Encompass Health
Valley of The Sun
Rehabilitation Hospital

Outpatient information record/history assessment

GENERAL INFORMATION

Name _____

Sex ☐ M ☐ F **Marital status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Daytime phone _____ Alternate/cell phone _____

Home phone _____

Address _____

City _____ State _____ Zip _____

Name of parent/guardian/caregiver _____

Relationship _____ Home/work phone_____

Primary care physician _____

Phone _____ Fax _____

Emergency contact _____

Relationship _____ Home/work phone _____

Known allergies: ☐ None ☐ Yes _____

_____

Adverse reactions to medications: ☐ None ☐ Yes _____

_____

To be completed by therapists on subsequent visits as change occurs.

UPDATES with therapists initials/date/time	UPDATES with therapists initials/date/time

Primary language spoken_____Caregiver language spoken _____ Date of birth: _____ Age:_____

Level of education ☐ 0-7 ☐ 8-12 ☐ College Caregiver ☐ 0-7 ☐ 8-12 ☐ College

Is your condition due to the ☐ Auto accident ☐ Fall ☐ Work injury ☐ Other _____ Date of onset _____

If this is a work injury, where were you working when the injury occurred? _____

Employer _____ Occupation_____ Last day worked _____

Employer address _____ Phone_____

If your primary insurance is Medicare and you have sustained an injury, please describe in detail how and where this injury occurred

_____

What is the problem that brings you to therapy? _____

Are there any cultural or religions beliefs that may impact your care? ☐ Yes ☐ No Please explain: _____

_____

At the present time, would you say that your health is (choose one of the following) ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Is there anything we need to know that is not covered on this form? Comments: ☐ No If so, please explain: _____

_____

What are your goals for therapy:_____

_____

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Surgeries/hospitalizations (include dates)

CURRENT PROBLEM					
	YES	NO	COMMENTS	** To be completed by therapists on subsequent visits as change occurs. **	
Bowel/bladder				**UPDATES with therapists initials/date/time**	**UPDATES with therapists initials/date/time**
Headaches					
Blurry/double vision/dizziness					
Shortness of breath					
Smoking/alcohol/street drugs					
Sleeping/fatigue					
Weight loss/gain					
Nausea/vomiting					
Skin/swelling					
Chest pain					
Falls/near falls					
Other					

MEDICAL/SURGICAL HISTORY					
	YES	NO	COMMENTS	To be completed by therapists on subsequent visits as change occurs.	
Respiratory: COPD, asthma/TB				**UPDATES with therapists initials/date/time**	**UPDATES with therapists initials/date/time**
High/low blood pressure					
Heart disease/heart attack/pacemaker					
Circulation/vascular					
Arthritis/osteoporosis/joint replacement					
Pregnancy					
Diabetes mellitus					
Cancer					
Kidney/urinary/intestinal trauma					
Epilepsy/seizures					
Stomach/gastrointestinal					
Neurological conditions/stroke					
Head or spinal cord injury					
Psychiatric history/depression					
Other					

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CURRENT MEDICATIONS ☐ NONE ☐ SEE ATTACHED LIST			
		To be completed by therapists on subsequent visits as change occurs.	
PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS/OTC DRUGS	DOSAGE/FREQUENCY	UPDATED PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS OTC DRUGS/DOSAGE/FREQUENCY Initials/date/time	UPDATED PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS OTC DRUGS/DOSAGE/FREQUENCY Initials/date/time

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist. If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients. We are obligated to record all cancellations and no shows in your medical record. If you are covered by worker's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier.

☐ **Patient/caregiver unable to complete form; information reviewed and completed by therapist.** _____ **Initials**

Name of person completing form: _____ Date: _____

_____ _____ _____ _____
Clinical signature/title/initials Date/time Clinical signature/title/initials Date/time

_____ _____ _____ _____
Clinical signature/title/initials Date/time Clinical signature/title/initials Date/time

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Patient's additional information:

Date	Therapist's notes/updates:	Initial/date/time

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Patient Identification

Consent to treatment (Outpatient Department)

Patient name:_____ M.R.# _____

Welcome! This form is designed to make sure you have the information you need to make an informed decision about being treated at this hospital Outpatient Department.

Our admitting staff, case managers, and other administrators will be happy to help you get all the information you need in order to enable you to provide us with your informed consent to be treated at our hospital Outpatient Department.

1. **Consent to Medical Treatment.** As the patient or agent of patient, I hereby consent to being treated at Encompass Health Valley of The Sun Rehabilitation Hospital (the "Hospital").

   I authorize employees of the Hospital to treat me while I am a patient. ("Employees"). Employees of the Hospital include therapists, nurses, and other clinicians who work under the clinical supervision of qualified and licensed clinicians.

   I authorize practitioners who have been granted Clinical Privileges at the hospital Outpatient Department and hold a license, certificate, or other credentials as required by a Licensure Entity ("Independent Practitioners") to provide me healthcare services within the scope of his or her State license while I am a patient of this hospital Outpatient Department. Independent Practitioners are not employed by the hospital and include, but are not limited to, physicians, nurse practitioners, physician assistants, psychologists, and podiatrists, in addition to clinical students, residents and fellows providing care under the appropriate clinical supervision.

   I authorize treatment that includes examinations, treatments, and/or diagnostic procedures under the direction of an Independent Practitioner as may be necessary for my medical care at the Hospital including, without limitation, specialized therapies, pain management, and other treatments and interventions under the general and specific instructions of an Independent Practitioner(s).

   I further consent to the presence of medical, nursing, and other healthcare practitioners who are not Employees or Independent Practitioners and who may not be directly involved in my medical treatment and care but who serve in educational or training functions. I acknowledge that I may be required to sign additional consent forms for certain specific medical treatments or procedures to confirm that I have received all the information I need to make an informed decision.

2. **Desire for Resuscitative Measures.** Services in an outpatient rehabilitation therapy setting are generally performed to enhance or improve the patient's quality of life. Therefore, it is the Hospital's policy that if you suffer a cardiac or respiratory arrest or other life-threatening situation while you are under our care, resuscitative measures will be initiated and you will be transported to an acute care hospital as appropriate in the clinical judgment of emergency responders.

Patient Identification

We respect your right to make decisions regarding your medical care. If you have an advance directive that you wish to be followed should a higher level of care be required, we request that you bring a copy of your advance directive with you to each visit. In the event that you must be transported to an acute care hospital, a copy of your advance directive will be provided to emergency responders to be taken with you.

I acknowledge that, in the event of a cardiac or respiratory arrest or other life-threatening situation, resuscitative measures will be initiated and I will be transported to an acute care hospital as appropriate in the clinical judgment of emergency responders.

3. **No Guaranteed Outcome.** I understand that the practice of medicine and the delivery of healthcare services are not exact sciences, and I acknowledge that no guarantee has been made to me as to the effect, result, or outcome of any examination or treatment I may receive at the Hospital. I acknowledge that the Hospital is not responsible for any consequences of my failure to follow the instructions of any Employee or Independent Practitioner who provides me care and/or treatment while I am receiving treatment at the Hospital.

4. **Financial Agreement.** I understand that I am obligated to pay the Hospital's usual and customary charges for all services I received at the Hospital Outpatient Department. I understand that failure to pay these charges within 120 days of receipt of the bill may result in a referral to an agency or attorney for collection. If my account is referred to a collection agency or attorney, I agree to pay the reasonable attorney fees and collection expenses associated with these collection efforts. I understand that I may be asked to sign a separate financial agreement for all amounts not covered under an insurance policy, healthcare service plan, and/or managed care program or by any other third party payor. I also understand that it is my responsibility to pursue resolutions for benefit reductions or non-payment by insurers or third party payors.

   I understand and acknowledge that, if I am a member of a healthcare service plan or covered under a managed care plan, it is my responsibility to provide the Hospital the name of the plan, my primary care physician's name and telephone number, confirmation of eligibility under the plan, and any other relevant information.

5. **Assignment of Benefits.** I hereby irrevocably assign and transfer directly to the Hospital all rights provided by any insurer or third party payor for services I received during my stay at the Hospital Outpatient Department. I understand that I am responsible for providing the Hospital with information necessary to allow the Hospital to bill my insurance carrier or other provider of medical benefits. I understand I may be financially responsible for payment of any charges not paid by insurance or other third party, including if I have no insurance or coverage is denied or coverage is terminated during the course of my outpatient admission. I further understand the Hospital is not responsible for filing any claims or collecting any insurance benefits on my behalf. I also understand that the Hospital is not responsible for negotiating a settlement on a disputed claim, and that I may be responsible for the timely payment of my account(s) related to the services I received at the Hospital Outpatient Department. I certify that the information given by me in applying for, or assigning, payment to any third party payers, including Medicare or Medicaid, is correct. I agree to request payment from all third party payers, including authorized Medicare or Medicaid benefits, be paid to the Hospital Outpatient Department on my behalf for services I received at the Hospital Outpatient Department. I authorize the Hospital to release information about me if necessary to receive payment for services I received while at the Hospital Outpatient Department.

Patient Identification

6. **Consent to Testing.** I understand that the law may allow for testing in the event a healthcare worker is exposed to blood or bodily fluids to ensure that the healthcare worker has not been put at risk for a communicable disease for which he or she may need treatment. If a healthcare worker is exposed to a communicable disease, I consent to Hospital team members drawing my blood and running tests for communicable diseases. I understand that I will not be responsible for the cost of this testing and that I can choose whether or not I want to be informed of the test results.

7. **Patient Valuables.** The Hospital recommends that patients leave any and all valuables at home when receiving treatment at the hospital Outpatient Department. I understand that the Hospital is not liable for damage to, or loss or theft of, any personal property of mine.

8. **Consent to Photograph.** This consent authorizes the Hospital to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment (including wound care), payment and healthcare operations of the Hospital. Any photographs or other images taken will become part of my medical record. The Hospital will not use such photographs or images for any other purpose without my specific written authorization.

9. **Patient Rights and Responsibilities.** As our patient, you have the right to safe, respectful and dignified care at all times. You will receive services and care that are medically suggested and within the Hospital's services, its stated mission, and required law and regulation. We ask that you recognize and respect the rights of other patients, families and staff. Threats, violence or harassment of other patients and Hospital Employees and staff will not be tolerated.

_____
Initials

I acknowledge that prior to receiving services at the Hospital I was provided a written copy of the Patient's Rights and Responsibilities statement informing me of my rights and responsibilities while receiving services at the Hospital.

10. **Disclosure of Health Information.** HIPAA allows you to restrict the use and/or disclosure of health information to your current health plan if your medical services or products are paid for in full as "out of pocket" expenses.

    ☐ I hereby request a restriction as described above on the use and/or disclosure of my health information my current health plan. I understand that this request requires payment for the medical services I received while in the Hospital in full as an out of pocket expense.

Name of Health Plan Restricted from Use/Disclosure: _____

Name of Subscriber: _____

Policy Number: _____

Patient Identification

I hereby acknowledge that prior to my receiving treatment at the Hospital Outpatient Department, I have read and understand this Consent to Treatment. By my signature below, I accept all terms and conditions. If I am executing this document on behalf of this patient, I certify that I have the authority to execute this form on behalf of the patient.

Patient signature

Personal representative signature

Personal representative (print)

Date

Relationship of representative to patient

Time

Witness signature

Encompass Health
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Acknowledgement of receipt of Notice of Privacy Practices*

You may refuse to sign this acknowledgement

The Hospital will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for the other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our hospitals and have copies for distribution.

I, _____, have received a copy of this hospital's Notice of Privacy Practices.

_____
Please print name

_____
Signature

_____
Relationship to patient

_____
Date/Time

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

☐ Individual refused to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (please specify) _____

_____

_____

_____ _____
Signature Date/Time

THE PATIENT IS ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT

Include completed acknowledgement in the patient's Medical Record

Revised 11/18/15

REORDER # EH-FM-453pt2

Encompass Health
Valley of The Sun
Rehabilitation Hospital

Accident questionnaire

If patient admission to the IRF is the result of an accident, please complete sections 1-5 below and the applicable accident/injury section:

1. **Patient name** _____
2. **Patient account #**_____ **Medical record #** _____
3. **Date of accident/injury?** _____
4. **Where did accident/injury occur?** _____
5. **Type of accident/injury** ☐ **MVA** ☐ **W/C** ☐ **Other**

   a) **If motor vehicle (MVA)**

      i. Was a police report filed? ☐ Yes ☐ No

         1. If yes, how can we obtain a copy of police report (case number, precinct, officer name etc)?

            _____

         2. Was this MVA patient's responsibility or other party?_____
         3. Based upon determination of fault, is patient's auto liability or other party's auto liability policy covering damages (unless No-fault state)?

            _____

         4. Name and telephone information of auto insurance handling auto liability coverage (patient and other parties)

            _____

            _____

         5. Will there be a lawsuit filed? ☐ Yes ☐ No If yes, complete section d.

   b) **If OTHER accident, please describe:** _____

      1. Was a police report filed? ☐ Yes ☐ No
      2. If yes, how can we obtain a copy of police report (case number, precinct, officer name, etc)?

         _____

      3. Will there be a lawsuit filed? ☐ Yes ☐ No If yes, complete section d.
      4. Is other party's homeowners policy and/or liability insurance involved in payment of medical expenses? ☐ Yes ☐ No
      5. Name and telephone information of liability insurance. Agent handling case.

         _____

c) **Workers Compensation**

a) If illness/injury was work related was a report filed with the employer? ☐ Yes ☐ No

b) Does the patient expect to receive or have they received W/C benefits? ☐ Yes ☐ No

Employer name: _____

Employer address: _____

Employer phone #: _____

W/C carrier and phone #: _____

Comments: _____

d) **If patient answered "Yes" to a lawsuit**

1. Name and telephone number of attorney.

   _____

2. Who is the suit against? _____

Information taken by:_____ Date/Time: _____

REORDER # EH-FM-516

Encompass Health
Valley of The Sun
Rehabilitation Hospital

Medicare secondary payor questionnaire (MSPQ)

1. **OP ONLY:** Are you currently being seen by a Home Health Agency? **Yes or No**
   If YES: provide information: Agency name and phone number: _____

2. Has patient received Hospice care in the last 6 months? **Yes or No (Go to #3)**
   If YES: provide information: Agency name and phone number _____

3. Are you covered by:
   a. Black Lung or Gov't Research? **Yes or No If YES:** Benefit start date: _____
   b. Are you a Veteran? **Yes or No**
      i. **If Yes** do you have benefits through a VA hospital **Yes or No**
      ii. **If Yes** which hospital _____
      iii. **If Yes** when was the last time you were seen at a VA hospital _____
   If A or B is YES: STOP Verify Benefits - if benefits cannot be verified immediately or are **NOT** approved **continue** but have Veteran sign the VA Admission form

4. Was illness or injury due to an accident? **Yes or No (If No go to #5)**
   If Yes: What type: Auto / patient fell / Workers Comp / Other **Accident Date:**_____
   If Yes: Complete the Accident form

5. Are you entitled to Medicare based on age? **Yes or No**
   Are you entitled to Medicare based on disability? **Yes or No**
   Are you entitled to Medicare based on ESRD? **Yes or No (If NO go to #7)**

6. Have you received a kidney transplant? **Yes or No** Date of Transplant_____
   Have you received maintenance dialysis? **Yes or No** Date began_____
   Are you within the 30 month coordination period? **Yes or No (Go to #7)**

7. Are you currently employed? **Yes No Never** Date of Retirement_____
   I**f Yes: Does patient have the company's insurance? (If NO go to #8)**
   If Yes: provide information below, then go to #9
   Patient Employer Name _____
   Patient Employer Address _____
   Name of Insurance _____
   Policy and Group Number _____

   If patient is MC eligible and has insurance through employment, that Insurance <u>normally</u> will be primary and MC would be secondary.

8. Do you have a spouse currently employed? **Yes No Never** Date of Retirement_____
   If Yes: Is patient on this policy? Yes or No **If No: PATIENT'S MEDICARE IS PRIMARY**
   If Yes: Fill in information below, then go to #9 **STOP HERE!**
   Spouse Date of Birth _____
   Spouse Employer Name _____
   Spouse Employer Address _____
   Name of Insurance _____
   Policy and Group _____

   If patient is MC eligible and the spouse is working and has the patient under their insurance plan, that Insurance <u>normally</u> will be primary and MC would be secondary.

9. Does this Group Health Plan employer have 20 or more employees? **Yes or No**