For office use only:
Start of Care:___________________
ICD-9 Codes:___________________

***Patient Information*:**

Name: _______________________________ Home Phone:_______________________

Address: _____________________________ Work Phone:_______________________

City: _______________ State: IL Zip: _______ Cell Phone:_______________________

Patient Date of Birth:_____________________ Social Security No:_________________

Policy Holders Date of Birth:_________________ Marital Status: Married/Single/Widowed/Divorced

Date of Injury or Onset of Symptoms:____________ Email: ___________________________

In Case of Emergency:

If married, please provide spouse's name:________________ Work Phone: _________________

Nearest relative not living with you:____________________ Phone: _____________________

Nearest friend not living with you: ____________________ Phone: _____________________

In an emergency, whom would you like us to contact: _______________________________

Landlord: _______________________________ Phone: _____________________

Physician:

Physician: __________________ Phone #: ____________ Fax #: __________________

Address: ________________________ City: __________ State: _____ Zip: _______

Insurance:

Type of Insurance: Medicare **Do you have any other insurance coverage**: **YES** **NO**

Who is responsible for this bill?____
Whom may we thank for referring you? ____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information and have completed all the answers. I certify that this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or in the above information.

Should it become necessary for City Center Rehabilitation West, Inc to send a patients account to a collection agency, the patient will be responsible for any and all fees associated with the collection effort of the account to include reasonable attorney fees, court costs, collection charges and interest.

_______________________________________ ________________________
Signature Date

PATIENT HISTORY

1. Please list any current medical problems or reason for therapy:
____
____

2. Please list your current medications and dosages:
____
____
____

3. Please list any surgeries related to this problem:
____

4. Please list any tests related to current problem, i.e. xray, MRI, etc.:
____

5. Please list any treatments related to current problem, i.e. physical therapy, chiropractic, injections, etc.:
____

6. Please list any other surgeries you have had:
____
____

7. Please check any present or past medical problems:

- □ Heart Problems
- □ Cancer
- □ Hypertension
- □ Diabetes
- □ Seizures
- □ Fractures
- □ Arthritis
- □ Osteoporosis
- □ Circulatory Problems
- □ Respiratory Problems
- □ Allergies
- □ Vision Problems
- □ Hearing Problems
- □ Other: ________________________

8. Have you fallen 2 or more times in the last 12 months? Yes No

9. Are you here because you fell? Yes No

10. Do you have difficulty with walking or balance? Yes No

Patient signature:____ Date:______________

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO CITY CENTER REHABILITATION WEST, INC.

Patient:____

Employer:____

Claim# or Group #:____

SSN# or ID #:____

I hereby instruct and direct that ____________________________(name of insurance company) to pay by check made out and mailed to:

City Center Rehabilitation West, Inc.
1627 4th Street
Peru, IL 61354

Or

If my current policy prohibits direct payment to the therapist/clinic, then I hereby also instruct and direct you to make out the check to me and mail it as follows:

Patient Name
c/o City Center Rehabilitation West, Inc.
at: 1627 4th Street
Peru, IL 61354

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment towards the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Dated at: City Center Rehabilitation West, Inc this ________ day of _______________, 20___.

_____________________________________ _____________________________________
Signature of Policy Holder Witness

____
Signature of Claimant if other than Policy Holder

INSTRUCTIONS: Rate your major area of pain on the 1-10 pain rating scale. Write down the number of your pain at the present time, your best time, and your worst time over the past 30 days. Remember the number refers to your pain. Not how strong or weak you feel. Number 1 is the low minimal pain and number 7 is low intense pain.

10	9	8	7	6	5	4	3	2	1	0
Unbearable	High Intense	Intense	Low Intense	High Moderate	Moderate	Low Moderate	High Minimal	Minimal	Low Minimal	No Pain

YOUR PAIN RATING:

Pain now: __________

Best day: ___________

Worst day: __________

I am getting _____ better ______ worse
_______staying the same these last 2 months.

Areas of discomfort:

Location: _______________________
____

Description: _____________________
____

When does it occur:_______________
____
____

How often does it occur? __________
____

What do you do to relieve your pain?
____
____

XXX – Pain
OOO- Numbness

I am __________% ready to return to work.

City Center Rehabilitation West, Inc

ACKNOWLEDGEMENT OF RECEIPT
OF NOTICE OF PRIVACY PRACTICES

I, ___________________________________ have received a copy of City Center Rehabilitation West, Inc. Noticy of Privacy Practices. I have read and understand my rights re: the privacy of my medical records.

____

Patient Signature Date

____

Guardian Signature (if applicable) Date

____

Witness-CCRW Date