Ypsi Rehab
Ypsilanti Rehabilitation Services, Inc.
Physical Therapy
Personal and Professional Since 1982

Health History

Name | Social Security Number | DOB

Emergency Contact Name | Phone

Why are you coming in for physical therapy today?

Health History-Have you ever had or been told that you have:

	Yes	No		Yes	No		Yes	No
Allergies	○	○	Depression	○	○	Low Blood Pressure	○	○
Anemia	○	○	Diabetes	○	○	Low Blood Sugar	○	○
Anxiety/Panic Attacks	○	○	Emphysema	○	○	Lupus	○	○
Arthritis	○	○	Fibromyalgia	○	○	Osteoporosis	○	○
Asthma	○	○	Hearing Aide	○	○	Seizure Disorder	○	○
Auto-Immune Diseases	○	○	Heart Disease	○	○	Sleeping Problems	○	○
Cancer	○	○	Hepatitis	○	○	Stroke	○	○
Chronic Headaches	○	○	High Blood Pressure	○	○	TMJ Problems	○	○
						Ulcers	○	○

Please list any other current health problems not listed above

Do you have; Pacemaker? Yes Metal Implants? No If you are a female, are you currently pregnant? No

Are you taking any medications? No If yes, please list

Have you ever been to a pain clinic? No If yes, where and what for

Please List Previous Surgeries.

How much do you smoke each day? How much alcohol do you drink each day?

How would you rate your pain level? 0-(No Pain) How would you rate your stress level? 10-(Very Stressful)

Are there any specific aspects of your life that are particularly stressful?(Work, family, finances, school,etc.)

Any major life changes in the past year?(birth, death, divorce, job change, etc.)

How has this condition affected your daily functioning? (housework, bathing grooming, meal prep, etc.)

2063 Rawsonville Rd.
Belleville, MI 48111

Phone 734.485.4544
Fax 734.485.8125

www.ypsirehab.com

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New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Ypsilanti Rehabilitation Services, Inc. originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a *Notice of Privacy Policies* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand that Ypsilanti Rehabilitation Services, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Ypsilanti Rehabilitation Services, Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Ypsilanti Rehabilitation Services, Inc. change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

Initials

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I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.
Signed Date

I understand that while Ypsilanti Rehabilitation Services, Inc. bills my insurance carrier as a courtesy to me, I am responsible for the entire bill when the services are rendered. If my insurance carrier does not remit payment within 60 days of submission of the bill, the balance will be due in full from me.
Signed Date

I **DO** authorize Ypsilanti Rehabilitation Services, Inc. to discuss my treatment or billing with the indicated persons:

Treatment	Billing
Spouse	Spouse
Child	Child
Other	Other
Other	Other

I **DO NOT** authorize Ypsilanti Rehabilitation Services, Inc. to discuss my treatment or billing with the indicated persons:

Treatment	Billing
Spouse	Spouse
Child	Child
Other	Other
Other	Other

Further, I permit a copy of this authorization to be used in place of the original, and I request payment of medical insurance benefits to Ypsilanti Rehabilitation Services, Inc. I also authorize Ypsilanti Rehabilitation Services, Inc. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
Signed Date

If not signed by the patient, indicate relationship to patient (e.g. parent)
Relationship Witnessed By

☐ By checking this box, I hereby agree to the use of my digital signature on this form.

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Patient Missed Appointment Policy

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and gain of your physical abilities is something everyone in our clinic takes quite seriously.

We care so much about you, we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need and to the actions we ask you to do.

Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain guidelines that need to be followed in order to ensure the most optimum results for you.

We encourage you to follow through with all of your appointments. You will be provided with a printed copy of your scheduled appointments.

With the exception of serious emergencies, it is expected that you keep all of your appointments. If you need to re-schedule an appointment we require a 24 hour notice. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. If an appointment cannot be made up within the same week, it will be extended to the end of your treatment.

In instances of repeated non-compliance with your scheduled visits, your therapist reserves the right to discontinue care and inform your physician that your treatment has been discontinued due to non-compliance with the prescribed rehabilitation order.

We appreciate you greatly as our patient and strive to accomplish the highest possible results and success for you.

Ypsilanti Rehabilitation Services, Inc

I have read and understand this policy: Date:

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