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 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
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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

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** _________________

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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** ________________

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Disorders

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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**

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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	______

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The Rehabilitation Group, PA. New Patient Intake Form

Patient Name: ____ Date: ________________________

CHIEF COMPLAINT/HISTORY OF PRESENT ILLNESS

What is the reason for today's visit: ____

Who is with you today? ______________________________________ Date of Injury or Start of condition: ____________

How did your complaints start? ____

Work related? **YES** or **NO. If yes, please complete:** DOI: _____________ Treating Doctor: _________________________

Diagnosis and Body areas covered by W Comp: ____

(Please leave this blank for doctor.)

Do you have Pain today: **YES** or **NO** Location of pain: ____

Quality of pain: dull/ stiffness/ aching/ burning/ throbbing/ radiating/sharp/cramping/stabbing or other: _____________

Duration of pain: acute/ intermittent/ chronic/ occasional/ constant or other: ___________________________________

On a scale of 0 - 10 (**0 = NO PAIN and 10 = EXTREME PAIN**), please state your **present PAIN level**: __________________

Any related symptoms? Tingling/ numbness/ weakness/headaches or other: _____________________________________

Any recent falls: **YES** or **NO.** When: _______________ Any Phantom Pain/Sensation symptoms **(If amputee)**: **YES** or **NO**

Pain is aggravated by: activity/ stress/ standing/ sitting/ lying down or other: ____________________________________

Pain is reduced by: rest/ medicine/ lying down/ stretches/ walking/ sitting or other: ________________________________

Tests or treatment you have had for your current condition: ____

Please check the following statement(s) that best describe your complaint(s):

_____ No affect on activity _____ Some affect on activity tolerance

_____ Moderate effect on activity tolerable _____ Severe complaint(s) that stops normal activity

Things you need help with: dressing/ bathing/ eating/ feeding/ grooming/ toileting/ walking or other: _______________

PAST MEDICAL HISTORY (Please inform us of your prior treated conditions and past surgeries: circle all that apply)

__ Traumatic Brain Injury, spasticity, paralysis on R or L side, seizures, trouble thinking

__Stroke or TIA, trouble communicating (aphasia) or trouble swallowing (dysphagia)

__ Amputation, foot ulcer, R or L foot amputation, R or L BKA, R or L AKA, Peripheral Vascular Disease

__ Spinal Cord Injury, paraplegia, quadriplegia, bowel problem, bladder problem

__ Osteoarthritis, Rheumatoid arthritis, lupus, gout, fibromyalgia, polymyositis, Chronic pain, RSD, CRPS

__ Peripheral Neuropathy, Bell's Palsy, R or L footdrop, neuropathy to feet, carpal tunnel R or L

__ Parkinson's disease, multiple sclerosis, post-polio syndrome, ALS, MSA, Cerebral palsy, dementia, hydrocephalus

__ Skin problems, dermatomyositis, vitiligo, eczema, decubitus ulcer, psoriasis, severe burns, contracture, scars

__ Pre-diabetes, diabetes on insulin, diabetes not on insulin, thyroid disease, obesity

__ Heart disease, history of heart attack, atrial fibrillation, hypertension

__ Lung disease, asthma, COPD, pneumonia, sleep apnea

__ Liver disease, cirrhosis, hepatitis, jaundice, gall bladder problem

__ Kidney disease, kidney stones, on dialysis

__ stomach problems, reflux, ulcers, gastritis, hiatal hernia, H pylori, gastro intestinal bleed, GERD

__ Colon problems, diverticulitis, polyps, irritable bowel disorder

__ Cancer, type: __________________ dx when: _________oncologist: ______________________ In remission: **Yes** or **No**

__ glaucoma, cataract, wear glasses, other: ____________________ Meniere's, hearing loss, other: ___________________

__ Depression, anxiety, OCD, schizophrenia, bipolar disorder, opioid dependent, other: ____________________________

__ infectious diseases, HIV, shingles, flu, TB, COVID-19, other: ____

__ Genetic disorders, Vit D deficiency, Vit B12 deficiency or other conditions not listed above: ______________________

Past Surgical History: Gallbladder removal, appendectomy, hysterectomy, colostomy, carpal tunnel L or R, eye surgery, tonsillectomy, cyst removal, R knee, L knee, Total Knee Replacement L or R, D&C, tubal ligation, cataract surgery, pacemaker, mastectomy, C-section, Above the Knee Amputation L or R, Below the Knee Amputation L or R, Laparoscopy, biopsy, endoscopy other:____

Previous injuries: ____

Date of last colonoscopy: __________________________________Results: ____

Date of last A1C blood test: ________________________________ Results: ____

Family History: Diseases in family members

Mother: ____ Father: ____

Sibling(s): ____ Children: ____

Grandparents: ____ Distant relatives: __________________________________

Social History

Single/ Married/ Separated/ Divorced/ Widowed/other: ______________________ Occupation: _____________________

Living Arrangement: house, apt; lives alone or with roommate, spouse, sig other, parents, mother, father, children

Equipment you have at home: rolling walker, wheelchair, bedside commode, other: ________________________________

Tobacco use: **YES** or **NO** Quit, if so when: _______ Would like to quit: **YES** or **NO.** Other recreational drugs: **__________**

Alcohol use: no alcohol intake, rarely, socially, daily, less than 2 drinks per day, more than 2 drinks per day

Are you**: Right**-**handed or Left-handed.** Number of steps to enter your home: ___________________________________

Your activity level: (please circle) active, moderate, sedentary, other: ____

With whom may we share your health information? _______________________________Do you have a DNR: **YES** or **NO**

Allergies:

Medication/Other	**Reactions**

Medications:

Please provide: **Name, dose, directions and indications of medications**

NAME	DOSE	DIRECTIONS	INDICATION

Review of Systems

Please circle any symptoms that you are experiencing, and if so, please give additional details.

General: fatigue, decreased appetite, decreased activity, fever, chills, night sweats, weight loss, weight gain or normal

Skin: rash, lumps, sores, itching, dryness, color change, changes in hair or nails or normal

HENT: dizziness, lightheadedness, vision changes, hearing problems, ringing in the ears (tinnitus), vertigo, earaches, nasal stuffiness, nasal discharge, nosebleeds, dry mouth, hoarseness, headaches or normal

Neck: lumps, enlarged glands, abnormal mass, pain, stiffness or normal

Cardiovascular: chest pain or discomfort, palpitations, difficulty breathing while lying down (orthopnea), swelling in the lower body (edema), HTN, irregular heartbeat or normal

Respiratory: cough, bloody sputum, shortness of breath (dyspnea), wheezing or normal

Gastrointestinal: trouble swallowing, heartburn, nausea, vomiting, diarrhea, constipation, rectal bleeding, abdominal pain, bowel incontinence, food intolerance or normal

Urinary: incontinence, dribbling, frequency of voiding, urinating at night (nocturia), urgency, burning, pain, blood in urine (hematuria), frequent urinary infections, UTI or normal

Peripheral vascular: pain with walking, intermittent claudication, leg cramps, varicose veins, pain at rest or normal

Musculoskeletal: muscle spasm, joint pain, stiffness, backache, swelling, redness, limitation of motion, pain with weight bearing, neck pain, activity limitations or normal

Neurologic: migraine, fainting, blackouts, seizures, weakness, paralysis, loss of sensation, tingling, tremors, tics, involuntary movements, trouble talking (aphasia), trouble swallowing, trouble with thinking, numbness and tingling in the feet or hands, contractures, phantom pain, migraines, dizziness, balance problems or normal

Endocrine: heat or cold intolerance, excessive sweating, excessive thirst or hunger, frequent urination (polyuria), change in glove or shoe size, diabetes, thyroid disease or normal

Psychiatric: nervousness, anxiety, depression, frustration, memory change, visual or auditory hallucinations, agitation, poor attention, poor concentration, crying spells, obsessive, compulsions, fearfulness, sleep disturbances or normal

Do you have other symptoms you wish to discuss with the doctor? ____

I understand that the above questionnaire will be relied upon by Health Care Personnel for my medical history to arrive at accurate diagnosis and treatment of my medical condition. I understand that all the answers will be held in the strictest confidence according to the current standards of medical records. My signature below certifies that the answers given are complete and true.

____

Patient/guardian signature/ Date