Adult Therapy
Patient Demographics

PATIENT INFORMATION

First Name:	Last Name:	Middle:	Sex: (circle) Male Female	Date of Birth:	Age:

Primary Phone: □ Cell □ Home ( )	Alternative Phone: □ Cell □ Home ( )	Email Address:
May we text appointment reminders to the above provided cell phone: □ Yes □ No	May we leave a voicemail to the above provided phone(s): □ Yes □ No	May we email PHI/ePHI to the above provided email address: □ Yes □ No

Street Address:	APT #	PO Box	City, State, ZIP Code:

Social Security Number:	Marital Status (circle): Single Married Divorced Separated Widowed	Do you have a DNR or living will: □ Yes □ No

Do you smoke: □ Yes □ No *If yes, number of packs/day*:

Employer:	Are you currently pregnant or think you might be pregnant? □ Yes □ No

THERAPY INFORMATION

Have you previously received outpatient Speech or Physical Therapy services at our facility or any other facility this year (as of January 1st)? □ Yes □ No	Are you receiving, or have you received, any Home Health services this year (as of January 1st)? □ Yes □ No *If yes, please provide name and address of the agency that provided services:*

EMERGENCY CONTACT INFORMATION

Name:	Relationship to Patient:	Phone: ( )

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder's Name:	Insurance Name:
Policy Holder's Social Security Number:	Policy Holder's DOB:

Policy/ID #:	Group #:	Effective Date:

SECONDARY INSURANCE

Policy Holder's Name:	Insurance Name:
Policy Holder's Social Security Number:	Policy Holder's DOB:

Policy/ID #:	Group #:	Effective Date:

If guarantor/responsible party is different from patient, please give the following information:

Name of Guarantor:	Relationship to Patient:	SSN:

Date of Birth:	If address or phone number is different from patient:

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Health History Information

PATIENT INFORMATION		
Full Name:		Date:
Primary Care Physician:	Height:	Weight:

Have you **RECENTLY** noticed any of the following (mark all that apply)?

□ headaches □ dizziness/lightheadedness □ nausea/vomiting □ changes in appetite
□ pain at night □ fever/chills/sweats □ shortness of breath □ changes in bowel or bladder function
□ weight loss/gain □ weakness/fatigue □ difficulty swallowing □ difficulty maintaining balance w/ walking

Have you **EVER** been diagnosed with any of the following conditions (mark all that apply)?

□ anemia □ heart disease □ thyroid problems □ kidney/liver problems
□ asthma □ lung problems □ parkinson's disease □ chemical dependency
□ stroke □ depression □ pacemaker inserted □ diabetes (type 1 or 2)
□ epilepsy □ osteoporosis □ multiple sclerosis □ cancer (type_____________________)
□ osteoarthritis □ high blood pressure □ rheumatoid arthritis □ other __________________________

FALL HISTORY	
Any history of falls in the last 12 months? □ Yes □ No	Date:

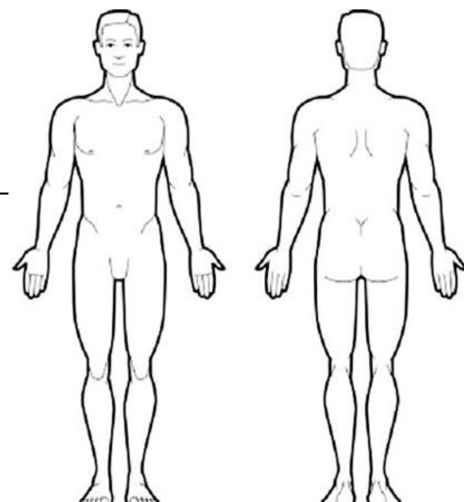
DESCRIPTION OF PROBLEM AREA		
Problem Area: □ Back □ Head/Neck □ Leg □ Arm □ Other (specify):		
Date of onset for this problem:		How did onset occur?
Surgery date (if applicable):		
Was this a work-related injury? □ Yes □ No	Was this an auto accident? □ Yes □ No	If applicable, state and location where auto accident occurred:

Please list surgeries or other conditions for which you have been hospitalized, including dates:
____

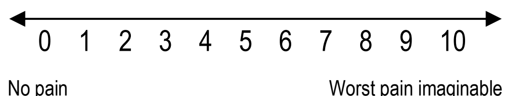
For the injury you are seeing us for today:

Body Chart: Please mark the location of your pain and type of pain on the chart.

X = sharp stabbing pain
0 = dull, achy pain
□ = numb/tingling
// = throbbing
* = burning

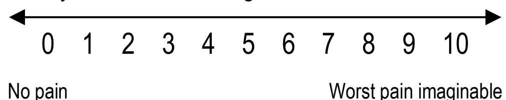


Rate your PAIN at the lowest in the **PAST 3 DAYS**:



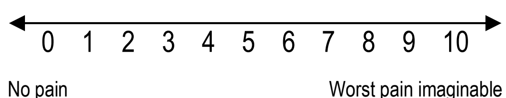
No pain Worst pain imaginable

Rate your PAIN at the highest in the **PAST 3 DAYS:**



No pain Worst pain imaginable

Rate your PAIN level **NOW:**



No pain Worst pain imaginable

What is your goal for therapy at this time? ____

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Notice of Policies

104 S. Washington
Junction City, KS 66441
Phone: 785.238.3747
Fax: 785.238.5514

CONSENT FOR TREATMENT

● I understand that I may have a condition requiring physical examination and/or medical treatment. I hereby voluntarily consent to such examination and treatment. I further acknowledge that no guarantees have been made to me as to the results of treatment provided by Geary Rehabilitation and Fitness Center. I also acknowledge that consent for examination and treatment does not constitute a medical diagnosis.

★ __________ *(initial)*

CANCELLATION / NO SHOW POLICY

● Due to our one-on-one, 30-60-minute treatments, missed appointments are a significant inconvenience to your therapy, the clinic, and other patients. Please, provide our office with 24-hour notice to change or cancel an appointment. Patients who do not attend a scheduled appointment or do not provide 24-hour notice to change a scheduled appointment may be responsible for a **$45.00 office visit charge**. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

★ __________ *(initial)*

FINANCIAL & PAYMENT AUTHORIZATION

● **It is your responsibility to understand your insurance plan limitation, benefits, deductibles, co-pays and co-insurance amounts.**
● You are responsible for payment of all amounts not covered by your insurance.
● If you have not met your deductible, your visit payment will be $50 per visit until that deductible has been met.
● If any past due balance is not paid at the time of your next appointment, you may be required to reschedule until payment is made.
● If you are unable to comply with our policy, payment arrangements can be made by calling our office.
● Any credit balance on your account at the end of treatment will be refunded as deemed appropriate.
● I authorize that the payment of my insurance benefits be made directly to Geary Rehabilitation and Fitness Center for all services rendered. If I am paid directly, I will promptly pay Geary Rehabilitation and Fitness Center all monies paid to me.
● I understand and agree that I am responsible for verifying my own insurance benefits. I agree to pay in full all charges shown on my billing statement upon receipt of the statement, unless other payment arrangements are made. It is agreed that payment will not be delayed or withheld because of any insurance claims pending or litigation. All process of insurance is assigned to this office where applicable. A copy of this assignment is as valid as the original. In the event legal action should become necessary to collect unpaid balance due for any services rendered, I agree to pay reasonable attorney fees or such costs as the court determines proper.
● I certify that the information I have provided Geary Rehabilitation and Fitness Center for payment including, but not limited to, related accident, illnesses, or other insurers is accurate and truthful.
● **If you have a set co-pay amount, that amount will be collected at each visit.** **CO-PAY AMOUNT: ______________**

★ __________ *(initial)*

NOTICE OF PRIVACY PRACTICES

● A copy of the Notice of Privacy Practice of Geary Rehabilitation and Fitness Center and patient Rights and Responsibilities are available online at www.gearyrehab.com/terms-policies. Patients may also receive a hard copy upon request. I acknowledge that I have had the opportunity to read this document and ask for clarification.

★ __________ *(initial)*

Signing below indicates you understand and agree to the terms of the Notice of Policies.

★ ______________________________ ______________________________ ________________

Signature (if under 18 guarantor sign) **Printed Name** (if under 18 guarantor name) **Date**

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Medication/Allergy List

PATIENT INFORMATION	
Full Name:	Date:
Please list all allergies (ex. latex):	

We can make a copy of your current medication list if you provide that at your first appointment.

Medication Name	Dosage

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