MATHIS REHAB CENTERS LLC

Patient Name _____

Mailing Address _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

SSN _____ DOB _____ Marital Status _____ Email _____

Insurance Policy Holder's Name _____ Policy Holder DOB _____

Patient's Relation to Policy Holder _____ Policy Holder SSN _____

Emergency Contact _____ Phone # _____

Patient's Relation to Emergency Contact _____

Auto Accident YES NO Work injury YES NO Other Accident YES NO

PRESENT ILLNESS AND MEDICAL HISTORY

Injury Date _____ Surgery Date _____

Based on your awareness, what are your rehabilitation expectations/goals while in this program?

_____

Do you now have or have you ever had any of the following?

_____ Cardiovascular Disease _____ Currently Pregnant _____ Osteoporosis

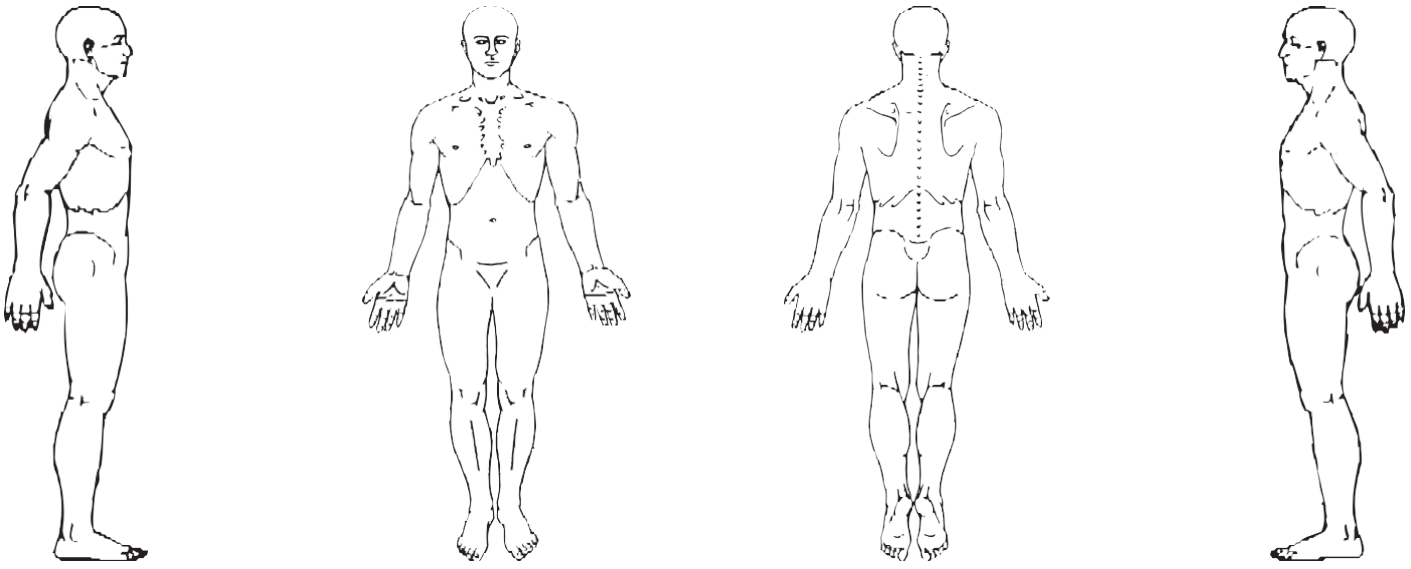
_____ Rheumatoid Arthritis _____ Pacemaker _____ Cancer/History of Cancer

_____ Recent Surgery _____ Diabetes _____ Epilepsy/Seizures

Have you had any physical therapy, occupational therapy, or speech therapy within the current calendar year? YES NO

PAIN AND SYMPTOMS

On the body diagram below, please mark the areas of your symptoms as they are at this moment.



No Pain _____ Extreme Pain

Please mark an (x) on the line above to indicates your level of pain.

Pain aggravating activities: _____

Pain Alleviating activities: _____

ACKNOWLEDGMENTS

Please initial each statement to indicate you thoroughly understand each of these authorizations.

_____ CONSENT TO TREATMENT: I hereby voluntarily consent to rehabilitation and related services at MATHIS REHAB CENTERS, LLC. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve physical examination and/or treatment. I further acknowledge that no guarantees have been made to me as to the results of treatment provided by MATHIS REHAB CENTERS providers. In addition, I acknowledge that consent for examination and treatment does not constitute a medical diagnosis.

_____ RECEIPT OF PRIVACY PRACTICES: We are required by law to provide this notice to you and obtain your acknowledgment of this receipt prior to providing any services to you. I acknowledge receipt of Notice of Privacy Practices.

CANCEL NO-SHOW AGREEMENT

The following policies outline our position regarding cancellations and no-shows for your therapy visits at Mathis Physical Therapy. These policies are important to us, and we hope that they are important to you because it can make the difference between whether or not you succeed in your treatment goals. Usually your referring doctor and/or therapist have prescribed a frequency of treatment. Your participation and compliance with the plan of care is of utmost importance will give you the best chance of achieving your goals and having a positive outcome.

- We require 24 hours notice in the event of a cancellation. It is your responsibility to have an alternative time in mind that will ensure you get your full-prescribed number of treatments that week. (In some cases, this may not work since some forms of treatment do not work when administered sequentially).
- For Worker's Compensation and personal injury patients, documentation of any missed appointments is forwarded to your physician, case manager and/or employer. This is a mandatory policy for all our therapists and may jeopardize your claim.
- Please understand that your pain may increase and/or decrease as your course of treatment progresses. Neither of these conditions should serve as a reason to miss your appointment. If you are in pain you have one of the best reasons to come in so we can address it, and if you are feeling good this is our best opportunity to make some great strides toward goal completion.
- When you fail to show as scheduled, three people are affected: You, because you do not get the treatment you need as prescribed by the doctor and/ or therapist; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient, who could have been scheduled for a therapy appointment.
- If you fail to attend your scheduled appointments, your therapist reserves the right to discharge you from physical therapy services.

Please acknowledge that you thoroughly understand these policies by signing below.

Patient/Guardian Signature Date