Patient Intake Form

First Name:	Street Address:
Last Name:	City:
Birthdate: SSN:	State: Zip Code:
Gender: M F	Marital Status: Single Married Other
Home Phone:	Spouse Name:
Work Phone:	Spouse DOB:
Employer:	Parent/ Guardian's Name (if patient is a child or dependent):
Emergency Contact & Phone:	
Email Address:	Family Physician:

Insurance (A copy of ALL insurance cards is required)

Is this a Workers Comp claim? Yes No	Is this an Auto Claim? Yes No
Employer:	Insurance Company:
Employer Address:	Address:
Insurance Carrier:	
Adjuster's Name and phone Number:	Adjuster's Name and phone Number:
Date of Injury:	Date of Accident:
Claim Number:	Claim Number:

Consent to Treatment: I hereby authorize Penn Ohio Rehabilitation, PC to provide medical treatment to myself/my dependent. I hereby authorize Penn Ohio Rehabilitation, PC to release to my insurance carrier and its agents any information needed to determine benefits and process claims for services provided to me by Penn Ohio Rehabilitation, PC and/or provided by law. I request that payment of the benefits, including any government benefits, including any portion of payment as determined by my insurance policy. I certify that I have provided true and accurate information to the best of my knowledge.

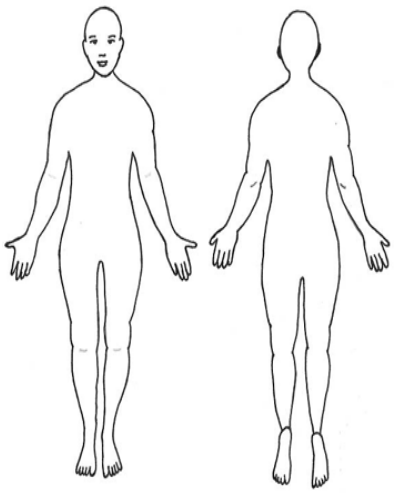
Signature: _____ **Date:** _____

Patient Health History

Patient Name: _____ **Date:** _____

Please indicate if you have ever been diagnosed with, treated for, andor experienced symptoms of any of the following:

Kidney Disease	Oesteoporosis	Unexplained cough of 2 weeks or more	Use the diagram to mark where you are experiencing pain.
Angina/Chest Pain	Stroke/TIA	Unexplained weight gain/loss	
Heart Attack/Heart Disease	Rheumatic Fever	Loss of Appetite	
High/Low Blood Pressure	Tuberculosis/TB	Night Sweats	
Diabetes	Hepatitis	Unexplained Fever	
Shortness of Breath	Arthritis	Bloody Sputum	
Asthma/Emphysema	Circulation Problems	Depression.Anxiety	
Dizziness/Syncope	Phlebitis	Pacemaker	
Seizures	Muscle Disorder	Cancer	
Bowel Problems (constipation/diarrhea)	Nerve Disorder	History of Positive COVID Test **Date:**	
Bladder Problems	Tobacco Use	Number of Falls in Past Year:	
Rectal/Vaginal Bleeding	Alcohol Use	Any Injuries from Falls:	



Please list your surgical history: _____

_____

_____ ____ See attached list

Please list any medications that you are taking and the dosage: _____

_____

_____ ____ See attached list

Symptoms began on: _____ Briefly describe your symptoms: _____

How did your symptoms start?_____

How often do you experience your symptoms? **Constant Frequently Occasionally Intermittently**

How much have your symptoms interfered with your usual activities?

Not at all A little Moderately Quite a bit Extremely

Use the following scale to rate your pain: _____ Pain in last 24 hours _____ Pain in last week

No Pain 1 2 3 4 5 6 7 8 9 10 Worse Pain

Notice of Privacy Practice Acknowledgement

I understand, that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address below to obtain a current company of the Notice of Privacy Practices and that the notice is also posted in the waiting rooms of the following offices.

POR Hermitage: 1599 N Hermitage Rd. Hermitage, PA 16148/phone: 724-962-7920

POR New Wilmington: 565 W Neshannock Ave. New Wilmington, PA 16142/phone: 724-946-3313

POR Harmony: 100 Perry Highway Suite 110, Harmony, PA 16037/phone: 412-499-4524

I understand that I may request in writing that you restrict how my privacy information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ Date:_____

Printed Name: _____

Signature of Parent/Guardian (if patient is under 18 years old): _____

Office Use Only: I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices, but was unable to do so as documented below:

Reason_____

Signature: _____ Date:_____

Payment and Financial Responsibility Agreement

Your health is important to us and we want to make sure that you received the care you need at the time that you need it. We realize that temporary financial problems may affect your timeliness of payment, if such problems do arise please contact us promptly for assistance in the management of your account. Penn Ohio Rehabilitation is obligated by law to collect all copays, deductibles and coinsurances that your insurance company may apply. As a courtesy, we will verify your health insurance coverage and notify you of the benefits that we are provided, however we are not always privileged to all information or given accurate information from your insurance company.

WE STRONGLY RECOMMEND THAT YOU ALSO CONTACT YOUR INSURANCE COMPANY TO DISCUSS YOUR INSURANCE BENEFITS AND FINANCIAL RESPONSIBILITY. YOU ARE RESPONSIBLE FOR ALL CHARGES NOT COVERED BY YOUR INSURANCE.

Insurance: We participate in most insurance plans, including Medicare. It is your responsibility to keep us updated on any changes that occur throughout your course of care.

Claim Submission: We will submit claims on your behalf to your insurance and assist you in any reasonable way to get your claims paid.

Copayment: All copays must be paid in full on the date of service unless a payment plan has been established with the office.

Deductibles: You will be responsible for all charges that your insurance company applies to your deductible. Portions of the deductible are expected to be paid at the time of services as follows with the remainder of the balance to be paid in full upon receipt of statement.

$100-1000 Deductible = $30/visit payment, **$1001-5000 Deductible=** $50/visit payment **$5000+ Deductible=** $70/visit payment

Co-Insurance: A co-insurance may be applied to your coverage until an out of pocket maximum is met. Co-insurance amounts vary based upon the percentage and amount billed. Portions of the co-insurance are expected to be paid at the time of service at a rate of $1.00/percentage with the remainder of the balance to be paid in full upon the receipt of the statement. (example: 20% con-insurance=$20/visit payment)

Cash Payment: Please speak to the office about this and a Good Faith Estimate will be provided.

Overpayment: All overpayments on accounts will be refunded to you within 45 days of the account being deemed paid in full.

Unpaid Balances: Statements will be mailed out monthly and payment is expected upon receipt. If your account is 90 days past due and no attempt to reach us for a payment plan, your account will be referred to a collection agency.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

Signature of Patient or Responsible Party: _____ **Date:**_____