**CONSENT FOR TREATMENT**

I, the undersigned, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and do hereby voluntarily consent to and authorize West Texas Rehabilitation Center, Inc., (WTRC), a Texas non-profit corporation, or other related entities to administer treatment as per the doctor's orders.

**ASSIGNMENT OF BENEFITS AND AUTHORIZATION OF RELEASE OF INFORMATION**

I hereby assign to WTRC all benefits provided under any healthcare plan, medical policy, motor vehicle insurance and/or any other entities paying on my behalf, otherwise due or payable to me provided the amount of such benefits shall not exceed the amount of said professional service charges. I understand that I am personally responsible to WTRC for all charges not covered by this assignment and that a photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any records/information, including papers, forms, videos, photographs and other records pertinent to my case, to any insurance company, adjuster, medical case manager, employer, physician or other medical entity, or attorney involved in the case.

**PAYMENT POLICIES**

1. Although you may be assisted by private insurance, Worker's Compensation, Medicare, Medicaid or even WTRC's Donor Sponsorship Program, payment for services received by you or your family is ultimately your responsibility. Cash, personal checks and major credit/debit cards are accepted.
2. Payment is required at the time of service if you have an insurance plan that dictates a per visit co-payment. Patients who do not have such a feature in their insurance coverage will be mailed a statement indicating their financial responsibility for the services provided.
3. WTRC is committed to assisting families with their financial responsibilities. The Donor Sponsorship Program is designed to identify families with various levels of need and provide them with corresponding assistance. Our staff will be glad to assist you in determining your eligibility for assistance. Before this process can begin; however, we need to know that you would like to seek assistance and are willing to provide the needed information.

WTRC hopes that this information helps to clarify our policy. If at any time you have a question or you would like to be reconsidered for sponsorship based on new information, do not hesitate to ask the Admissions staff.

**THIRD PARTY DISCLOSURES** I, _____, am the patient (or guardian, Healthcare Power of Attorney, or the patient's duly authorized representative) and give the following person(s) or representative(s) permission to discuss appointments, medical treatments and/or any financial matters on my behalf and request copies of medical records.

_____ _____

Printed Name Relation (Phone) Printed Name Relation (Phone)

*Please circle "yes" or "no":*

**Y N** I grant permission for WTRC personnel to leave messages on my home voice mail and/or cell phone.
**Y N** I grant permission for WTRC personnel to send me text messages on my cell phone.
**Y N** I grant permission for WTRC personnel to leave messages on my work voice mail, if applicable.
**Y N** I grant permission for WTRC to communicate via email. If Yes, Email: _____
**Y N** I grant permission for WTRC personnel to contact me for fundraising efforts.
**Y N** I grant permission for WTRC to use my name and/or image in marketing materials as outlined in the Media Release in the orientation packet.

I have been offered a copy of the appropriate orientation to West Texas Rehabilitation Center. I have been offered a copy of "Your Information. Your Rights. Our Responsibilities." which describes how medical information about you may be used and disclosed and how you can get access to this information. If after reviewing the document, should you have any questions, our Admissions staff would be glad to answer them.

_____ _____

Signature of Patient or Guardian Date WTRC Witness Date

# DEMOGRAPHICS UPDATE

*** *Please Print* ***

**Address:** _____ **City/State:** _____ **Zip:** _____

**Home Phone:** _____ **Cell Phone:** _____ **Work Phone:** _____

**Sex:** ***M*** ***F*** *(Please circle)*

**Emergency Contact:** _____
*(Name)* *(Relation)* *(Phone)*

**Form Completed By:** _____ **Relation:** _____
*(Signature)*

**Parent/Guardian's Name(*s*) (*If Minor*):** _____
*(Name)* *(Relation)*

## PRIMARY INSURANCE INFORMATION

**Company:** _____ **Phone Number:** _____

**Policy Holder:** _____ **Relation:** _____ **DOB:** _____

**Policy #:** _____ **Group #:** _____

## SECONDARY INSURANCE INFORMATION

**Company:** _____ **Phone Number:** _____

**Policy Holder:** _____ **Relation:** _____ **DOB:** _____

**Policy #:** _____ **Group #:** _____

## WORK COMP/LIABILITY/AUTO ACCIDENT

**Employer:** _____ **Adjuster's Name:** _____

**Date of Injury/Accident:** _____ **Adjuster's Phone #:** _____

**Claim Number:** _____ **Legal Rep:** YES NO **Police Report:** YES NO

**Auto Insurance:** _____ **Legal Rep Name:** _____

**For WTRC Staff Only**

☐ **Picture ID of Parent/Guardian** ☐ **Copy of Current Insurance**

**Received by:** _____ **Date:** _____

## MEDICAL/SOCIAL HISTORY

**What is the reason your doctor sent you for treatment?**

**What do you want us to help you be able to do?**

**How long have you had this problem?** *(please give a date or length of time)*

## Medical History

***Are you receiving any home nursing?** O Yes O No
*(Is any healthcare provider coming to your home to check your blood pressure or give you medications?)*

***Are you receiving any home therapy?** O Yes O No
**If Yes, who is the home health agency?*

**Past Hospitalizations/Surgeries:**

**Please list or attach the medications that you are currently taking**

| Medication | Prescribing Physician | Physician Phone # |
|---|---|---|
| | | |

**Do you have any known medication allergies?** O Yes O No **If Yes, please list**

**Please place an "X" in front of <u>all</u> the answers that apply to you.**

Which of the following medical conditions do you *currently* have?

| | | | |
|---|---|---|---|
| O Asthma | O Fibromyalgia | O Traumatic Brain Injury | O Hyper/Hypothyroid |
| O Emphysema | O Diabetes | O Stroke | O Incontinence - Bowel |
| O COPD | O HIV | O Vision Problems | O Incontinence - Bladder |
| O Chronic Bronchitis | O Heart Disease | O Cataracts | O Bone Fracture |
| O Tuberculosis | O AIDS | O Multiple Sclerosis | O Carpal Tunnel Syndrome |
| O Lupus | O Cancer | O Seizure Disorder | O Back Injury |
| O High/Low BP | O Hepatitis | O Alzheimer's | O Depression, Anxiety and/or any other mental illness |
| O Arthritis | O Paralysis | O Parkinson's | |
| O Chronic Pain | O Hearing Problems | O Congestive Heart Failure | O Osteoporosis |
| O Degenerative Joint Disease | | | O Pregnant<br>O Other: |

**Please indicate with an "X" whether you do them alone or with help.**

| Alone | With Help | | Alone | With Help | |
|---|---|---|---|---|---|
| O | O | Walking | O | O | Getting in/out of bed |
| O | O | Eating/Swallowing | O | O | Getting in/out of chairs |
| O | O | Household activities | O | O | Getting in/out of the bath |
| O | O | Grooming/Bathing/Toilet | O | O | Speaking and Hearing |
| O | O | Meal preparation | O | O | Dressing |
| O | O | Transportation | O | O | Remembering |
| O | O | Personal Finances | O | O | Problem Solving |

**Has your current illness or injury caused any of the following?**

| Yes | No | | Yes | No | |
|---|---|---|---|---|---|
| O | O | Financial Stress | O | O | Sleep Disturbances |
| O | O | Family Problems | O | O | Irritability |
| O | O | Anger | O | O | Fear |
| O | O | Anxiety | O | O | Loss of Appetite |
| O | O | Sadness | O | O | Suicidal Thoughts in the last month |
| O | O | Depression | | | |
| O | O | Frustration | O | O | Have you felt so overwhelmed that you wanted to die or go to sleep and not wake up? |

Do you smoke? O Yes O No If yes, packs/day: _____

Do you currently have a **Universal DO NOT RESUSCITATE (DNR) Order?** O Yes O No
If yes, please provide a copy.

Do you currently have a **Hospital Procedure-Specific DO NOT RESUSCITATE (DNR) Order?** O Yes O No

Do you have a preferred name we should use? _____

Would you like to meet with a Social Worker? O Yes O No

**Printed name of person that completed this form.** **Relationship to patient**

**Signature of person that completed this form** **Patient Phone Number** **Date**

**Please answer the following questions to the best of your abilities**

1. Mobility Assistance
   - O Wheelchair/Power Chair
   - O Cane/Walker
   - O None

2. Home Environment:
   - O Live Alone
   - O With Spouse
   - O Other _____

3. Type of Residence:
   - O Single Story
   - O Multi Story
   - O Stairs How many? _____
   - O Steps How many? _____
   - O Ramps How many? _____

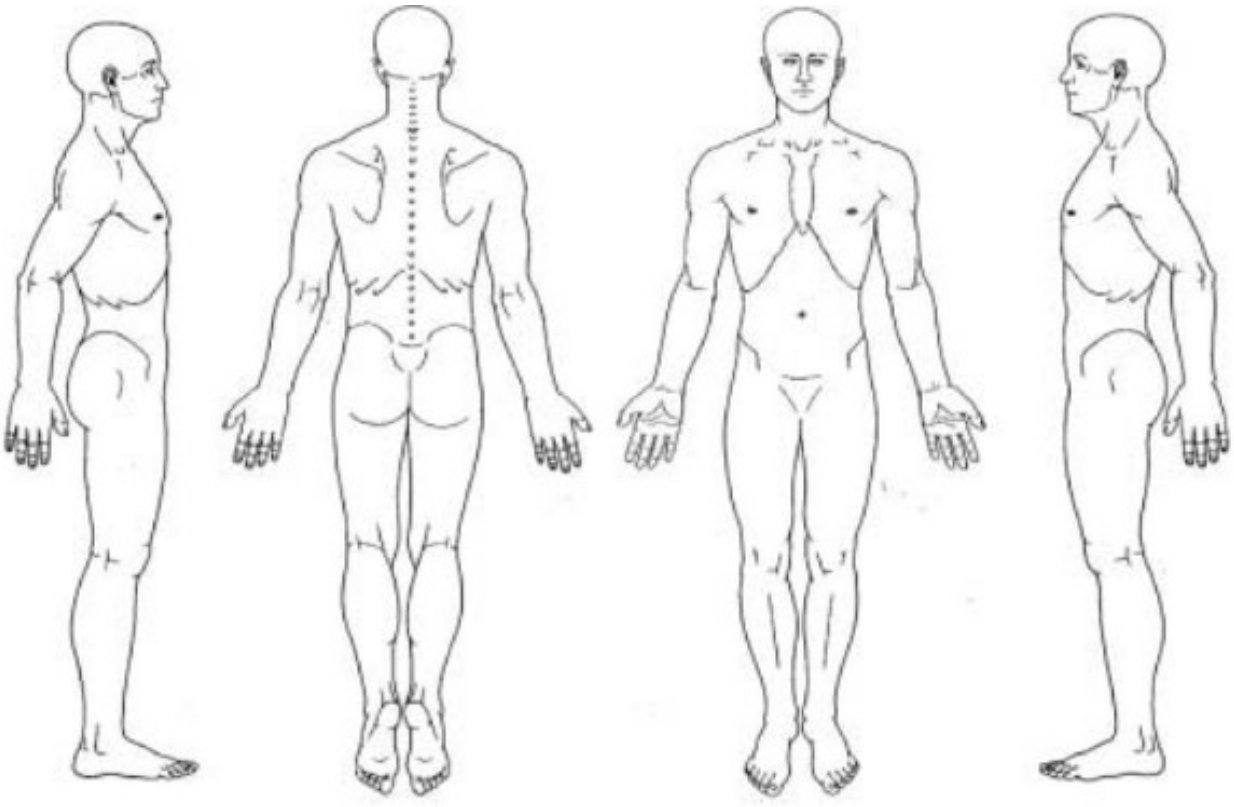
4. Employment Status
   - O Retired
   - O Disabled
   - O Unemployed
   - O Employed
     - → Employer Name:
     - → Job Description:
     - → Lifting and/or physical requirements:

5. Quality of Life
   - O Excellent
   - O Good
   - O Fair
   - O Poor
   - O Unable to Communicate

**Please mark the areas where you feel symptoms**

↓ Shooting Pain
O Dull/Aching Pain

III Numbness
= Tingling



# ATTENDANCE POLICY

At WTRC, we strive to provide individualized therapy to each and every patient. It is very important that you follow the recommendations of your therapist. You will be expected to attend and be on time to all scheduled therapy appointments. Please notify us of your attendance by checking in at the reception window. If you will be unable to attend your scheduled therapy visits, **please call (325)223-6304** at least 24 hours in advance or as soon as possible.

- Two (2) absences without 24 hr. notice will result in discharge. Frequent absences (even those reported in advance) could have a negative impact on you reaching your treatment goals and may also result in discharge.
- The frequency of your therapy sessions will depend on the treatment plan approved by your physician. Please notify your therapist/clinician at the time of evaluation of any special requests you may have for appointment scheduling. Average appointment length of time will vary between 30mins-1hour
- Please understand that, while we will do our best to schedule your appointments at times that are convenient for you, it may not always be possible to meet every special request that we receive.
- Service dogs must be harnessed with a standard leash that is not retractable and attended at all times.
- While in therapy, it is important to wear comfortable clothing that allows you to move easily. If you have questions, please speak with your therapist.

**NOTE:** If you wait longer than 15 minutes after your scheduled appointment, please notify a staff member. Our goal is to increase your overall function at home and/or at work. Please make your therapist aware of upcoming doctor's appointments so that your Therapist can submit updated information about your status to your doctor prior to your visit.

_____ _____

Patient Printed Name Patient Signature Date

_____ _____

WTRC Witness Signature Date