THE REHABILITATION GROUP, P.A. PATIENT INTAKE FORM

TODAY'S DATE: _____

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Name: _____

Gender: _____ Date of Birth: _____ SS: _____-_____-_____

Address: _____ City: _____State: _____ Zip Code: _____

Phone Number: _____ Alternate Number: _____

Would you like to access to our Patient Portal? Yes or No Email: _____

EMERGENCY CONTACT:

Name: _____ Phone: _____ Relationship: _____

REFERRING/PCP DOCTOR:

Name: _____

INSURANCE INFORMATION:

Insurance Co. Name: _____ Policy/ID: _____

Insured's Name (if other than patient): _____ Date of Birth: _____

Insured Relationship to patient: _____

WORKERS COMP INSURANCE INFORMATION:

Insurance Co. Name: _____ Claim Number: _____

Insurance Phone Number: _____ Insured's Employer's Name: _____

DOI: _____Diagnosis/compensable injury: _____

Adjuster: _____ Phone: _____ Fax: _____

Case Manager: _____ Phone: _____ Fax: _____

Patient's signature: _____

Guardian signature (if minor): _____

Date Signed: _____

The Rehabilitation Group, P.A.
2701 Babcock Rd, Ste A
San Antonio, TX 78229

210-614-3225
210-614-3231 (Fax)
(Referral Fax)
210-614-4381

Marc D. Pecha, M.D.**
Jahnavi R. Manocha, M.D.
Chaula J. Rana, M.D.
Jose A. Santos, M.D.

Diplomates
American Board of
Physical Medicine
and Rehabilitation

** Diplomate of American Board of Electrodiagnostic Medicine

*Physical Medicine & Rehabilitation

*Electromyography

*Medical Management of
- Amputee
- Stroke
- Spasticity
- Spinal Cord Injury
- Traumatic Brain Injury

*Injured Workers

*Sports Medicine

*Spine Care

*Repetitive Motion Disorders

*Geriatric Rehabilitation

AANEM Accredited Laboratory *Exemplary Status

TheRehabilitationGroup,com

Patient Financial Obligation Agreement
Information Disclosure and Consent

I understand that all applicable copayments and deductibles are due at the time of service. I agree to be financially responsible and make full payment for all charges not covered by my insurance company.

I authorize my insurance benefits be paid directly to **The Rehabilitation Group, P.A.** (**TRGPA**) for services rendered. I authorize representatives of **TRGPA.** to release pertinent medical information to my insurance company when requested or to facilitate payment of a claim.

I also understand that **TRGPA** does not accept third party insurance. I understand that if decide to be treated by a provider who does not accept my health plan, I will be asked to sign a consent form agreeing that I accept treatment from that provider**.**

I understand that any benefit verification provided to me by **TRGPA** is information received from my insurance carrier who states**, "The benefits are an estimation given and are not guarantee of payment",** which means that ***verification or preauthorization is not a promise of payment.***

I UNDERSTAND AND AGREE THAT (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE OF MY ACOUNT FOR ANY PROFESSIONAL SERVICES RENDERED BY TRGPA.

Notice of Privacy Practices: Acknowledgement of Receipt

I acknowledge that I was provided with a copy of the **The Rehabilitation Group, P.A.** Notice of Privacy Practices (NOPP).

□ Received

□ N/A (only if you received the notice from **The Rehabilitation Group, P.A.** previously)

I read and agree to all the above (Patient Financial Obligation Agreement, Notice of Privacy, Insurance Information). I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.

By signing this form, I attest that I have personally read this form (or had it explained to me) and fully understand and agree to its contents; have had my questions answered to my satisfaction and I understand that this document will become a part of my medical record.

If I am out of town temporarily, I will notify the office staff when my Telehealth visit is scheduled.

Patient or POA Printed Name _____

Signature _____ Date _____

The Rehabilitation Group, P.A.
2701 Babcock Rd, Ste A
San Antonio, TX 78229

210-614-3225
210-614-3231 (Fax)
(Referral Fax)
210-614-4381

Marc D. Pecha, M.D.**
Jahnavi R. Manocha, M.D.
Chaula J. Rana, M.D.
Jose A. Santos, M.D.

Diplomates
American Board of
Physical Medicine
and Rehabilitation

** Diplomate of American Board of Electrodiagnostic Medicine

*Physical Medicine & Rehabilitation

*Electromyography

*Medical Management of
- Amputee
- Stroke
- Spasticity
- Spinal Cord Injury
- Traumatic Brain Injury

*Injured Workers

*Sports Medicine

*Spine Care

*Repetitive Motion Disorders

*Geriatric Rehabilitation

AANEM Accredited Laboratory *Exemplary Status

TheRehabilitationGroup,com

Patient Acknowledgement
Telemedicine services Policy

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care provider to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of, and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting The Rehabilitation Group, P.A. office at 210-614-3225.
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

If I am out of town temporarily, I will notify the office staff when my Telehealth visit is scheduled.

Patient or POA Printed Name _____

Signature _____ **Date** _____

The Rehabilitation Group, P.A.
2701 Babcock Rd, Ste A
San Antonio, TX 78229

210-614-3225
210-614-3231 (Fax)
(Referral Fax)
210-614-4381

Marc D. Pecha, M.D.**
Jahnavi R. Manocha, M.D.
Chaula J. Rana, M.D.
Jose A. Santos, M.D.

Diplomates
American Board of
Physical Medicine
and Rehabilitation

** Diplomate of American Board of Electrodiagnostic Medicine

*Physical Medicine & Rehabilitation

*Electromyography

*Medical Management of
- Amputee
- Stroke
- Spasticity
- Spinal Cord Injury
- Traumatic Brain Injury

*Injured Workers

*Sports Medicine

*Spine Care

*Repetitive Motion Disorders

*Geriatric Rehabilitation

AANEM Accredited Laboratory *Exemplary Status

TheRehabilitationGroup,com

Authorization for Disclosure of Confidential Information

Patient Name: _____

Social Security Number: _____

Date of birth: _____

I authorize _____ to release the following information to:

The Rehabilitation Group, PA
2701 Babcock Rd, Ste A San Antonio, TX 78229
210-614-3225 fax 210-614-3231

Check all that may be released:

__ History/Physical __ Progress Notes __ Lab Reports
__ Radiology Reports __ Therapy Notes __ Psychological reports
__ Medication List __ EMG/ NCV __ OP/ Procedure Reports
__ Any and all records __ Other: _____

This authorization covers patient care from _____ to present.

Purpose of disclosure:
__ Medical care __ Insurance __ Attorney
__ Other: _____

The patient agrees that photocopy of this authorization may be considered valid. ____ YES ____ NO

This authorization will be valid for 365 days from the date of signature. The patient can revoke this authorization in writing at any time prior to the expiration date.

_____ _____
Patient Signature **Date**

The Rehabilitation Group, P.A.
2701 Babcock Rd, Ste A
San Antonio, TX 78229

210-614-3225
210-614-3231 (Fax)
(Referral Fax)
210-614-4381

Marc D. Pecha, M.D.**
Jahnavi R. Manocha, M.D.
Chaula J. Rana, M.D.
Jose A. Santos, M.D.

Diplomates
American Board of
Physical Medicine
and Rehabilitation

** Diplomate of American Board of Electrodiagnostic Medicine

*Physical Medicine & Rehabilitation

*Electromyography

*Medical Management of
- Amputee
- Stroke
- Spasticity
- Spinal Cord Injury
- Traumatic Brain Injury

*Injured Workers

*Sports Medicine

*Spine Care

*Repetitive Motion Disorders

*Geriatric Rehabilitation

AANEM Accredited Laboratory *Exemplary Status

TheRehabilitationGroup,com

Patient Acknowledgement

Appointment Cancellation Policy

TRG schedules appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That is why it is very important that you keep your scheduled appointment with us and arrive on time.

As a courtesy, and to help patients remember their scheduled appointments, TRG sends text message and email reminders two days in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact our office so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office, as well as to those patients who are waiting to schedule with the physician, please give at least two business days' notice.

If you do not cancel or reschedule your appointment with at least two business days' notice, we may assess a **$25.00** "no show" service charge to your account. This "no show charge" is not reimbursable by your insurance company. You will be billed directly for it.

After three consecutive no-shows to your appointment, our practice may decide to terminate its relationship with you.

I understand that I must cancel or reschedule any appointment at least two business days in advance to avoid a potential "no-show charge".

Email address: _____

Cell phone: _____

Patient Name: _____

Patient Signature: _____
Date: _____

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL: _____

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

Copyright © 1999 Pfizer Inc. All rights reserved. Reproduced with permission. PRIME-MD© is a trademark of Pfizer Inc.

A2663B 10-04-2005

Welcome to our practice! The answers to the following questions will be relied upon by Health Care Personnel for your medical history. Please help us determine the nature of your conditions by answering as completely and accurately as possible. Treatment solution(s) for your medical problem(s) depends upon the accuracy of your medical history given below.

Name of patient's PCP: _____

Do you have any allergies to any medications? YES NO If yes, please list the names of the medication(s) and reaction(s):_____
_____

Are you currently taking any medications? YES NO If so, please list the NAME of the medication and also the DOSAGE and DIRECTIONS:
_____
_____
_____
_____
_____

Do you have pain today? YES NO If so, on a scale of 0-10 (0= no pain and 10= extreme pain), please state what best matches your present pain level: _____ Location of greatest pain: _____

Review of Systems: Today, do you have:

Fever	Yes	No
Chest pain	Yes	No
Abdominal pain	Yes	No
Night sweats	Yes	No
Nausea/vomiting	Yes	No
Diarrhea	Yes	No
Skin rash	Yes	No
Weight change in the past 2 months	Yes	No
Recent falls in the past 2 months	Yes	No

Is there a family history of any disease? YES NO If yes, please list the family member and which disease:
_____
_____

Please list prior surgeries:
_____
_____

Tobacco use: YES NO If so, how much? _____

Alcohol use: YES NO If so, how much? _____

Please circle one dominant hand: Right handed Left handed

Have you had a Colonoscopy? YES NO Date: _____ Results: _____

Have you had any other colon cancer testing done (FOBT, Flex Sig, CT of Colon, FIT-DNA): YES NO

Test: _____ Date: _____ Results: _____

NAME: _____ DATE: _____