Atlantic Rehabilitation Center

Patient Medical History

Name: _____ Date: _____/_____/_____

Present/Past History: (Check if you ever had)

Arthritis/swollen joints		Gout	
Asthma, Bronchitis, or Emphysema		High Blood Pressure	
Angina, Coronary Heart Disease		Heart Attack or Surgery	
Anemia		Infectious Diseases (i.e. Active TB)	
Bowel/Bladder Problems		Osteoporosis	
Breathing difficulties/Shortness of breath		Pacemaker	
Blood Clot/Emboli		Psychological/Emotional Problems	
Cancer or Chemotherapy/Radiation		Problems Sleeping	
Diabetes		Stroke/TIA	
Epilepsy/Seizures		Thyroid Problems	

Other Medical History:

_____

_____

Please check if you are taking any of the following medications:

Anti-inflammatory ___ Muscle Relaxers ___ Pain Medications ___ Other _____

List names of medications: _____

Do you have any allergies? Yes__ No__ If yes, please list _____

Date of injury: ____/____/____

Have you had any surgeries? Yes__ No__ If yes, please list _____

Do you smoke? Yes__ No__

Are you pregnant? Yes__ No__

What is your main problem/complaint?

_____

What are your goals/expectations for physical therapy?

_____

Have you had any of the following medical or therapy services for this condition?

☐ Physical Therapy	☐ CT Scan	☐ Podiatrist
☐ Occupational Thera	☐ EMG/NCV	☐ Myelogram
☐ Massage	☐ Neurologist	☐ MRI
☐ Chiropractor	☐ Orthopedist	
☐ X-Ray	☐ General Practitioner	

Other_____

Are you currently working?

Full Time__ Part Time__ Modified Duty__ Not working__ Retired__

Is there an attorney involved in this case? Yes__ No__

Date of next (referring) doctor's appointment: _____/_____/_____

Patient's Signature: _____ Date: _____/_____/_____

Atlantic Rehabilitation Center

Agreement and Release Form

Consent for Treatment: I consent to evaluation, treatment and care by Atlantic Rehabilitation Center (ARC) staff and therapists.

Obligation for Payment: I hereby agree to pay usual and customary charges for all services provided by ARC, except those covered by insurance (which includes all commercial and government 3rd party payers. Such as HMO and Medicare) ARC will assist in insurance coverage matters, but I understand that it is my responsibility to comply with all requirements for insurance coverage. I agree to pay all charges that are not paid by insurance. In the event I fail to fulfill any of the obligations on this section, I agree to pay any and all collection costs incurred by ARC in the enforcement of this section. I hereby authorize and consent to ARC release of medical information to obtain payments as described in ARC privacy notice.

Assignments of Benefits: I hereby irrevocably assign payments to ARC for all medical benefits applicable and otherwise payable to me. Where Medicare and Medicaid benefits are applicable, I certify that the information given by me in applying for payment, under title XVII or XIX of the social security act is correct and request of said payment of authorized benefits are made on my behalf. I understand that I am financially responsible to ARC for charges the carrier declines to pay. It is furthered agreed that any credit balance resulting from payment by my insurance or other sources may be applied to any other accounts owed to ARC by the insured or immediate family.

Permission to send automated text messages
Please be aware that, by signing your name below, you are acknowledging that you are currently set to receive text messages for appointment reminders, promotions or other services we offer. We look forward to providing better and more convenient communications with you via text messaging.

Permission to Use Photograph/Videos: I grant to Atlantic Rehab Center the right to take photographs/videos of me. I authorize Atlantic Rehab Center, its transferees to copyright, use and publish the same in print and/or electronically.

YES_____ NO_____ Initial_____

I agree that Atlantic Rehab Center may use such photographs/videos of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and web content.

YES_____ NO_____ Initial_____

Cancellation, Rescheduling, No Show and Late Policy: In order to provide each patient with the highest quality service we ask that you call 24 hours in advance if you are unable to keep scheduled appointments. In the event the patient demonstrates disregard for this policy, a charge of $25 for each missed or cancelled appointment will be assessed on the next visit. Please note that you can cancel or inform us of your inability to attend via voicemail. We also reserve the right to refuse treatment if you are late to scheduled appointments in order to ensure appropriate time and personal attention to each patient.

_____ _____ _____

Print Name Patient Signature Date