

Patient Name:
DOB:

West Texas Rehabilitation Center
Medical Record#

Date:

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
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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: _____

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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?**

Yes

No

(Is any healthcare provider coming to your home to check your blood pressure or give you medications?)

***Are you receiving any home therapy?**

Yes

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?

Yes No

If Yes, please list

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Please place an "X" in front of all the answers that apply to you.

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

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

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

Alone	With Help		Alone	With Help	
<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	Getting in/out of bed
<input type="checkbox"/>	<input type="checkbox"/>	Eating/Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Getting in/out of chairs
<input type="checkbox"/>	<input type="checkbox"/>	Household activities	<input type="checkbox"/>	<input type="checkbox"/>	Getting in/out of the bath
<input type="checkbox"/>	<input type="checkbox"/>	Grooming/Bathing/Toilet	<input type="checkbox"/>	<input type="checkbox"/>	Speaking and Hearing
<input type="checkbox"/>	<input type="checkbox"/>	Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	Dressing
<input type="checkbox"/>	<input type="checkbox"/>	Transportation	<input type="checkbox"/>	<input type="checkbox"/>	Remembering
<input type="checkbox"/>	<input type="checkbox"/>	Personal Finances	<input type="checkbox"/>	<input type="checkbox"/>	Problem Solving

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

Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Financial Stress	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Disturbances
<input type="checkbox"/>	<input type="checkbox"/>	Family Problems	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Anger	<input type="checkbox"/>	<input type="checkbox"/>	Fear
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Loss of Appetite
<input type="checkbox"/>	<input type="checkbox"/>	Sadness	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal Thoughts in the last month
<input type="checkbox"/>	<input type="checkbox"/>	Depression			
<input type="checkbox"/>	<input type="checkbox"/>	Frustration	<input type="checkbox"/>	<input type="checkbox"/>	Have you felt so overwhelmed that you wanted to die or go to sleep and not wake up?

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

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

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

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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

- Wheelchair/Power Chair
- Cane/Walker

- None

2. Home Environment:

- Live Alone
- With Spouse
- Other _____

3. Type of Residence:

- Single Story
- Multi Story
- Stairs How many? _____
- Steps How many? _____
- Ramps How many? _____

4. Employment Status

- Retired
- Disabled
- Unemployed
- Employed
- Employer Name:

- Job Description:

5. Quality of Life

- Excellent
- Good
- Fair
- Poor
- Unable to Communicate

→ Lifting and/or physical requirements:

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Please mark the areas where you feel symptoms

↓ Shooting Pain
○ Dull/Aching Pain

III Numbness
= Tingling



