920 East 56th Street
Kearney Ne, 68847
(308)233-5060
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www.alpharehab.com

Adult Intake Forms

Today's Date _____
How did you hear about us? _____
Name_____Address_____City_____State_____
Zip_____Email_____Sex Male Female
Date of Birth _____Main Phone(____)_____Work Phone(____)_____
Other Phone(____)_____ Social Security Number_____
Referring Physician_____Date of Injury_____
Employer_____JobTitle_____
Address_____City_____State_____Zip_____

Is this claim covered by: Worker's Compensation_____
Motor Vehicle Accident? _____
Have you recently received or are currently receiving home health care?_____

Insurance
Primary Insurance _____Policy Holder(insured)_____
Birth date of insured_____Patient relationship to insured _____
ID Number_____Group#_____
Secondary Insurance _____Policy_____
Birth date of insured_____Patient relationship to insured _____
ID Number _____ Group Number_____

Emergency Contact
Name_____Realtionship_____ Phone_____

Health Information
Please describe your Current Complaint or Limitation_____
Please describe how your problem began_____
Recent Hospitalization Date_____ Location_____
Please indicate the daily activities that you cannot perform_____
Have you had X-rays or MRI's taken? Location_____
Have you or will you be having surgery? _____
Date of Surgery_____ Procedure: _____
Falls:
Have you had an injury as a result of a fall in the last year?____
Have you had two or more falls in the last year?____

Allergies___Depression___Multiple Sclerosis___Anemia___Diabetes___Seizures___
Osteoporosis___Anxiety___Dizzy Spells___Parkinson's___Arthritis___Strokes___
Emphysema/Bronchitis___Rheumatoid Arthritis___Asthma___Fractures___Hepatitis___
Cancer____Gallbladder Problems___Speech Problems___Cardiac Conditions____Hepatitis___
Cardiac Pacemaker___High Blood Pressure___Thyroid Disease___HIV___Night pain___
Motor Vehicle Accident___Cancer___Changes in vision___Neurological Weakness___
Headaches___Fatigue___Pregnant___Heart problems___Urinary problems___Lung disease__
Swallowing problems___Smoking___Alcohol use___
Other_____

CONSENT SECTION

____**Consent for Treatment:** I hereby consent to receive care for therapy services by Alpha Rehabilitation. I consent to medical treatment as is deemed necessary or advisable by the treating therapist. I have the right to refuse any procedure or treatment.

____**Consent to Release Medical Information:** I authorize Alpha Rehabilitation to release any information acquired in connection with my therapy services including, but not limited to, diagnosis, clinical records, to myself, my insurance(s), physician(s), and _____

____**Consent to Obtain Medical Information:** I authorize Alpha Rehabilitation to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat scans, and MRI reports, along with Physician's Documentation.

____**Assignment of Benefits:** I hereby authorize payment to be made directly to Alpha Rehabilitation.

___**Cancelation Policy**: I understand that I must give 12 hours notice prior to cancelation. An answering machine is available for your convenience. Excessive cancellations/no shows will result in cancellation of all future appointments. Physician will be notified.

____**Financial Policy**: I understand Alpha Rehabilitation bills my insurance and explains my benefits as a courtesy to me. Insurance benefits are not guaranteed after verification. I will be responsible for all charges/copays/deductibles not covered by my insurance plan. It is my responsibility to notify Alpha Rehabilitation immediately if changes occur with my insurance coverage. Any failure to notify of change will place me solely responsible for laps in coverage or authorization of benefits

____**Guarantee of Payment:** I agree to pay any charges that my insurance does not pay. I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees, legal fees, and collection agency fees. I hereby certify that I understand these rights as set forth.

____**Worker's Compensation Claims:** I understand that if I claim Workman's Compensation benefits and they are subsequently denied I will be responsible for the charges.

____The undersigned does hereby acknowledge that I have received a copy Alpha's Notice of Privacy Practices Pursuant to HIPAA and has been advised that a full copy of this office's HIPAA Compliance Manual is available upon request. The undersign does hereby consent to the use of his or her health information in a manner consistent with the Notice of Privacy Practices Pursuant to HIPAA, the HIPAA Compliance Manual, State Law, and Federal Law.

Patient/Responsible Party
Signature:_____Date:_____