vital REHABILITATION

PATIENT REGISTRATION FORM

(KARTA REJESTRACYJNA PACJENTA/FORMULARIO DE REGISTRO DE PACIENTES

PATIENT INFORMATION
(Informacja O Pacjencie/Nombre Del Paciente)

Last Name (Nazwisko/Apellido):	First Name (Imie/Nombre):	Guardian's Name(Nazwisko Opiekuna/Nombre del tutor):	Sex (Plec/Sexo): ☐ M ☐ F

Address (Adres/Dirección):	City, State, Zip Code (Miasto, Stan, Kod Pocztowy/Cuidad, Estado, Código postal):
Home Phone (Numer Telefonu/Telefono):	Social Security No.(Numer Social Security/ número de seguro social):
Work Phone (Numbero de trabajo)	Date of Birth (Data Urodzenia/Fecha de Nacimiento): Age: ☐ 0-17 yrs. ☐ 18 yrs.- older
Cell Phone (Numbero de cellular)	Height (Wzrost/Altura)/ Weight (Waga/Peso):: Preferred Language other than English: ☐ Polish ☐Spanish ☐ Other: _____
Reason for Visit (Powod Wizyty/Motiva de visita):	Email Address:
Referring Physician (Lekarz Referujacy/Refiriéndose Médico):	Physician's Phone No. (Telefon Lekarz/Medico telefono):
Employer (Miejsce Zatrudnienia/Empresario):	Occupation (Zawod/Ocupacion):

Is your reason for today's visit the result of a work-related injury? ☐ No ☐Yes, please explain:

La razon por su vista fue un resultado de accidente en el trabajo? ☐ No ☐Si, explique:

Do you currently have a nurse or therapist coming to your home? ☐ No ☐Yes, name of agency _____

Tiene una Enfermera o un Terapista que lo visita a su casa? ☐ No ☐Si, , nombre de agencia _____

How Did You Hear About Vital?	☐ Doctor	☐ Friend/Family	☐ Walked-by
Skąd dowiedziałeś się o Vital?	☐ Insurance	☐ Yellow Pages	☐ Internet
Como se entero de Vital?	☐ Attorney	☐ In Neighborhood	☐ Returning/Other _____

IN CASE OF EMERGENCY, CONTACT (Alarmowe/Contacto de Emergencia)

Relative/Friend/Guardian:	Phone No.:

INSURANCE INFORMATION (Ubezpieczenia Informacje/Información del Seguro)

PRIMARY INSURANCE (Glowne Ubezpieczenia/ Primaria de Seguros):	SECONDARY INSURANCE (Ubezpieczenia Uzupetniajace/Seguro Secundario):
☐ Worker's Comp. Injury Date_____ ☐ Commercial/PPO_____ ☐ Cars Ins._____ ☐ Other_____	☐ Commercial/PPO_____ ☐ Other_____
Telephone No. (Telefon/Telefono):	Telephone No. (Telefon/Telefono):
Group No. (Numer Grupy/ Número de grupo):	Group No. (Numer Grupy/ Número de grupo):
Policy No. (Numer Polisy/Número de Póliza):	Policy No. (Numer Polisy/Número de Póliza):
Policy Holder's Name (Ubezpieczający nazwisko /Nombre del titular de la política):	Policy Holder's Name (Ubezpieczający nazwisko /Nombre del titular de la política):

OFFICE USE ONLY:

☐ RETURNING PATIENT; NO CHANGES	☐ Adult ☐ Pediatric	Service: ☐PT ☐OT ☐ST ☐POOL ☐Other _____

REFFERAL TAKEN BY:	DATE:	Eval Date:	Therapist:

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ILLNESSES/CHOROBY/ENFERMEDAD (Check if you have any of the following/Prosze zaznaczyc przebyte choroby i/lub stany przewlekle)		
☐ Alcoholism/Alkoholizm/Alcoholismo	☐ Eye problems/Choroby oczu/problemas oculares	☐ Pacemaker/Rozrusznik serca/ marcapasos
☐ Anemia/Anemia/Anemia	☐ Fractures/Zlamania/ Fracturas	☐ Phlebitis/Zapalenie zyl/ flebitis
☐ Arthritis/Artretyzm/Artritis	☐ Glaucoma/Jaskra	☐ Rheumatic fever/ Goraczka reumatyczna/ la fiebre reumática
☐ Bleeds easily/Latwe krwawienia/Sangra con facilidad	☐ Heart disease/Choroby serca/Enfermedades del Corazón	☐ Rubella, German Measles/Rozyczka/ la rubéola, el sarampión alemán
☐ Blood transfusion/Transfuzja krwi/La transfusión de sangre	☐ Hepatitis/Zapalenie watroby	☐ Sport contusions/Kontuzje sportowe/ contusiones en el deporte
☐ Brain injury/Uraz mozgu/lesión cerebral	☐ High Blood Pressure/Wysokie cisnienie krwi/Presión arterial alta	☐ STDs/ Choroby weneryczne/ enfermedades de transmisión sexual
☐ Cancer, tumor/ Rak, nowotwor	☐ Implants/Implanty (sruby, blaszki, druty, czesci plastikowe, itp.)/Implantes	☐ Stomach ulcers/Wrzody zoladka lub dwunastnicy/ úlceras de estómago
☐ Depression/Depresja/Depresión	☐ Liver disease, jaundice/Choroby watroby, zoltaczka/Enfermedades del Hígado	☐ Stroke/Udar mozgu/Golpe
☐ Diabetes/Cukrzyca	☐ Lung disease/Choroby pluc/Enfermedades Respiratorias	☐ Suicide attempts/Proby samobojcze/ intentos de suicidio
☐ Drug abuse/Uzywanie narkotykow/uso indebido de drogas	☐ Mumps, measles, chicken pox/Swinka, odra, ospa wietrzna/ Paperas, sarampión, varicela	☐ Thyroid disease/Choroby tarczycy/ la enfermedad de la tiroides
☐ Eczema, hives, rashes/Egzema I inne choroby skorne/eczema, erupción cutánea, urticaria	☐ Nervous breakdown/Zalamanie nerwowe/ ataque de nervios	☐ Other/Inne choroby
☐ Epilepsy, seizures/Padaczka/epilepsia, convulsions	☐ Osteoporosis/Osteoporoza	
ALLERGIES/ALERGIE, UCZULENIA/ALERGIAS		
☐ Cortisone, hydrocortisone	☐ Medications/leki	☐ Latex
☐ Food/Alergie pokarmowe	☐ Ointments, creams/ Masci, kremy	☐ Other/Inne
☐ Lidocaine/Lidokaina	☐ Seasonal / Uczulenia sezonowe (np. katar sienny)	
LOSS OF SENSATION/UTRATA CZUCIA SKORNEGO/PERDIDA DE LA SENSIBLIDAD		
☐ Numbness/Zdretwieua	☐ Touch (if yes, indicate area/Dotyk (prosze wskazac miejsce)	☐ Sharp/Ostre klucie
☐ Warm-cold/Cieplo-zimno	☐ Other/Inne	

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HOSPITALIZATION, SURGERY / HOSPITALIZACJE, OPERACJE/HOSPITALIZACION, CIRUGIA

List illnesses or surgeries and its approx.date. Include normal pregnancies.

Prosze wymienic wszystkie przebyte choroby / operacje wymagajace pobytu w szpitalu (takze ciaze)/ Lista de enfermedades o cirugías y sus approx.date. Se incluyen los embarazos normales.

Date (Year)/Data (Rok):

_____ _____

_____ _____

_____ _____

MEDICINES / STOSOWANE LEKI/MEDICAMENTOS

List medicines, birth control pills, vitamins or herbs you take with or without prescription.

Prosze wymienic leki, pigulki antykoncepcyjne, witaminy oraz ziola, zazywane na recepte lub bez

Lista de medicamentos, píldoras anticonceptivas, vitaminas o hierbas que usted toma con o sin receta médica

Have you ever had previous treatment such as orthopedic, chiropractic or physical/occupational/speech therapy? Please underline correct.

Czy kiedykolwiek korzystal (a) Pan(i) z pomocy ortopedy, chiropraktyka, fizjoterapii, terapii zajeciowej lub terapii mowy? Prosze podkreslic wlasciwa.

¿Ha tenido tratamiento previo, tales como ortopedia, quiropráctica o física / terapia de lenguaje ocupacional /? Subrayar correcta.

_____

_____

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Financial Policy, Release of Information, Assignment of Benefits

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. If your insurance company does not pay us within a reasonable time period, we require you to pay the outstanding balance.
- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service.
- If you have a co-pay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe – i.e. deductible, coinsurance, co-pay, until all claims have been processed. **Payment is due upon receipt of our bill.**
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis.
- Unless other arrangements have been made in advance by you, your health insurance carrier, also agree upon by Vital Rehabilitation, **payment for services are due at the time of service**.
- In the event your health plan determines a service to be "not covered" and we are unaware or you do not have authorization, you will be responsible for the complete charge.
- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.
- For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent or guardian for payment.

Payments and Patient Signature

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.
- A $35 f**ee** will be charged for all **"No Shows" & Cancellations without 48-hour advance notice**. This fee is not reimbursable by insurance.
- I have read and understand the financial policy of Vital Rehabilitation and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.
- I authorize the release of information necessary for treatment, payment & health care operations. I also authorize assignment of benefits for services rendered by Vital Rehabilitation.

I do hereby consent to such treatment by the authorized personnel of Vital Rehabilitation as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment except for act of negligence.

I have read and understand the above information. I believe the information I have given to be accurate/true.

_____ _____

Patient or Parent/Guardian Signature **Date**

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HIPAA Patient Signature Form

Patient Name Printed: _____ Date of birth: _____

Vital Rehabilitation's Privacy Notice is available at the front desk for patients who request a copy. In addition, at the time of registration, all patients are offered a copy of Vital Rehabilitation Privacy Notice. Please address the following to our front desk staff: requests to review your medical records, requests for copies of your medical records, requests for amendments to your medical records, and requests for a list of disclosures of your records.

I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices from the office staff and have been informed of my additional rights (above) under HIPAA.

_____ _____

Signature of patient or authorized representative Date

_____ _____

If signed above by representative, relationship to patient Name of patient if different from above

In lieu of the patient signature, I _____, a staff member of Vital Rehabilitation state that this patient has been offered our current Notice of Privacy Practices.