

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
---	---------------	-----------------------	---------------

Patient Name:
DOB:

West Texas Rehabilitation Center
Medical Record#

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: _____

Patient Name:
DOB:

West Texas Rehabilitation Center
Medical Record#

Date:

MEDICAL/SOCIAL HISTORY

What is the reason your doctor sent you for treatment?

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

Current school: _____ **Grade:** _____
Sports/Hobby/Activities: _____

Past Medical History: (Hospitalizations/Surgeries)

Please list or attach the medications currently prescribed to you

<u>Medication</u>	<u>Prescribing Physician</u>	<u>Physician Phone #</u>

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

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

- | | | | |
|--|-------------------------------------|-------------------------------------|---|
| <input type="radio"/> Asthma | <input type="radio"/> Hernia | <input type="radio"/> Back Injury | <input type="radio"/> Hyper/HypoThyroid |
| <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> Fibromyalgia | <input type="radio"/> Vision Problems |
| <input type="radio"/> Cancer | <input type="radio"/> Heart Disease | <input type="radio"/> Concussion | <input type="radio"/> Depression, Anxiety, and/or any other mental illness? |
| <input type="radio"/> Lupus | <input type="radio"/> Pregnant | <input type="radio"/> Bone Fracture | <input type="radio"/> Seizure Disorder |
| <input type="radio"/> Hypermobility Syndrome (EDS) | <input type="radio"/> Neck Injury | | |

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

- | Yes | No | Yes | No |
|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

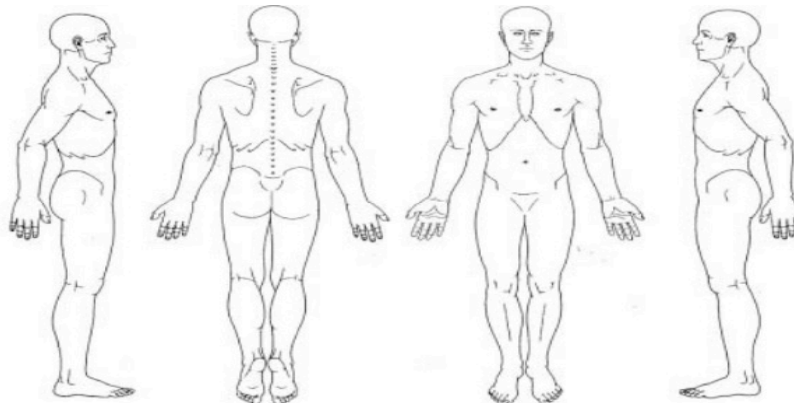
Printed name of person that completed this form. _____ **Relationship to the patient:** _____

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

Please mark the areas where you feel symptoms

↓ Shooting Pain
○ Dull/Aching Pain

III Numbness
= Tingling



Patient Name:
DOB:

West Texas Rehabilitation Center
Medical Record#

Date:

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 Abilene at (325)793-3441, San Angelo at (325)223-6304, or Ozona at (325)392-9872** 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