FASTER RECOVERY, LASTING RESULTS

IMPROVED QUALITY OF LIFE

Allied REHAB CARE SPECIALISTS

1135 Clifton Avenue Suite 204 | Clifton, NJ 07016
Tel: 973-955-2656 Fax: 973-955-2657
www.alliedrehabcare.net

PATIENT INTAKE & CONSENT FORM

First Name _____ MI _____ Last Name _____

Address _____
(Street) (City) (State) (Zip Code)

Date of Birth: _____ Age: _____ Sex: M F Social Security #: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Contact Preference: Phone Cell Email SMS

Emergency Contact: _____ Phone: _____ Relationship: _____

How Did You Hear About Us?

____ Physician ____ Friend/Relative/Patient ____ Employee
____ Advertisement ____ Insurance ____ Internet
____ Yellow Pages ____ Former Patient Other: _____

Employer: _____

Address _____
(Street) (City) (State) (Zip Code)

Contact Person @ Work: _____ Occupation: _____

Primary Insurance: _____ Subscriber ID: _____

Billing Address: _____ Phone: _____

Subscriber's Name: _____ Date of Birth: _____

Patient Relationship to Insured: SELF SPOUSE CHILD OTHER _____

Deductible/CoPay: _____ Verification Comments: _____

_____ Verified by: _____

Secondary Insurance: _____ Subscriber ID: _____

Billing Address: _____ Phone: _____

Subscriber's Name: _____ Date of Birth: _____

Patient Relationship to Insured: SELF SPOUSE CHILD OTHER _____

Deductible/CoPay: _____ Verification Comments: _____

_____ Verified by: _____

CONSENT TO TREATMENT:
I consent to rehabilitation and related services as prescribed by the referring physician at Allied Rehab Care Specialists. In so doing, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature.

Initial: _____

TREATMENT OF MINORS:
I, as a Parent/Guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

Initial: _____

LIABILITY:
I agree that Allied Rehab Care Specialists is not responsible for loss or damage to personal valuables.

Initial: _____

WAIVER AND RELEASE:
I hereby release, discharge and acquit Allied Rehab Care Specialists, its agents, employees, representatives, or assigns of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind, arising out of or resulting from my refusal to accept, receive, or allow emergency and/or medical services, including, but not limited to ambulance service, Emergency Medical Technician, or urgent care services.

Initial: _____

DESIGNATED PERSONAL REPRESENTATIVE:

I, _____ hereby authorize _____
(Patient Name) (Patient Representative)
_____ as my designated personal representative. The above referenced
(Relationship to Patient)
referenced representative, for purposed of Allied Rehab Care Specialists, LLC, may communicate on my behalf regarding treatment, insurance verification, authorization, referral, and insurance payment or denial. The representative designation is effective from initial evaluation through account reconciliation.

_____ I decline to designate a personal representative. _____
(Patient signature if declining)

ASSIGNMENT OF BENEFITS:
I irrevocably assign to Allied Rehab Care Specialists, LLC (ARCS) all my rights and benefits under any insurance contracts for payment for services rendered to me by ARCS. I irrevocably authorize all information regarding my benefits under any insurance policy relating to any claims by ARCS to be released to ARCS. I irrevocably authorize ARCS to file insurance claims on my behalf for services rendered to me. I irrevocably direct that all such payments go directly to ARCS. I irrevocably authorize ARCS to act in my behalf and report any suspected violations of proper claims practices to the proper regulatory authorities. This assignment of benefits has been explained to my full satisfaction and I understand its nature and effect.

_____ _____ _____
(Patient/Responsible Party Signature) (Relationship to Patient) (Date)

HORIZON BCBS NJ PATIENTS ONLY:
Due to our non-participating status with your insurance carrier, all check payments will be sent to you. Please forward the payment along with the Explanation of Benefits to us immediately. Please understand that if we do not receive the payment, you will be fully responsible for the entire bill and any financial hardship agreements will be voided.

_____ _____ _____
(Patient/Responsible Party Signature) (Relationship to Patient) (Date)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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

- Conduct, plan and direct my treatment and following-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I can 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 you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except that you have taken action relying on this content.

_____
(Patient Signature)

I certifiy that all of the information provided herein is true and correct.

_____ _____ _____
(Print Patient Name) (Relationship to Patient) (Date)

_____
(Patient Signature)

Name: _____ Referring Doctor: _____

Primary Doctor: _____ Date of 1st doctor visit for this injury: _____

Last day worked due to injury: _____ Date Returned to Work: _____ Restricted Duty? Y N

If Accident: AUTO WORK OTHER _____ Claim Filed? Y N

Is an attorney involved in this case? Yes No If Yes, Name: _____

Have you had surgery for this injury? Yes No Number of Surgeries? _____

Type of Surgery: _____

Took Place In: HOSPITAL SURGICAL CENTER

Are you currently taking any prescription or non-prescription medications? Yes No

Anti-Inflammatories: _____ Muscle Relaxants: _____

Pain Medications : _____

Please list all Medications: _____

Have you ever had any of the following Medical or Rehabilitative Services for this injury?

	YES	NO		YES	NO
Chiropractor	____	____	CT Scan	____	____
EMG/NCV	____	____	General Practitioner	____	____
Massage Therapy	____	____	MRI	____	____
Epidurals	____	____	X-Ray	____	____
Physical Therapy	____	____	Neurologist	____	____
Pain Specialist	____	____	Emergency Room Care	____	____
Orthopedist	____	____	Other	____	____

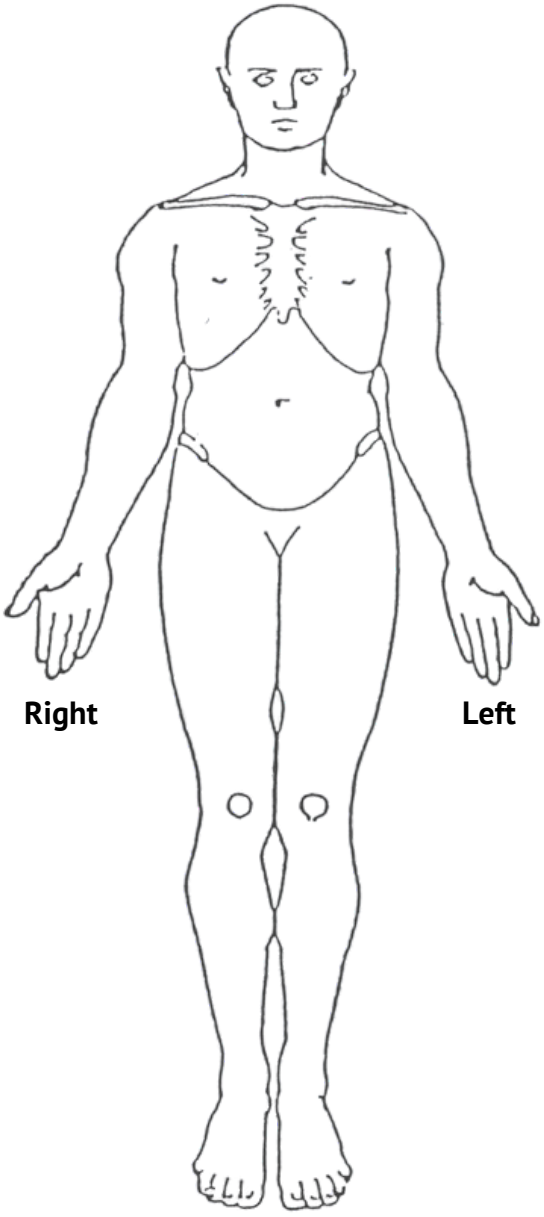
Do you have or have you HAD ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Severe or Frequent Headaches	____	____
Shortness of Breath or Chest Pain	____	____	Vision or Hearing Difficulty	____	____
Coronary Heart Disease or Angina	____	____	Numbness or Tingling	____	____
Allergies	____	____	Dizziness or Fainting	____	____
High Blood Pressure	____	____	Bowel or Bladder Issues	____	____
Heart Attack/Stents	____	____	Weakness	____	____
Stroke/TIA	____	____	Weight Loss/Energy Loss	____	____
Congestive Heart Disease	____	____	Hernia	____	____
Blood Clot/Emboli	____	____	Varicose Veins	____	____
Epilepsy/Seizures	____	____	Do you have a Pacemaker?	____	____
Thyroid Disease/Goiter	____	____	Any Pins or Metal Implants?	____	____
Anemia	____	____	Joint Replacement Surgery	____	____
Infectious Disease	____	____	Neck Injury/Surgery	____	____
Diabetes	____	____	Shoulder Injury/Surgery	____	____
Cancer or Chemotherapy Radiation	____	____	Elbow or Hand Injury/Surgery	____	____
Arthritis	____	____	Back Injury/Surgery	____	____
Osteoporosis	____	____	Knee Injury/Surgery	____	____
Gout	____	____	Leg or Ankle or Foot Injury/Surgery	____	____
Sleeping Problems/Difficulties	____	____	Are you Pregnant?	____	____
Emotional/Psychiatric Problems	____	____	Do you smoke?	____	____

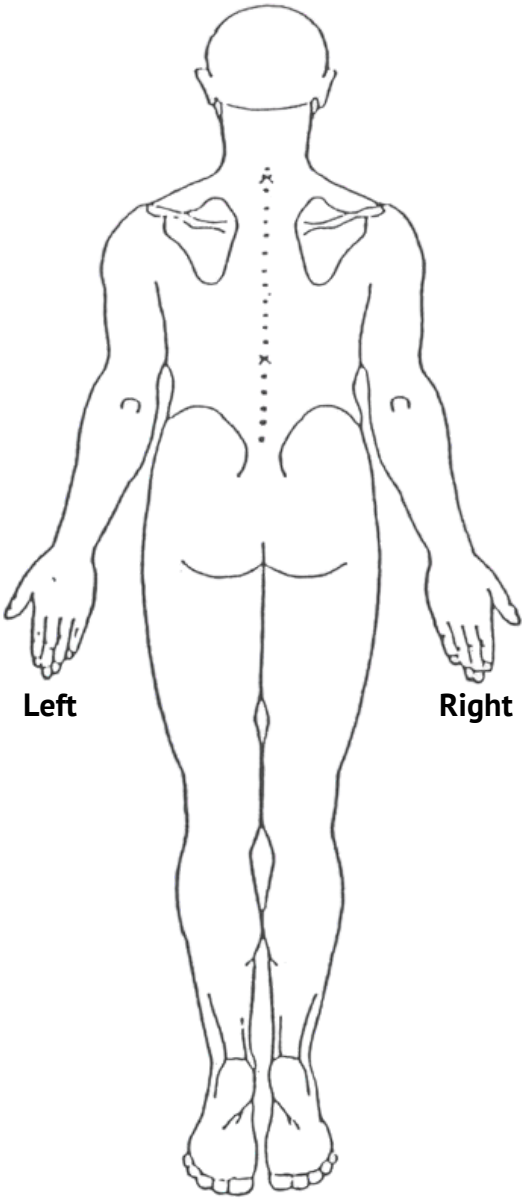
Please let us know what your personal goals are with therapy. _____
_____

Patient Signature: _____ Date: _____

PLEASE MARK ON THE FIGURE BELOW THE AREA(S) OF PAIN.



Right **Left**



Left **Right**

Please describe:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Signature: _____ Date: _____