1190 East Missouri Avenue, Suite 100 • Phoenix, AZ 85014
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Today's Date _______________

Patient Information

Patient Name____ Height_______________ Weight_______________
Last First Middle

Gender: ___Male ___Female Date of Birth______________ Age_______ Social Security #_____________________

Marital Status (circle one): Single Married Widowed Divorced Separated

Name of Spouse / Guardian / Caregiver (circle one) ____

Address ____

Phone # (_____)________________ Cell # (_____)_______________ Email ___________________________________

May we leave messages for you at: **Home**: Yes No **Cell**: Yes No **Email**: Yes No

Would you like text or e mail reminders: If yes, what address/phone #____

Emergency Contact: ____ Relationship____________________________

Emergency Contact Home #_____________________________ Emergency Contact Cell #__________________________

May we speak with your Emergency Contact about your medical condition, needs and account? Yes No

Is there anyone else that you are authorizing us to discuss your medical conditions, needs and account with? Yes No

Name: ____ Relationship: _____________________________________

Contact Home #_______________________________________ Contact Cell #______________________________________

How did you learn about us? ____

Physician Information

Referring Physician __________________________________ Phone _____________________ Fax__________________

Address____

Primary Physician ____ Phone # __________________________________

Insurance Information

Primary Insurance ____ ID #___________________________________

Secondary Insurance____ ID #___________________________________

Policy Holder's Name _______________________________________ Relationship to Patient______________________

Address ____ DOB__________________________

Assignment of benefits/authorization to release information

I authorize pay of my insurance benefits directly to SWAN Rehab and authorize SWAN Rehab to disclose my protected health information to assist with the processing of my claim(s); carry out my treatment; and for health care operations like quality reviews. I understand I am personally responsible for balances not paid by my insurance.

X____ Date ______/______/ 20_____
Patient / Responsible Party

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PAST MEDICAL HISTORY FORM

Patient Name: ________________________________ DOB: __________ Today's Date: _______________

Primary Language Spoken: ☐ English ☐ Spanish ☐ Other: ________________

Name of Referring Physician: ________________________________ Date of next physician's visit: ___/___/___

Reason for visit:
☐ Stroke ☐ Multiple Sclerosis (MS)
☐ Parkinson's Disease ☐ Spinal Cord Injury (SCI)
☐ Traumatic Brain Injury (TBI) ☐ Other: ______________________

Date of injury / onset: ___/___/___ Have you ever had physical therapy for theses symptoms before? ☐ Yes ☐ No

If you have had a stroke which side of the body was affected? Right / Left

Type of stroke: ☐ Bleed ☐ Clot ☐ Unknown

Dominant hand (please circle): RIGHT / LEFT

If you have had a Traumatic Brain Injury (TBI), please briefly describe the incident:

Have you received Physical Therapy within the past year? ☐ Yes ☐ No

Have you had surgery for your current condition/ injury? ☐ Yes ☐ No

Have you had any other major surgeries? ☐ Yes ☐ No

If you have had any relevant surgeries, please briefly explain and give approximate date of operation:

Please indicate if any of the following are applicable to you (Circle YES or NO):

Are you able to walk? YES / NO – If YES, do you require assistance? ____________________________________
Do you use a leg brace, cane, or another device? YES / NO – If YES, what? ________________________________
Do you use a walker? YES / NO – If YES, what type of walker? ____
Do you use a wheelchair? YES / NO – If YES, manual or automatic? ______________________________________
Do you require a Hoyer Lift to transfer? YES / NO
Have you fallen in the past year? YES / NO – If YES, please list the approximate number of falls: _______________
Have you fallen in the past month? YES / NO – If YES, please list the approximate number of falls: _____________
Are you fearful of falling? YES / NO
Do you have any voice difficulties? YES / NO
Do you have any difficulty swallowing? YES / NO
Have you had a swallow X-ray? YES / NO – If YES, please bring or send results in advance of first appointment.
Do you have difficulty with pronunciation? YES / NO
Do you have difficulty finding words during a conversation? YES / NO

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Do you have any problems regarding memory/thinking/concentrating? YES / NO
Do you smoke? YES / NO – If YES, how much: ________________
Are you able to drive? YES / NO – If NO, do you want to drive? ________________
Do you use your affected arm for anything? YES / NO – If YES, explain: ________________

Please indicate if you need assistance with any of the following below (Circle YES or NO):
Getting in and out of bed? YES / NO – If YES, how much assistance is required? ________________
Getting dressed / undressed? YES / NO – If YES, how much assistance is required? ________________
Toileting? YES / NO – If YES, how much assistance is required? ________________
Eating? YES / NO – If YES, how much assistance is required? ________________
Preparing/ cooking food? YES / NO – If YES, how much assistance is required? ________________
Showering / bathing? YES / NO – If YES, how much assistance is required? ________________

Do you have, or have you had any of the following?

GENERAL
- ☐ Currently pregnant
- ☐ Special diet guidelines
- ☐ Autoimmune disorder
- ☐ Cancer
- ☐ HIV/AIDS
- ☐ Diabetes
- ☐ Fibromyalgia
- ☐ MRSA
- ☐ Chemical dependency
- ☐ Thyroid Disease
- ☐ Hepatitis

EYES
- ☐ Loss of vision
- ☐ Double or blurred vision
- ☐ Eye pain
- ☐ Redness

EARS/NOSE/THROAT
- ☐ Hearing impairment
- ☐ Ringing in your ears
- ☐ Difficulty swallowing

GASTROINTESTINAL
- ☐ Nausea
- ☐ Heartburn
- ☐ Vomiting
- ☐ Gallbladder problems

GENITOURINARY
- ☐ Frequent or painful urination
- ☐ Incontinence
- ☐ Kidney disease
- ☐ Difficulty voiding

ALLERGIC/IMMUNOLOGIC
- ☐ Allergies
- ☐ Poor tolerance to cold
- ☐ Rheumatoid arthritis

MOOD
- ☐ Depression
- ☐ Anxiety
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep

HEMATOLOGY/LYMPH
- ☐ Anemia
- ☐ Clots
- ☐ Lymphedema

MUSCULOSKELETAL
- ☐ Fractures
- ☐ Muscular disease
- ☐ Metal implants
  Where? ____________
- ☐ Osteoporosis
- ☐ Joint pain
  Where? ____________
- ☐ Joint swelling
  Where? ____________
- ☐ Muscle Pain
  Where? ____________

RESPIRATORY
- ☐ Asthma
  Do you use an inhaler? YES/NO
- ☐ Emphysema/Bronchitis
- ☐ COPD
- ☐ Tuberculosis
- ☐ Shortness of breath

NEUROLOGICAL
- ☐ Seizures
- ☐ Weakness
- ☐ Numbness
- ☐ Stroke/CVA
- ☐ Parkinson's disease
- ☐ Multiple Sclerosis
- ☐ Headaches
- ☐ Memory loss

SKIN
- ☐ Rash
- ☐ Redness
- ☐ Abnormalities

CARDIOVASCULAR
- ☐ Cardiac pacemaker
- ☐ Circulatory problems
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Abnormal Heart Beat
- ☐ Fainting
- ☐ Swollen legs or feet
- ☐ Chest pain
- ☐ Cardiac conditions

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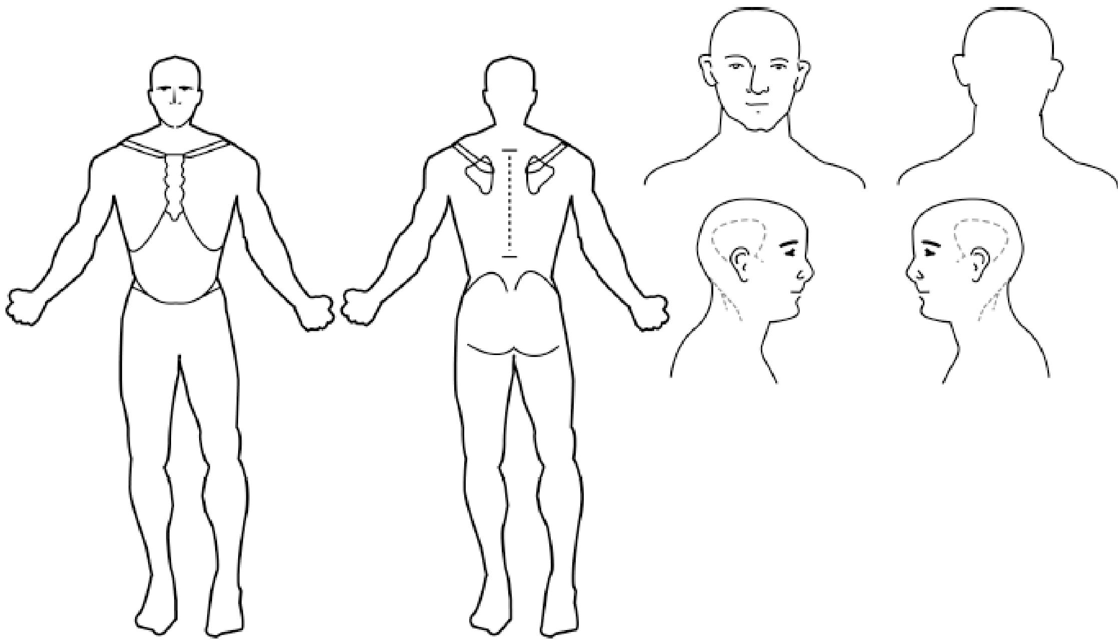
If you said 'yes' to any of the above, please briefly explain:

Is there any other information regarding your past medical history that we should know about?

Are you presently taking Medication? ☐ Yes ☐ No

If yes, please list what medications and for what condition:		
Name	Dosage and Frequency	Purpose

Please indicate below where your symptoms are located.



Type of pain (please circle):

ACHE **BURNING** **TINGLING** **SHARP**

SHOOTING **THROBBING** **NUMBNESS** **DULL**

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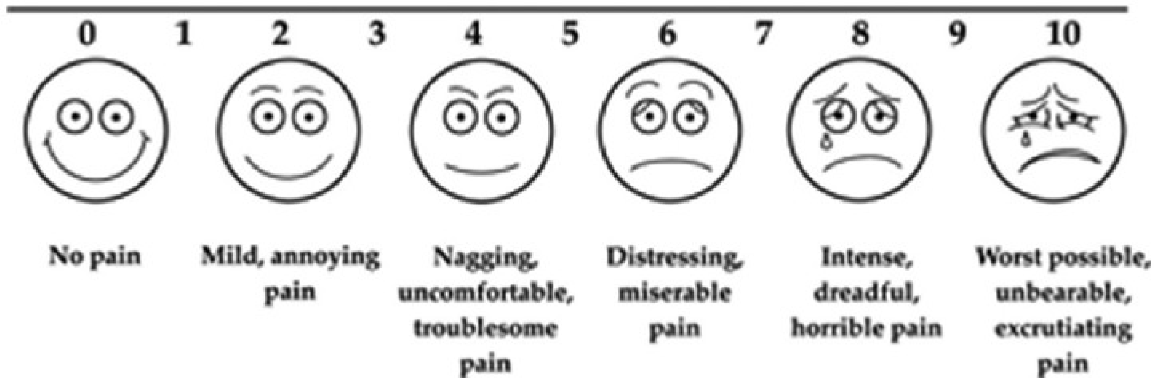
Is your pain constant? YES / NO

If you are having pain, please circle the average intensity of your pain on a scale of 0 to 10, with 0 being no pain and 10 being the worst pain possible:



Do you currently live alone? ☐ Yes ☐ No – If NO, with who? ______________________________
How many stories is your home? _________________
Do you have any stairs in your home? ☐ Yes ☐ No Do you have a step-out entry? ☐ Yes ☐ No

Do you have any social support? (Friends, family, etc.) ☐ Yes ☐ No – If YES, please briefly explain: ________________
____

Are you currently working? ☐ Yes ☐ No – If YES, where? ____________________

Please list any hobbies below:

Please describe any goals you have for therapy below including, but not limited to walking and balance goals, arm and hand goals, speech ad swallowing goals:

x____/_______/_______

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INFORMED CONSENT AGREEMENT

Thank you for choosing to use the facilities, services, or programs of SWAN Rehab. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, the undersigned, declare that I intend to use some or all of the activities, facilities, programs, and services offered by SWAN Rehab and I understand that each person, (myself included), has a different capacity for participation in such activities, facilities, programs, and services. I am aware that all activities, services, and programs offered are educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or heath (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, services, and program of SWAN Rehab brings with it my assumption of those risks or results stemming from this choice and the fitness, health, and awareness, care, and skill that I possess and use.

I further understand that personnel, who may not be licensed, certified, or registered instructors or professionals sometimes conduct the activities, programs, and services offered by SWAN Rehab. I accept that fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offered assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certifier, or registered and herein employed to provide such professional services. I recognize that by participating in the activities, facilities, programs, and services offered by SWAN Rehab, that I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation or information about the activities, facilities, programs, and services offered by SWAN Rehab at any time before, during, or after my participation. I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

x____/______/______

Patient/Responsible Party Relationship to patient Date

PHOTO AND VIDEO AUTHORIZATION

At times we take photos or video to monitor and record your progress. At other times we may use video for teaching or marketing purposes. I hereby consent without further consideration or compensation, to give SWAN Rehab, the absolute right and permission to use my photograph or video in its promotional materials, publicity efforts, advertisements and social media. I hereby grant permission to SWAN Rehabilitation to crop, screen or alter the photograph or video as necessary for use on materials produced by and on behalf of SWAN Rehabilitation. I understand that these images may be used alone or in conjunction with other photographs or videos for educational purposes, still or moving, sketches, advertising and publication in any manner and in any medium whatsoever without limitation or reservation. *I release all claims against SWAN Rehabilitation, their employees, agents and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.*

x____/______/______

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NOTICE OF PRIVACY POLICIES

In this document, "we, us and our" refers to RWW Outpatient Rehab Services,LLC d.b.a. SWAN Rehab. "you" or "yours" refers to individual patients. We are required by federal law to protect the privacy of your individual health information (referred to in this notice as "Protected Health Information" or PHI). We are also required to provide you with this notice regarding our legal duties and privacy practices with respect to your PHI, and to abide by the terms of this notice. We maintain medical information about you in the course of providing health services to you. We also hire business associates, such as billing service an d a transportation service, and bill third party payers, such as Medicare, in the process of providing and billing these services. These business associates also receive and maintain medical information about you.

We may use and disclose medical information about you with our consent for the following purposes:

- **Health Care Providers' Treatment Purposes.** For example, to communicate with your doctor we may disclose medical information about you.
- Payment. For example, we may use or disclose medical information about you to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- **Health Care Operations.** For example, we may use or disclose medical information about you for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of contracts or previous contract(s).
- **Health services.** For example, we may use medical information about you to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **As Required By Law.** For example, we must allow the U.S Department of Health And Human Services to audit our records. We may also disclose medical information about you as authorized by and to the extent necessary to comply with worker's compensation or other similar laws.
- **To Business Associates.** We may disclose medical information about you to business associates we hire to assist us in your care. Each business associate must agree in writing to ensure the continuing confidentiality and security of medical information about you.

We may also use and disclose medical information about you as follows; to comply with legal proceedings, such as a court or administrative order or subpoena ,to law enforcement officials for limited law enforcement purposes, to your personal representatives appointed by you or designated by the applicable law, for research purposes, as long as certain privacy-related standards are satisfied, to a government agency authorized to oversee the health care system or government programs, we may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care.

Authorizations: Uses and Disclosures With Your Permission

We will not use or disclose medical information about you for any other purposes unless you give us your written authorization to do so. If you give us written authorization to use or disclose medical information about you for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all medical information about you that we maintain, except for information we have already released based on your authorization.

Your Rights

You may make a written request to SWAN Rehab to do one or more of the following concerning medical info about you to put additional restrictions on our disclosure of medical information about you we do not have to agree to your request, to communicate with you in confidence about medical information about you by a different means or location, to see and get copies of medical information about you, we do not have to agree to your request, to amend medical information about you, in some cases we do not have to agree to your request.

Complaints

If you believe your privacy rights have been violated, you may notify us in writing or The Secretary Of The Department Of Health Services. You will not be retaliated against for filing a complaint.

PHI use and disclosure by SWAN Rehab is regulated by federal law known as HIPPA. You may find these rules at 45 Code Of Federal Regulations part 160 and 164. This Notice attempts to summarize the Privacy standards. The Privacy Standards will supersede any discrepancy between the information in the Notice and Privacy Standards. I hereby acknowledge that I have been provided and have reviewed SWAN Rehab's Notice Of Privacy Practice

X____/_____/_____

Patient/Responsible Party   Relationship to patient   Date

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iFINANCIAL POLICIES AND PROCEDURES

Patient Name____Date of Birth__________________Today's Date_________

I authorize payment of my insurance benefits directly to SWAN Rehab and authorize SWAN Rehab to disclose my protected health information to assist with the processing of my claim(s); carry out my treatment; and for health care operations like quality reviews. I understand I am personally responsible for balances not paid by my insurance. I understand I will be notified by invoice of the amount charged to either my insurance/bank account/or credit card. Claims are submitted by SWAN within 48 hours of the date of service.

BILLING PROCEDURE: You will receive a statement with your remainder balance once a reply is received from your insurance company from our billing company until paid in full.

MEDICARE PATIENTS: If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the 20 percent. A Payment plan can be set up for special circumstances.

BALANCES DUE AFTER INSURANCE PAYS: If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting the office manager within 30 days of the receipt of the invoice. It is your responsibility to make contact with our office to make special arrangements.

PAYMENT AT THE TIME OF SERVICE:
I or my Guarantor will be paying for service by Check

SELF PAY: If insurance does not cover your therapy and you are a self-paying, all payments will be due at the time services are rendered unless you have made arrangements with the office manager.

Patient or Guarantor Initials:

DELIQUENT ACCOUNTS: We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 180 days will be sent to an outside agency for collections. Delinquent accounts will be reported to our collection's agency, KEA Recovery, after normal collections procedures. Please contact our billing company at 864-679-1600, if temporary financial problems will affect timely payment of your account or if a payment plan is required to prevent your account from going to collections. Patient/Guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

PAYMENT ARRANGEMENTS: Under special circumstances, payment arrangements can be made. These arrangements are made with the Office Manager. Our office can set this up for you as a courtesy. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time of your payment arrangement is set up. After the second missed payment, the account will be sent to an outside agency for collections.

COMMUNICATIONS CONSENT: You agree, in order for us to service your account or to collect any amounts you may owe, that we, or any third-party vendor authorized by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, or any third-party vendor authorized by SWAN Rehab, may also contact you by sending text messages or emails you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

x____/_______/_______

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Patient Name: ________________________ Date of Birth: _________ Today's Date: _________

Cancellation/ No Show Policy

Your progress and recovery are dependent on both our expertise and your active participation and commitment to your appointments.

Please call **48 hours** prior to your appointment if you need to cancel or reschedule.

A $50 fee per 1 hour session will be due on your next scheduled date of service if you no show or cancel 48 hours or less before your appointment.

3 cancellations or no shows without 48 hour notice in a 3 month period will result in automatic cancellation of all your future appointments. You may go back onto our waiting list once you are fully committed to return to your scheduled therapies.

x____/______/______

Patient/Responsible Party Relationship to patient Date

x____/______/______

SWAN Employee Witness Date