VEREEN
REHABILITATION CENTER
SPORTS MEDICINE

NEW PATIENT REGISTRATION

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____ Age: _____ SSN: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Sex: M / F Marital Status: _____

Patient Employer Information

Employer: _____ Occupation: _____

Address: _____ Work Phone: _____

Person to Contact in Case of Emergency

Name: _____ Relationship: _____

Address: _____ Phone: _____

Next of Kin □ *Same as Person to Contact (Above)*

Name: _____ Relationship: _____

Address: _____ Phone: _____

Guarantor Information (Required for Minors) □ *Same as Patient / Self*

Name: _____ Relationship: _____

Address: _____ Phone: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone: _____

Person(s) Authorized to Discuss Medical Information

_____

Primary Insurance Information

Insurance Company: _____ Phone: _____

Address: _____

Group Name/Number: _____ ID #: _____

Insured Name: _____ Relationship: _____ DOB: _____

Secondary Insurance Information

Insurance Company: _____ Phone: _____

Address: _____

Group Name/Number: _____ ID #: _____

Insured Name: _____ Relationship: _____ DOB: _____

Patient Medical History

Current Location of Pain: _____

Description of Pain (Duration, Intensity):

_____

Prior Treatment/Therapy for Pain:

_____

Injury?
Yes /// No
Workers Comp?
Yes /// No

Primary Care Physician: _____

Address: _____ Phone: _____

Referring Physician: _____

Address: _____ Phone: _____

Authorization and Release

I certify that I have accurately answered the above questions to the best of my knowledge. I authorize the Vereen Rehabilitation Center to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such medical care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the Vereen Rehabilitation Center any monies due. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf.

_____ _____

Signature of Patient *Date*

_____ _____

Signature of Parent/Guardian (If Patient is a Minor) *Date*

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Patient Information & Medical History Form

Date: _____

Name: _____ Birthdate: _____ Age: _____

Phone: _____ Email: _____

Bill To: □ Insurance □ Accident Liability □ Worker's Comp □ Self Pay □ Other: _____

Height: _____ Weight: _____ Referring Physician: _____ Primary Physician: _____

SOCIAL HISTORY: □ Single □ Married □ Divorced □ Widowed

Current Living Arrangements: □ Alone □ With Spouse □ With Other: _____

Children: □ No □ Yes, # _____ Grandchildren: □ No □ Yes, # _____

Use of Alcohol: □ No □ Yes Use of Tobacco: □ No □ Yes

Prior to Injury/Illness: □ Employed □ Retired □ Semi-Retired

Previous Functional Status: □ Independent □ Required Assistance: _____

Hobbies & Interests: (check all that apply)

□ sports □ fishing □ TV □ automobiles □ computer
□ cooking □ hunting □ movies □ music □ exercise
□ shopping □ gardening □ reading □ woodwork □ collector of: _____

Therapist's Comments: _____

MEDICAL HISTORY: (check all that apply)

□ heart disease □ diabetes □ high blood pressure □ pacemaker □ osteoporosis
□ cancer □ tuberculosis □ vision impaired □ epilepsy □ hepatitis
□ HIV/AIDS □ arthritis □ hearing impaired □ scoliosis □ pregnant
□ stroke □ asthma □ latex allergy □ fibromyalgia □ other

Therapist's Comments: _____

What durable medical equipment (DME) company do you use? _____

Where is your pain located? _____

What are your current symptoms? _____

When (***Please provide Date***) did the injury or problem occur? _____

First episode: _____ Second episode: _____ Third episode: _____

How did the injury or problem occur? _____

_____

Rate your pain using a 0-10 scale (0 = no pain, 10 = worst possible pain)

Worst Pain since Onset: _____ Least Pain since Onset: _____ Today's Pain: _____

What diagnostic test have you had for this problem?

□ X-ray □ MRI □ CT Scan □ Bone Scan □ EMG / NCV □ Other: _____

What medications are you currently taking for this problem? _____

List other medications: _____

Have you had any injections for this problem? □ No □ Yes; when? _____

Have you had surgery for this condition? □ No □ Yes; when? _____

List other surgeries: _____

What makes your pain/problem Better? _____

What makes your pain/problem Worse? _____

Is there pain at night? □ No □ Yes In what position do you sleep best? _____

Is your pain: □ CONSTANT or □ INTERMITTANT

Is your pain satisfactorily controlled now? □ No □ Yes

Therapist's Comments: _____

_____

Are you exercising at home? □ No □ Yes; explain:_____

Are you using heat or cold? □ No □ Yes; explain: _____

Are you using a brace or sling? □ No □ Yes; explain: _____

When do you see a doctor for a follow-up appointment? _____

EMPLOYMENT HISTORY:

Are you currently working? □ No □ Returned □ Disabled □ Yes; where?_____

Are your work duties: □ Full □ Restricted Number of Days Missed: _____

What are your current duties or job description? _____

_____

What duties at work are restricted by your problem? _____

_____

FUNCTIONAL ASSESSMENT: Rate your abilities using the following scale.

Circle the number that best describes your ability for each area listed.

1 = Can do without difficulty 3 = Can do with great difficulty

2 = Can do with some difficulty 4 = Can't do at all

Lying down	1 2 3 4	Overhead reaching	1 2 3 4
Sitting	1 2 3 4	Driving a car	1 2 3 4
Standing	1 2 3 4	House work	1 2 3 4
Walking	1 2 3 4	Yard work	1 2 3 4
Jogging / Running	1 2 3 4	Self-Dressing / Hygiene	1 2 3 4
Going up stairs	1 2 3 4	Sexual activity	1 2 3 4
Going down stairs	1 2 3 4	Talking / Swallowing	1 2 3 4
Lifting / Carrying	1 2 3 4		

Therapist's Comments: _____

_____

How do you learn best? □ Demonstration □ Listening □ Video □ Reading

What are your desired outcomes with therapy? _____

_____

Therapist's Comments: _____

_____

To the best of my knowledge and belief, the information I have provided is complete and true. I herby give my consent to receive therapy services at Colquitt Regional Medical Center. I understand and agree with the treatment plan and goals that have been discussed with me.

Patient Signature: _____

Caregiver / Significant Other Signature: _____

Therapist Signature: _____

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Rehabilitation Services Guidelines

Welcome to the Vereen Rehabilitation Center! We are delighted that you have chosen us to serve you. While you are under our care we will do everything we can to assist you. Our goal is to meet your needs in the most caring and efficient way. In order to do this, we have developed the following policies for our department. We will be happy to answer any questions you may have.

Office Hours	Monday-Friday 8:00 A.M to 5:00 P.M.
Appointments	If you cannot keep an appointment, we request at least *24 Hours Notice*.
Missed Appointments	When scheduled appointments are missed without being cancelled, your therapist will make at least three (3) attempts to contact you regarding these missed appointments. You or your child may be discharged under your therapist's discretion if he/she is unable to contact you. We will also notify your physician of the situation.
Excessive Cancellations	In order for you/your child to make the most progress in the shortest amount of time, it is important to attend therapy on a consistent basis. If an excessive amount of appointments are missed in a one-month period, your therapist will attempt to contact you regarding the situation. If the situation cannot be resolved, you/your child will be discharged at the discretion of your therapist and your physician will be notified.
Arriving On Time	Please make sure you are on time for you appointment. Arriving late could result in your appointment being rescheduled. It is not our desire to reschedule a patient who is tardy; however, due to the nature of the service and the volume of patients scheduled we simply have no choice. We realize there are sometimes extenuating circumstances and this will be taken into consideration. Please let us know if you have any questions or concerns.
Registration	All patients are required to register on the first visit of each month. This is beneficial for both patient and facility. Registering monthly ensures accurate insurance information, preventing the undesirable event of your claims being denied.
Fees & Payments	If you do not have insurance, we ask that you accept the responsibility to inform your therapist who will notify appropriate staff to involve a hospital financial counselor. The counselor will assist you by setting up a monthly payment plan.
Prior Authorization	Some insurance companies require prior authorization for rehabilitation services. This is the patient's responsibility. Therefore we ask you to work with us by informing us when prior authorization is required. We will be happy to assist you with obtaining authorization.

We want to make your experience as comfortable and pleasant as possible. We are glad have chosen the Vereen Center to treat you!

Therapist Signature

Patient Signature

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the YMCA

Vereen Rehabilitation Center has partnered with the Moultrie YMCA to offer an 8-week medical based wellness program. This free-of-charge program is based upon physician and therapist referral and is initiated upon discharge from therapy.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize the Vereen Rehabilitation Center and treating physician(s) to release any information acquired in the course of my examination and treatment in connection with this outpatient rehabilitation for the purpose of participation in the YMCA medical based wellness program.

_____ _____

Signature of Patient or Legal Representative *Date*

_____

Printed Name of Patient or Legal Representative

If signed by Legal Representative, list relationship to patient: _____

_____ _____

Signature of Witness *Date*