



**Mercer Health**

Therapy & Rehabilitation



Form 501

## Pediatric New Patient Intake Form

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Date: \_\_\_\_\_

Are you presently receiving ANY type of home health care services from ANY home health agency or hospice?  
Examples: Mercer Health Home Health or Celina Visiting Nurses  Yes  No

Have you received ANY other therapy services throughout the year from another therapy agency?  Yes  No

Are you currently being treated by another physician or health care practitioner (chiropractor, physical therapist, etc.)?  
 Yes  No If yes, who? \_\_\_\_\_

For what? \_\_\_\_\_

What diagnosis/injury has brought you to therapy? \_\_\_\_\_  
\_\_\_\_\_

When did it start? \_\_\_\_\_

What is your goal(s) to accomplish in therapy? \_\_\_\_\_  
\_\_\_\_\_

Birth History (Full-term, NICU, Apgar Score, Natural Birth Vs. C-Section)? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current and Past Medical History (*Check all that apply.*)

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                       | <input type="checkbox"/> Angina/Chest Pain     | <input type="checkbox"/> Arrhythmia               |
| <input type="checkbox"/> Asthma/Emphysema/COPD        | <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Blood Clots              |
| <input type="checkbox"/> CAD (Coronary Heart Disease) | <input type="checkbox"/> Cancer                | <input type="checkbox"/> Congenital Heart Disease |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Diabetes              | <input type="checkbox"/> Drug/Alcohol Abuse       |
| <input type="checkbox"/> Fractures                    | <input type="checkbox"/> GERD                  | <input type="checkbox"/> Hepatitis                |
| <input type="checkbox"/> High Blood Pressure          | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> HIV/AIDS                 |
| <input type="checkbox"/> Hyperthyroidism              | <input type="checkbox"/> Hypothyroidism        | <input type="checkbox"/> Kidney Disease           |
| <input type="checkbox"/> Liver Disease                | <input type="checkbox"/> Mental Health Issues  | <input type="checkbox"/> MI/Heart Attack          |
| <input type="checkbox"/> Migraines/Headaches          | <input type="checkbox"/> Neurological Diseases | <input type="checkbox"/> Obstructive Sleep Apnea  |
| <input type="checkbox"/> Renal Disease                | <input type="checkbox"/> Seizures              | <input type="checkbox"/> Sickle Cell              |
| <input type="checkbox"/> Stroke/CVA/TIA               | <input type="checkbox"/> Vascular Disease      |   |

If you checked any of the above, please explain: \_\_\_\_\_  
\_\_\_\_\_



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Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

List all surgeries: \_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies?  Yes  No If yes, please list: \_\_\_\_\_  
\_\_\_\_\_

If you are obtaining therapy without a physician referral, please list a physician in which we can share your therapy information/notes.

Physician: \_\_\_\_\_

**\*\*Medicare Patients** – in order to bill Medicare we require a physician referral due to physician certification and recertification requirements by Medicare.\*\*

Please check any of the following treatments you have had in the past.

- Physical therapy \_\_\_\_\_
- Occupational therapy \_\_\_\_\_
- Pain program \_\_\_\_\_
- Back school \_\_\_\_\_
- Other \_\_\_\_\_
- Psychologist \_\_\_\_\_
- Chiropractor \_\_\_\_\_
- Nerve block \_\_\_\_\_
- TENS \_\_\_\_\_

Do you have any religious or cultural considerations we need to know about before you start our program?

Yes  No If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you in a situation with someone who is physically, emotionally, or sexually hurting you?  Yes  No

**\*\*Please feel free to ask our staff any questions you may have regarding our services or any billing/price information. We will be glad to assist you in any way we can.\*\***

**Several insurance companies require you to contact them before you receive therapy services. It is your responsibility to see that this is done but our staff will assist you as much as possible. Insurance coverage varies from company to company. It is the patient's ultimate responsibility to verify insurance coverage for services received. Please note that we are a hospital-based facility, not a free-standing facility, and our billing at all locations is completed through Mercer Health hospital.**



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**Our goal is to provide you with the highest quality professional service in an efficient manner. We have allocated sufficient time to properly meet your needs. If for any reason you cannot make your therapy appointment, please notify us at least 8 hours before the scheduled appointment. If you fail to do so, we reserve the right to charge a missed appointment charge that insurance usually does not cover.**

We are a clinical education site for multiple universities and professional schools. There are times we have therapy students in our department. They may observe and at times perform your treatment program in aspects of your care that they have been determined to be competent in and with proper supervision. May we have your permission for students to perform and/or observe your treatment? If at any time you feel uncomfortable with this you may let us know and we will make other arrangements.

- Yes, students may perform, participate and/or observe my treatment with proper supervision.**
- Yes, students may observe and participate in my treatment, but not perform any treatment.**
- No, students may not perform, participate and/or observe my treatment.**

There are also volunteers in our department observing this field of the medical environment in further medical education. Volunteers by policy do not perform treatment in our department.

- Yes, volunteers **may** observe my treatment.
- No, volunteers **may not** observe my treatment.

How did you hear about us? (Check all that apply.)

- Doctor
- Newspaper Ad
- Radio Ad
- Social Media
- Friend/Relative
- Website/Internet
- Previous Experience
- Other: \_\_\_\_\_

Email Address: \_\_\_\_\_

**TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.**

I, the patient have also reviewed the Rehabilitative Services Department’s Patient Bill of Rights and Responsibilities statement and I am committed to cooperating and participating at my fullest capacity. A copy of the hospital Patient Bill of Rights and Responsibilities (Policy #A-3) that addresses the rights and responsibilities of patients is also available upon request.

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

## Informed Consent for Physical, Occupational and Speech Therapy

Physical, occupational and speech therapy involve the use of many different types of physical examination and treatment. At Mercer Health Therapy and Rehabilitation we use a variety of procedures and modalities to help us attempt to improve your function. As with all forms of medical treatment, there are benefits and risks involved with therapy.

The physical response to a specific treatment can vary widely from person to person. It is not always possible to predict your response to a certain procedure or modality. We are not able to guarantee what your reaction will be to a particular treatment, nor can we guarantee that our treatment will help the condition you are seeking treatment.

Benefits may include improvement in symptoms and overall function. You might also experience decreased pain and discomfort. You could also gain a greater knowledge about your condition and how to manage your condition.

Potential risks may include increase in current level of pain, aggravation of previously existing conditions, and could involve life-threatening situations.

I understand that the physical therapist, occupational therapist and/or speech language pathologist provides a wide range of services. I acknowledge that my treatment program has been explained and that I have been given an opportunity to ask questions. I understand the risks associated with a program of physical, occupational, and/or speech therapy. I confirm that I have read and fully understand this consent form. I wish to proceed with all therapy services.

\_\_\_\_\_  
Name of Patient (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Patient/Legal Guardian

I hereby certify that I have explained the proposed evaluation and treatment. I have offered to answer questions. I believe that the patient/guardian understands what I have explained and answered.

\_\_\_\_\_  
Therapist Signature

\_\_\_\_\_  
Date



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## Medical Information Release

In order for our staff to discuss your medical care (or your child's medical care) with someone other than yourself (including a spouse or other family member) we must have your consent. If you know of anyone that may be requesting your (or your child's) medical information from our office (not including another physician or clinic) please give your consent below. By signing this you are releasing the staff of Mercer Health Therapy and Rehabilitation from any and all liability for fulfilling this authorization request.

**I hereby authorize the staff of Mercer Health Therapy and Rehabilitation to disclose information related to my (or my child's) current episode of care to the person's listed below:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Telephone \_\_\_\_\_

**This authorization will expire upon me (or my child) being discharged from this episode of care.**

\_\_\_\_\_  
Name of Patient (Printed)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Name of Parent/Legal Guardian, if applicable (Printed)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Patient/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

**Authorization is valid from the date of signature or until we receive written notification from you. I understand that I may revoke this authorization in writing at any time.**

**Date Revoked:** \_\_\_\_\_ **Time:** \_\_\_\_\_ **Signature:** \_\_\_\_\_

**Patient or Parent/Legal Guardian**



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## Patient Consent to Photograph, Videotape or Utilize Written Endorsement

1. \_\_\_\_\_  
Full Name Date of Birth

2. I hereby grant Mercer Health Therapy & Rehabilitation permission to photograph/videotape me or to use any written endorsements or communications from me for the following purpose. Check all that apply.

- Medical Reasons such as diagnosis, care, treatment, research or education throughout my current episode of care.
- Public Relations Promotion  
This includes granting permission for Mercer Health Therapy & Rehabilitation to use my name in any publicity (i.e. Facebook, Twitter, Mercer Health website, etc.) accompanying any photograph and/or videotape which has been taken, or written endorsement and communication from me and relinquish any claims of rights to these items and the use of my name with them.
- Law Enforcement
- Other (specify): \_\_\_\_\_

3. I relinquish any claims to any photograph and/or video taken or written endorsement and communication from me and understand that they are the possession of Mercer Health Therapy & Rehabilitation and/or an appointed agent. I understand that I will receive no compensation for any photograph, videotape, written endorsement and/or communication taken or used.

\_\_\_\_\_  
Signature of Patient/Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date



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## Minor Child Travel Consent

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

- I, \_\_\_\_\_, parent or legal guardian, will organize transportation to and from Mercer Health Therapy and Rehabilitation for \_\_\_\_\_, minor child. I will allow the following names to provide transport for my child.

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

- I, \_\_\_\_\_, parent or legal guardian, give \_\_\_\_\_, minor child, permission to commute to and from Mercer Health Therapy and Rehabilitation without organized transportation.

\_\_\_\_\_  
Signature of Parent/Legal Guardian Date

Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Witness Date

## Mercer Health Therapy & Rehabilitation – No Show Policy

**Intent:** To ensure that all patients can receive the therapy care they need and desire. This policy is implemented to ensure reasonable attendance for scheduled therapy appointments by minimizing “No-Show” appointments and provide the availability of therapy to those in need.

**Definition:** An appointment “No Show” is defined as any appointment cancelled 2 hours or less prior to a scheduled outpatient appointment or for any appointment that the patient does not show up for the respective appointment.

Each time a patient has a “No-show”, the office staff will follow the below process. (Exceptions for waiving “No-Show’s” may only be made by the office manager under special circumstances such as weather, hospitalizations, illness, etc.)

- **Regular Patient Programs:** For short to moderate term outpatient programs that receive outpatient treatment appointments, treatment appointments will continue to be scheduled if the patient does not have more than two “No-Show” Appointments during the course of their outpatient therapy program. **If they have more than two “No-shows”, they will be discharged from their outpatient therapy program plan of care.** Patients whose programs are discontinued will need to receive a new physician order for therapy. Once the new order(s) to resume treatment are received the patient will be placed on the waiting list to restart their outpatient program.
- **Reoccurring Patient Programs:** For long-term patient programs that receive ongoing treatment appointments, treatment appointments will be booked in blocks of 10 outpatient sessions. **If reoccurring patients do not attend at least 8 of 10 appointments in each of their respective scheduled blocks of appointments, they will be discharged from their plan of care.** A member from the front office will contact patient and referring doctor to inform that all remaining visits will be canceled. The patient will need to receive a new physician order if more therapy is warranted. Once the new order(s) to resume treatment is received, the patient will be placed on the waiting list to restart their outpatient program.
- Questions in regards to no show policy will be directed to the office manager of the outpatient clinic. Patient

Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Representative Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_