REHAB XCEL, LLC.
NEW PATIENT INFORMATION

DATE: _____
NAME:
LAST: _____ FIRST: _____ MID: _____

MAIL ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____

WORK PHONE: _____

DATE OF BIRTH: _____SS#_____ SEX: M OR F

EMERGENCY CONTACT: _____ PHONE: _____

MARITAL STATUS: M OR S DATE OF INJURY: _____

ARE YOU BEING SEEN BY A HOME HEALTH AGENCY? _____

WHOM MAY WE THANK FOR REFERRING YOU TO US? (CIRCLE) FRIEND_____

SELF REFERRAL DR._____ DIRECT MAIL BILLBOARD

NEWSPAPER AD YELLOW PAGES

EMPLOYER: _____
NAME ADDRESS CONTACT PERSON

INSURED'S NAME: _____ RELATIONSHIP: _____

INSURED'S SS#_____ INSURED'S DOB: _____

REFERRING PHYSICIAN: _____

DATE OF NEXT APPOINTMENT: _____

I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT.

SIGNATURE OF PATIENT RELATION TO PATIENT DATE
18 YEARS OR OLDER

PATIENT MEDICAL HISTORY & PHYSICAL CONDITION

Answers to following questions will assist the therapist in providing a safe and effective treatment program.

NAME: _____ AGE: _____

REFERRING PHYSICIAN: _____

PROBLEM TO BE TREATED: _____

Have you been treated for this problem before? YES NO
If yes, state specifics_____

Have you had surgery assoc. with this problem? YES NO
Please list date and type_____

_____

Other major illness or surgery in the past year? _____

Are you currently taking medications? YES NO
Please list_____

_____

Have you had any of the following at any time?

High Blood Pressure	Y	N	Sensitivity to Heat or Ice	Y	N
Heart Disease	Y	N	Allergies	Y	N
Pacemaker	Y	N	Diabetes	Y	N
Seizures	Y	N	Metal Implants	Y	N
Balance Problems	Y	N	Plastic Implants	Y	N
Vision Problems	Y	N			

Please explain and give approx. dates_____

Please list any other medical conditions that would interfere with treatment._____

_____

The above information is correct to the best of my knowledge.

Patient_____ Date_____

Therapist_____ Date_____

REHAB XCEL, LLC
RELEASE AND ASSIGNMENT

TO MY INSURANCE CARRIER(S):

1. I authorize the release of any medical information necessary to process my insurance claim(s).

2. I authorize and request payment of medical benefits herein specified and otherwise payable to me, directly to Rehab Xcel, LLC. I understand that I am ultimately responsible for payment of all charges incurred for my therapy.

3. I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

4. I agree that a photocopy of this form may be used in lien of the original.

INFORMED CONSENT

5. I AUTHORIZE Rehab Xcel, LLC to render treatment to me as ordered by my physician and grant permission to Rehab Xcel, LLC to obtain my medical records from my physician.

6. As parent / guardian of _____ (minor child) I release him / her in the care of the physical / occupational therapist as prescribed by his / her physician.

Patient's name

_____ _____

Signature of patient or parent / guardian Date

REHAB XCEL OF EUNICE, LLC
PATIENT INFORMATION CONSENT FORM

I have read and fully understand REHAB XCEL OF EUNICE, LLC's Notice of Information Practices. I understand that REHAB XCEL OF EUNICE, LLC may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating that quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that REHAB XCEL OF EUNICE, LLC PT/OT will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in REHAB XCEL OF EUNICE, LLC's Notice of Information Practices. I understand that I retain the right to revoke this on sent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

REHAB XCEL OF EUNICE, LLC
NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

REHAB OF EUNICE, LLC LEGAL DUTY

REHAB XCEL OF EUNICE, LLC is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described within.

USES AND DISCLOSURES OF HEALTH INFORMATION

REHAB XCEL OF EUNICE, LLC uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, REHAB XCEL OF EUNICE, LLC may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health-related benefits that could be of interest to you.

REHAB XCEL OF EUNICE, LLC may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, REHAB XCEL OF EUNICE, LLC's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

REHAB XCEL OF EUNICE, LLC may change its policy at any time. When changes are made, a new Notice of Information Practice will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in an emergency circumstance. REHAB XCEL OF EUNICE, LLC will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that REHAB XCEL OF EUNICE, LLC may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on REHAB XCEL OF EUNICE, LLC's health information practice or if you have a complaint, please contact the following person:

REHAB XCEL OF EUNICE, LLC
Office administrator
441 MOOSA BLVD., EUNICE, LA 70535
Telephone: (337) 457-8164 Fax: (337) 546-6515