** (____)_____

Social Security No.: _____-_____-_____ **Patient Gender:** Male ☐ Female ☐

E-mail:_____ (to receive appointment confirmations and reminders)

Single ☐ Married ☐ Widowed ☐ Divorced ☐

Sponsor's or Insurance Subscriber Name: _____ Male ☐ Female ☐

Sponsor's Social Security #: _____-_____-_____ Sponsor's DOB: _____/_____/_____

Spouse or Parent/Guardian:

Name: _____ Relationship to Patient: _____

Address: _____

Employer: _____ Business Phone: (____)_____

In case of emergency, whom may we contact? _____

Phone: (____)_____ Relationship to patient: _____

DATE OF INJURY/ONSET OF PAIN: _____/_____/_____ SURGERY: _____/_____/_____

Area(s) of pain and area(s) to be treated: _____

Have you had any physical therapy visits this year? _____

Have you received home health services this year? Agency name?_____ Number of visits?____
Please describe your response to the treatment:

_____

_____

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Insurance verified by clinic? YES☐ / NO☐

INSURANCE INFORMATION: Primary Insurance: (Disregard if we already verified your insurance)

Name of Policy Holder: _____ Relationship to Patient: _____

Name of Insurance: _____ Policy/Group No: _____

Insurance Phone for verification of benefits: (____)_____Contact: _____

INSURANCE INFORMATION: Secondary Insurance: (Disregard if we already verified your insurance)

Name of Insurance: _____Policy Holder's Name: _____

SS#: _____ Phone No: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Comments:

_____

_____

_____

Patient Signature: _____ Date: _____/_____/_____

INSURANCE BENEFIT VERIFICATION

Please Initial next to every co-pay, deductible, co-insurance, and number of treatments info.

I have reviewed my insurance benefits and understand my responsibilities for **co-payments_____, deductibles_____, co-insurance % _____** and **number of treatments _____** allowed per my insurance company. I have asked questions about my insurance plan as needed and fully understand my responsibility for the overall treatment.

I further understand that when services are no longer of medical necessity or insurance benefits have been exhausted, I will be discharged on my own recognizance with the appropriate home care plan. You may continue physical therapy treatments in our clinic for the out-of-pocket rate. Please inquire as to this rate if interested.

By signing below, I agree to adhere to the benefits in my insurance plan and to the plan of care set forth by the physical therapist involved in my care.

Full Name (please print): _____

Signature: _____ Date: _____

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24 HOUR CANCELLATION POLICY

Failure to cancel appointments within 24 hours of the scheduled appointment time will result in a $35 cash fee to be assessed.

By signing my name below, I agree to adhere to the above mentioned 24 cancellation policy and understand that I will be charged for not cancelling within 24 hours.

Patient Signature:_____ Date: _____

HIPAA ACKNOWLEDGEMENT

The Federal Health Information Portability and Accountability Act (HIPAA) requires us to be very careful with patient information.

Please read the summary of the HIPAA Privacy Rule provided behind this intake packet.

Patient Signature:_____ Date: _____

ASSIGNMENT OF BENEFITS

I hereby authorize Paloma Wellness and Rehabilitation, PLLC to furnish to my insurance carrier(s) any and all requested information concerning my health care.

I also authorize my insurance carrier(s) to pay Paloma Wellness and Rehabilitation directly for services rendered.

Patient Signature:_____ Date:_____

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Patient Medical History Questionnaire

Patient Name: _____ Date of Birth:_____

PRESENT ILLNESS OR INJURY:

For what condition or symptoms are you being seen at this time? _____

When did this condition begin? _____

What treatment have you already received? _____

Has this problem occurred in the past _____

PAST MEDICAL HISTORY

Please check if you have had any of the following conditions:

☐Heart Disease ☐Rheumatic Fever
☐High Blood Pressure ☐Stroke ☐**Blood Clots/DVT**
☐Epilepsy or Convulsions ☐Kidney or Bladder Problems
☐Diabetes ☐**Tumor or cancer**
☐Dizziness/Vertigo ☐HIV/AIDS
☐Respiratory Disease ☐Pneumonia or Emphysema
☐Tuberculosis (TB) ☐Asthma
☐Hepatitis: Type _____ ☐Are you now pregnant?
☐Do you have a **pacemaker?**
☐Do you have surgical implants?
☐Pain: Scale 0 to 10 : (10 being the highest)_____
☐**ALLERGIES:** _____

INTERNAL USE ONLY - ***Notes:***

Recommendations:

SURGERY:

Please list all previous operations and indicate the approximate date or age at the time of the procedure

(e.g.: Left Hip Replacement: 3/1998, L4/L5 fusion: 11/2004)

_____

FRACTURES OR OTHER SERIOUS INJURIES: (Please list type and date)

_____

MEDICATION(s): (Please list all present medications, include dosage and how often you take it.)

_____

_____

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AUTHORIZATION FOR RELEASE OF INFORMATION

(1) Patient's Printed Name:

_____
Last First Initial or Other

Date of Birth: ___/___/_____ Insurance # exactly as on card (including letters) _____

(2) Paloma Wellness and Rehabilitation, PLLC, henceforth PW&R, will only disclose the protected health information you want disclosed.

Check only one box to tell PW&R the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at PW&R to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence regarding your Physical Therapy Services
_____ Past Medical History _____ Treatments _____ Other _____

(4) Complete only if you selected "limited information". I only authorize the release information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ Other: _____

(5) Check only one box indicating how long PW&R can use this authorization:

☐ Disclose my information indefinitely (as long as PW&R has custody of my files)

☐ Disclose my PHI for the following period beginning _____/_____/_____ and ending _____/_____/_____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_____ I understand that this authorization does not expire unless I have indicated an expiration date above
_____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_____ I understand that if I give authorization I may revoke it at any time by notifying PW&R in writing
_____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_____ I understand that if PW&R requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_____ PW&R will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtain to the patient after full disclose of purpose and intent

_____ _____ **or** _____ _____
Signature of Patient **Date** **Parent or Authorized Representative Signature (Indicate the Relationship)** **Date**

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ACKNOWLEDGEMENT OF RECIEPT OF NOTICE OF PRIVACY PRACTICES and PATIENT/CLIENT RIGHTS & RESPONSIBILITES

My signature indicates that I have been given/notified of the Notice of Privacy Practices and the Patient/Client Rights & Responsibilities for **Paloma Wellness and Rehabilitation, PLLC**. I recognize that outside of purpose for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Paloma Wellness and Rehabilitation, PLLC to release any of my protected healthcare information.

_____

Printed Name & Date

_____

Patients or Authorized Representative Signature

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Patient Name: _____

PHYSICAL or OCCUPATIONAL THERAPIST/PATIENT COLLABORATIVE DECISION-MAKING & PLAN OF CARE CHECKLIST (Formerly Informed Consent)

☐ Review physical findings

☐ Review functional findings

☐ Discuss proposed long term plan and expected goals

☐ Rehabilitation potential/prognosis

☐ Rehabilitation diagnosis

☐ Determine frequency and duration of treatment sessions

☐ Discuss precautions and limitations

☐ Discuss alternative and related outcomes

☐ Discuss substantial risks

☐ Obtain verbal or written consent to initiate treatment and plan of care

<u>Collaborative Decision Making Statement:</u> The patient and I reviewed his/her clinical and functional status, pros, cons and alternatives of care. We also discussed the plan of care which is outlined above. We conferred about his/her rehabilitation prognosis for improvement/recovery and consent to the plan of care and treatment interventions was obtained.

_____ _____ _____

Therapist's signature **Date** **Patient's signature**