OCCUPATIONAL THERAPY ADULT INTAKE FORM

NEW PATIENT INFORMATION

DATE: ______________________________

PATIENT: ____ DOB: _____________________________

AGE: _________________ SEX: ☐ FEMALE ☐ MALE

TELEPHONE HOME NUMBER: _______________________ CELL NUMBER:_________________________

ADDRESS: ____

CITY /STATE/ ZIP:

____

PERSON COMPLETING FORM: _____________________________ RELATIONSHIP: ___________________

E-MAIL: ____

NAME OF PERSON FILLING OUT FORM IF OTHER THAN CLIENT:

____

RELATION TO CLIENT:____

TELEPHONE HOME NUMBER: _______________________ CELL NUMBER:_________________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐WIDOWED

FULL NAME OF SPOUSE: ____

OTHERS LIVING IN HOME: ____

PATIENT EMPLOYMENT: ____________________________ WORK#: ______________________________

PRIMARY CARE PHYSICIAN:___________________________PHONE NUMBER: _______________________

SPECIALIST:_______________________________________ PHONE NUMBER: _______________________

SPECIALIST:_______________________________________ PHONE NUMBER: _______________________

RECEIVING IN HOME ASSISTANCE? ☐ YES ☐ NO

HOW OFTEN?: ____

WHO MAY WE THANK FOR THIS REFERRAL? ____

EMERGENCY INFORMATION SHEET: (2013-2014)

Patient: _________________________________ Birth date:_____________ Phone:(___)____________

Address:____Zip:_________________

Email:____

Contact Name (1): _____________________________________ Relation:___________________________

Work Phone Number:(____)________________Cell Phone Number :(___)_________________________

Contact Name (2): _____________________________________ Relation:___________________________

Work Phone Number:(____)________________Cell Phone Number :(___)_________________________

Contact Name (3): _____________________________________ Relation:___________________________

Work Phone Number:(____)________________Cell Phone Number :(___)_________________________

Conditions Which May Require Immediate or Emergency Care (i.e., diabetes, epilepsy, bee sting reactions, allergies, etc.)

1. __________________________________ Treatment:____

2. __________________________________Treatment: ____

3. __________________________________Treatment: ____

Please indicate name of medications that are taken on a regular basis and the purpose of the medication as well as any other pertinent information below:

1.) ____ 2.)____

3.) ____ 4.)____

5.) ____ 6.)____

Please list any and all allergies patient has (food, latex,ect.):_____________________________________

____

Does patient wear glasses/corrective lenses? ____

If patient becomes ill or involved in an accident and an emergency contact cannot be reached, I authorize the following hospital or above-named physician to give the emergency medical treatment required:

Hospital: _____________________________ Address: ____

Signature: X____ Date:___________________________

RELEVANT MEDICAL HISTORY:

Please check any of the following medical conditions which apply to you:

☐ Depression/mental illness ☐ Stroke/TIA ☐ Cancer
☐ Neurological Disease/Disorder ☐ Obesity ☐ Vision Problems
☐ Heart Problems ☐ Alzheimer's/Dementia ☐ Breathing Problems
☐ Degenerative Disease ☐ Stomach Problems ☐ Headaches
☐ Osteoporosis ☐ Fractures ☐ Falls
☐ Muscle/Tendon injury ☐ Arthritis ☐ Back Pain
☐ Circulation/Vascular Problems ☐ Diabetes ☐ Head Injury
☐ Joint Replacement ☐ Seizures/epilepsy
☐ Other:____

Please provide details regarding any of the medical conditions you identified above:
____
____

Recent/Relevant Surgery:
____
____

Current Medications:
____
____

If applicable, please list any specialists you currently see:
____
____

If applicable, please list any recent x-rays, MRI's, or diagnostic tests that you have had and list results:____
____

Contraindications/Precautions
(a physician's order must include any precautions necessary for treatment):

☐ None ☐ Osteoporosis ☐ Cardiac
☐ Seizure disorder ☐ Pacemaker or other metal implants ☐ Hip
☐ Braces(orthopedic) ☐ Lifting/weight limitations
☐ Other:____

RELEVANT SOCIAL HISTORY:

Employment/Work (job/school/play):

Work: ☐ Full Time ☐ Part Time ☐ Retired ☐ Student ☐ Unemployed

Sports/Hobbies:____
____

____
____

Please Describe your concerns:

____
____
____
____
____

Please list any illnesses, hospitalizations, or injuries that have affected/contributed to your concern:

____
____
____

Please describe events leading up to and following the illness:

____
____
____

Onset Date of Above: ____

What do you hope to accomplish with therapy services?_________________________________
____
____

Please list any questions you would like to have answered:

____
____
____
____
____

SPEECH/LANGUAGE HISTORY:

Have you had speech therapy before? ☐ Yes ☐No

Where? _______________________ When?____

Results/Area of Focus: ____

Reason for Discharge: ____

Do you have hearing loss/wear hearing aides? ☐ Yes ☐No

Do you have or have you ever had difficulty chewing and swallowing? ☐ Yes ☐No

If yes, Please explain: ____

OCCUPATIONAL THERAPY HISTORY:

Have you had occupational therapy before? ☐ Yes ☐No

Where? ________________________ When?____

Results/Areas of Focus: ____

Reason for discharge: ____

PHYSICAL THERAPY HISTORY:

Have you had physical therapy before? ☐ Yes ☐No

Where? ________________________ When?____
Results/Areas of Focus: ____
Reason for discharge: ____

REHABILITATION INFORMATION:
Do you have any deficits from a prior illness/injury which were not resolved with prior therapy? ☐ Yes ☐ No
List:____
Do you use any adapted equipment (reacher, etc.), orthotics/splints, or have modifications? ☐Yes ☐ No
List:____
Do you use any adapted devices (walker, cane, wheelchair, etc)? ☐ Yes ☐No
Describe what daily activities, leisure activities, and/or current occupation/job duties are being affected and how? ____
____
____

CONSENT TO TREATMENT/CONSENT TO RELEASE INFORMATION

I authorize the staff at Transformations Rehabilitation Services, occupational therapists as well as any support staff to provide care which they deem beneficial to the patient. Furthermore, I understand that Transformations Rehabilitation Services, has promised no specific outcomes as to the services provided at this facility.

X___________________________________ X_______________________________
Signature Patient Name

____________________________________ _______________________________
Relationship Date

____________________________________ _______________________________
Witness Date

*patient must be 18 years old or older to sign for their care

I authorize the occupational therapists and support staff of this facility consent to release any or all pertinent medical information to the referring physician and any additional physicians listed below to maintain quality of care. Furthermore, I authorize Transformations Rehabilitation Services, to release information to insurance providers to coordinate payment of benefits.

X___________________________________ X_______________________________
Signature Patient Name

____________________________________ _______________________________
Relationship Date

____________________________________ _______________________________
Witness Date

Additional physicians:

Name:_______________________ Name:____________________
Address:____________________ Address:__________________
___________________________ _________________________
___________________________ _________________________
Phone:______________________ Phone:_____________________
Fax:_________________________ Fax:______________________

RELEASE FOR EDUCATIONAL AND TEACHING PURPOSES

I, _____________________________, authorize the therapists at Transformations Rehabilitation services, to be observed and or receive therapy during sessions by fieldwork students/interns and/or volunteers in our usual practice. I understand that these individuals will be signing confidentiality agreements as mandated by HIPAA and that any information will be used for teaching purposes only.

X____________________________________
Signature

X_______________________________
Patient Name

____
Relationship

____
Date

CANCELLATION POLICY

Transformation Rehabilitation Services, takes the care of our patients and their families very seriously. It is very important to us that you attend your regularly scheduled appointments. These scheduled appointments are part of a recommended treatment plan aimed at improving health, function, and the overall quality of life of our patients. Without regularly attending your scheduled appointments, the benefits of therapy will be limited. In addition, several patients are waiting to receive therapy services during optimal times such as afternoons following school or in the evenings when parents are home from work. Due to the high number of individuals in need of these times, Transformations Rehabilitation Services, would like to make every effort to accommodate those in need and who are available to make their appointment times. We understand that families are busy and schedules are often difficult to manage. Patients who are late for or cancel (without a excuses or doctors note) for 3 therapy sessions in a row for their treatment time, they will be contacted to be removed from the scheduled time. If more than 4 cancellations/no shows occur within a patient's recommended plan of care timeframe, Transformations Rehabilitation Services, will hold the right to recommend discontinuing therapy services. The patient will then be removed from their therapist's schedule to allow for other individuals to use this time slot.

X___________________________________ X_______________________________
Signature Patient Name

____________________________________ ________________________________
Relationship Date

WAIVER OF H.I.P.A.A. LIABILITY

Due to federal guidelines protecting all private patient health information, Transformation Rehabilitation Services has a policy in place that prohibits discussion of all information regarding the patients assessment, treatment and care, in public areas such as the patient waiting room or in the open treatment clinic.

All discussion regarding the patient will take place in a private room away from the general public.

By signing this waiver of H.I.P.A.A. liability, you as the patient or caregiver, are releasing Transformation Rehabilitation Services from any harm or fault caused by discussing the private health information in such open access areas in our facility such as the waiting room area. This waiver is to encourage ongoing discussion between the therapist and family. This waiver will be in place from the date signed below, until such a time that you as patient or caregiver request in writing to Transformation Rehabilitation Services that all discussion take place in a private setting.

X___________________________________ X_______________________________

Signature Patient Name

____________________________________ ________________________________

Relationship Date

Patients Insurance Information

Patient Name:__________________________ DOB:_________ SS#:______________

Address:____

Insured's or Sponsor's Name (if different then patients name):____

Relation to patient: _________________SS#:______________ DOB:______________

Insured's or Sponsor's Address:____

Patient Relationship To Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:____________

Home Phone Number:(___)____________ Cell Phone Number:(___)_____________

Insurance:____________________________________ ID#:____________________

Secondary Insurance:______________________________ ID#:_________________

Financial Responsibility / Insurance Disclosure

I authorize Transformation Rehabilitation Services, to bill my insurance and receive direct payment from my primary insurance as well as my secondary insurance companies so that Transformation Rehabilitation Services, will be paid for the therapy services provided. Furthermore, I understand that I am financially responsible for any fees not paid
or covered by my insurance providers. I also acknowledge that I am responsible for co-pays, co-insurance and deductibles which are included as part of my insurance contracts. It is my responsibility to inquire and understand my insurance policy(s) and communicate with Transformation Rehabilitation Services when coverage changes occur.
By signing this form, I understand and agree that (regardless of insurance status), I am ultimately responsible for the balance of my account for any professional services rendered.

____ ________________________
Patient Name Date

X_______________________________________ _________________________
Signature Relationship

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about the patient may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Responsibilities:
We are required by law to maintain the privacy of your health information and provide you with a description of our privacy practices. We will abide by the terms of this notice.

Uses and Disclosures:
The following categories describe how we may use and disclose your medical information.

For Treatment:
We may use health information about you to provide you treatment or services. This means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

For Payment:
We may use and disclose health information about your treatment and services for such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.

For Health Care Operations:
Members of our staff may use information in your health record for the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review. We may disclose information to students for educational purposes. We may remove information that identifies you from this set of health information to protect your privacy. We may contact you to remind you that you have an appointment; assess your satisfaction with our services; tell you about possible treatment alternatives; tell you about health-related benefits or services;
and we may leave messages on your answering machine or voice mail regarding primary appointment reminders and billing/collections efforts.

Future Communications:
We may contact you in the future via newsletters, mail outs, or other means regarding treatment options, health related information, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement:
This facility and its staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment, and healthcare operations. Therapists and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Law Enforcement/Legal Proceedings:
We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

Your Health Information Rights:
Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the right to:

Inspect and Copy:
You have the right to inspect and obtain a copy of your health information, including billing records.

Amend:
If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for our facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.

An Accounting of Disclosures: You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment, or healthcare operations where an authorization was not required.

Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care (i.e., family member or friend). Any request for a restriction must be sent in writing to the Facility Privacy Official.
We are required to agree to your request only if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose related to payment of health care operations (and not treatment purposes), and 2) your information pertains solely to health care services for which you have paid in full. For other requests, we are not required to agree. If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment.
Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we contact you at work instead of at home or in a private room, rather than in the waiting room. The facility will grant requests for confidential communication at alternative locations and/or alternative means if the request is submitted in writing and the written request include a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.

A Paper Copy of this Notice:
You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

Changes To This Notice:
We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date.

Complaints:
If you believe your privacy rights have been violated, you may file a complaint with this facility. You may also file a complaint with the Secretary of the Department of Health and Human Services. You will not be penalized for filing a complaint.

Other Uses of Health Information
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us with permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you and documented in our facility.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Provide treatment and services
-Bill and collect payment from you, your insurance company, or a third party payer
- Conduct healthcare operations such as assess my care and outcomes and quality assessments

I have received, read, and understand your *Notice of Privacy Practices* containing a more complete description of my rights and the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* and that I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices.* I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that this organization is not required to agree to my requested restrictions, but if the organization does agree then it is bound to abide by such restrictions.

___________________________________ ________________________________
Patient Name Date

X__________________________________ ________________________________
Signature Relationship to Patient