CITY CENTER
REHABILITATION

For office use only:
Start of Care:_____
ICD-10 Codes:_____

***Patient Information*:**

Name: _____ Home Phone:_____

Address: _____ Work Phone:_____
May we contact you at work? YES NO

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: (Please circle) **Workers Compensation** **Private Healthcare** **Medicare** **Auto** **Other**

Insurance Company: _____ Phone#: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID #: _____ Group/Policy #: _____ Claim #: _____
(if accident related)

Do you have any other insurance coverage: **YES** **NO**
If YES, Please indicate secondary insurance information:

Insurance Company:_____ Phone#: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

ID#: _____ Group/Policy # : _____

Employer:

Are you employed: YES NO

Employer:_____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Job Title: _____ Contact Person: _____

Attorney:

Do you have an attorney representing you that may be requesting medical record? YES NO

If Yes: Name: _____ Phone#: _____

Address: _____ City: _____ State: _____ Zip: _____

Case Manager:

Do you have a Case Manager assigned? YES NO

If YES:
Rehab Case Manager Name: _____ Phone #: _____

Company: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip:_____

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

_____ _____
Parent (if minor) Date

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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. For females, are you pregnant? Please circle: Yes No

9. Height: _____ Weight: _____

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

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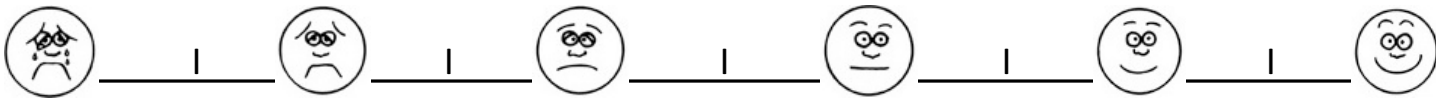
INSTRUCTIONS: Rate your major area of pain on the 1-10 pain rating scale. Write down the number of your pain at the present time, your best time, and your worst time over the past 30 days. Remember the number refers to your pain. Not how strong or weak you feel. Number 1 is the low minimal pain and number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

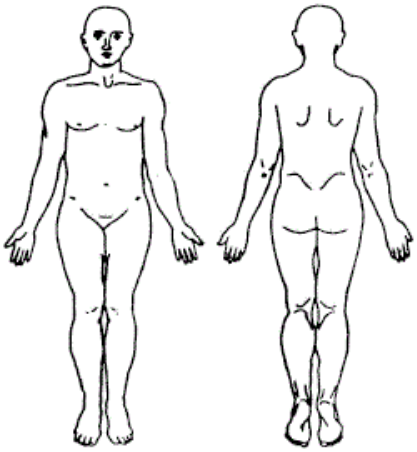
YOUR PAIN RATING:

Pain now: _____

Best day: _____

Worst day: _____

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



XXX – Pain
OOO- Numbness

Areas of discomfort:

Location: _____
_____

Description: _____
_____

When does it occur:_____
_____
_____

How often does it occur? _____
_____

What do you do to relieve your pain?
_____
_____

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. Notice 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