Mercer Health
Therapy & Rehabilitation

LABEL

Form 504

Adult Intake Form

Physical and Occupational Therapy

Name: _____ DOB:_____

Next Referring Doctor's Appointment: _____

Are you presently receiving ANY type of Home Health Care Services: □ Yes □ No

What is the reason for coming to therapy? _____

Was it caused by a specific incident? □ Yes □ No Is there legal action? □ Yes □ No

If yes, please explain _____

What is the date of onset for this condition? _____

What are your goals for therapy? _____

Have you seen other specialists (i.e. psychologists, neurologists, orthopedist, gynecologist.)? □ Yes □ No

Have you seen a chiropractor this year? □ Yes □ No If yes, billed to insurance? □ Yes □ No

Have you had any special tests to determine the cause of your problem? Please choose all that apply:

□ X-Ray □ MRI □ CT Scan □ Labwork □ Other: _____ □ None

Are more tests being planned? □Yes □No If yes, when? _____

If you are obtaining therapy without a physical referral, please list the physician in which we can share you therapy information with: _____

Medicare Patients: in order to bill Medicare, we require a physician referral due to requirements by Medicare

Do you have any rashes or other skin conditions? _____

Over the past 2 weeks how often have you been bothered by any of the following problems?

0 = not at all, 1 = several days

Little interest or pleasure in doing things? _____ Feeling down, depressed or hopeless? _____

Females: Is there any chance you could be pregnant? □Yes □No

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Other Medical History:

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

- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arrhythmia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ CAD (Coronary Heart Disease)
- ☐ Cancer
- ☐ CHF (Congestive Heart Failure)
- ☐ Congenital Heart Defect
- ☐ COPD/Emphysema
- ☐ Dementia/Alzheimer's
- ☐ Depression/PTSD
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Fractures
- ☐ Glaucoma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Mental Health Issues
- ☐ MI/Heart Attack
- ☐ Migraines/Headaches
- ☐ Neurological Disease
- ☐ Osteoporosis/Osteopenia
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Smoker (Current)
- ☐ Stroke/CVA/TIA
- ☐ Vascular Disease
- ☐ Psychological/Emotional issues such as Bipolar Disorder, Depression, Anxiety and/or panic disorder
- ☐ Other _____
- ☐ Allergies – Please List: _____

Please list any prior surgeries and dates: _____

_____

Person completing this form: _____

Signature: _____ **Date:** _____

Therapist Signature: _____ **Date:** _____

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Informed Consent for Physical, Occupational and Speech Therapy

I consent to receive Physical, Occupational, and/or Speech Therapy services as recommended by my provider. I understand the nature and purpose of these services, including potential benefits and risks. I acknowledge that no guarantees have been made regarding outcomes. I understand I may ask questions and may withdraw consent at any time.

I authorize the therapist and staff to provide evaluation and treatment as deemed appropriate.

Insurance: As a courtesy, we have contacted your insurance company to verify your therapy benefits and will follow your plan's guidelines. However, we cannot guarantee payment for services rendered. We recommend contacting your insurance provider directly for a complete explanation of your benefits and coverage. The patient is ultimately responsible for payment for services rendered.

_____ _____

Signature of Patient/Legal Guardian **Date**

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 from any and all liability for fulfilling this authorization request.

I hereby authorize the staff of Mercer Health 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: _____ **Signature:** _____
Patient or Parent/Legal Guardian

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No Show Policy

To ensure all patients have access to needed therapy services, regular attendance is required. A "No-Show" is defined as missing an appointment or canceling within 2 hours of the scheduled time.

Exceptions may be made by the Office Manager for special circumstances (e.g., illness, hospitalization, weather).

- Patients with more than two No-Shows during their therapy plan will be discharged and will need a new physician order to resume services on the third No-Show. They will be placed on a waiting list once the new order is received.

Questions regarding this policy should be directed to the Office Manager.

Patient Signature: _____ Date: _____

Representative Signature: _____Relationship: _____

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