AgileRPM

# SUBJECTIVE PATIENT INTAKE FORM

## PATIENT INFORMATION

| Name: | | Date of Birth: |
|---|---|---|
| Referring Physician: | Additional Physician(s): | Next Physician Appt: |
| Reason for Treatment: | | |

## PERSONAL INFORMATION

| Occupation: | General Activity Level: *(please circle)* | | | |
|---|---|---|---|---|
| | Sedentary | Lightly Active | Active | Very Active |
| Job Duties: | Hobby/Interest: | | | |

## WORK STATUS & RESTRICTIONS

| Work Status: *(please check one)* | Duty Level: *(please check one)* |
|---|---|
| Employed – Full Time | Transitional |
| Employed – Part Time | Light |
| Employed – On Leave | Regular |
| Self-Employed | Heavy |
| Unemployed | |
| Retired | |
| List Work Restrictions: | |
| Leave Date: | Return Date: |

## LIVING SITUATION

| Lives in: *(please circle)* | | |
|---|---|---|
| House | Apartment | Assisted Living |
| Describe Living Situation: | | |

## PSYCHO-SOCIAL CONSIDERATIONS

| How is your support system? | Good | Fair | Poor |
|---|---|---|---|
| Mark any area below that you have concerns with? | | | |
| Transportation | Financial | Other | |
| Who do you provide care to? | | | |
| Who do you receive care from? | | | |

## LEARNING STYLE & READINESS

| Preferred Learning Method: | | | |
|---|---|---|---|
| Hands On | Verbal | Visual | Written |

## MEDICAL HISTORY

| Medications? | Yes | No | Past Surgery? | Yes | No |
|---|---|---|---|---|---|
| If YES, please list | | | IF YES, please list | | |

## COMORBIDITIES/PRECAUTIONS

Below is a list of comorbities/precautions. Please mark if any of the items apply to you:

| None | Cancer | Diabetes | HIV/AIDS | MS | Pneumonia | Stroke |
|---|---|---|---|---|---|---|
| ADD/ADHD | Chest Pain | Fall Risk | Hypertension | Obesity | Pregnant | VRE |
| Allergies | Cognition | Fibromyalgia | Lung Disease | Osteoarthritis | Recent Surgery | Vision Impaired |
| Anxiety | COPD | Head Trauma | Metal Implants | Osteoporosis | Arthritis | Other: |
| Asthma | Emphysema | Hearing Impaired | Migraines | Pacemaker | Seizures | |
| Blood Clots | Depression | Heart Disease | MRSA | Parkinson's | STD | |

## FALL HISTORY

| How many falls? | Injury? | Yes | No |
|---|---|---|---|
| If Yes, Most Recent Occurrence: *(please circle one)* | | | |
| Last 6 weeks | Last 6 months | Last 12 months | More than year |

## DRUG HISTORY

| History of: *(please mark applicable)* | | |
|---|---|---|
| Tobacco Use | Alcohol Use | Smoker |
| Other: | | |

**Continued on Next Page**

## REASON FOR TREATMENT



Patient Initials _____

AgileRPM

# SUBJECTIVE PATIENT INTAKE FORM

| When did you start experiencing this issue? | Date of Onset/Injury: |
|---|---|

## PRIOR TREATMENTS

| Have you had prior treatments for this issue? | Yes | No |
|---|---|---|

If yes, please mark all that apply below:

| | | | |
|---|---|---|---|
| Audiologist | Massage Therapy | Postoperative PT | Swallowing Treatment |
| Acupuncturist | Neurologist | Preoperative PT | Other: |
| Cardiologist | Occupational Therapy | Primary Care Doctor | |
| Chiropractor | Orthopedist | SLP | |
| Cortizone Injection | Otolaryngologist | Surgery | |
| ER/Urgent Care | Podiatrist | Specialist | |

## PRIOR TESTS

| Have you had prior tests for this issue? | Yes | No |
|---|---|---|

If yes, please mark all that apply below:

| | | | |
|---|---|---|---|
| CT Scan | Hearing Test | Prostate Exam | Work Tolerance Test |
| Discogram | MRI | Rotational Chair | X-Ray |
| EEG | Myelogram | Thermogram | Vision Exam |
| EKG | Nerve Conduction Test | Urinalysis | Other: |
| ENG | Pelvic Exam | Videogram | |
| EMG | Posturography | Videofluroscopy | |

## PATIENT CONCERNS

Please list any and all concerns you have:

1.

2.

3.

## FUNCTIONAL PROBLEMS

Please list any and all functional problems you currently have due to your diagnosis:

1.

2

3.

## PAIN ASSESSMENT

Please report a pain assessment on the scales below where **0 is no pain** and **10 is the worst pain imaginable**:

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Pain at Rest: | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain with Activity: | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Pain Range: (low to high) | N/A | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Pain Description:

Pain Location:

## AGGRAVATING FACTORS

Please list any aggravating factors for pain: (e.g. movement)

## ALLEVIATING FACTORS

Please list any alleviating factors for pain (e.g. laying down)

## SIGNATURES

| Signature of patient (or guardian): | Date: |
|---|---|

Wickenburg Community Hospital

## Notification of Rehabilitation No Show, Tardiness and Cancellation Policies

Thank you for choosing WCH for your Rehabilitation Needs. We are very happy that you're here and dedicated to your success.

The following policies are geared toward offering each of our patient's enough time during their appointments, to maximize therapy outcomes.

Patients are expected to keep all scheduled appointments to maximize the benefits of their treatment plan. It is important to be on time therefore, if the patient is more than eight (8) minutes late, we reserve the right to cancel or reschedule the appointment. We realize that there are times when unforeseen circumstances make it impossible to attend your appointment. If you are unable to make a scheduled appointment, you are expected to give 24-hour advance notice. Please call us at **928-684-5529** to reschedule.

If the patient has two (2) consecutive appointment no-shows, it may result in discontinuation of the current appointment schedule. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services. Planned absences from scheduled therapy will not be considered cancellations or no-shows. Please discuss scheduling options with your therapist. We will try to accommodate your needs.

**In signing below, you are acknowledging that you understand our policies regarding no-shows, tardiness and cancellations and commit to your therapy plan.**

**Patient/Guardian Signature:** _____ **Therapist Initials:** _____

*520 ROSE LANE, WICKENBURG, ARIZONA 85390*
*(928)684-5529 - FAX (928)684-8717*
*WWW.WICKHOSP.COM*

Wickenburg Community Hospital, 520 Rose Lane, Wickenburg, AZ 85390
Community Hospital Clinic, Surgeons, 519 Rose Lane, Wickenburg, AZ 85390
WCH Bagdad Physical Therapy, 700 Palo Verde, Bagdad, AZ 86321

Wickenburg Community Hospital

PATIENT LABEL

# CONDITIONS OF ADMISSION

## CONSENT TO MEDICAL AND SURGICAL PROCEDURES

I voluntarily consent to diagnostic procedures and medical treatment deemed necessary by authorized providers and employees of the hospital and clinic staff.

## LEGAL RELATIONSHIP BETWEEN HOSPITAL AND PHYSICIANS

I understand some providers and surgeons providing services to me, including Emergency Room Physicians, Hospitalists, Surgeons, Anesthesiologist and others, are not employees, representatives or agents of the hospital. They are independent practitioners who have been granted the privilege of using the hospital for the care and treatment of their patients. **Professional services rendered by independent practitioners are not part of the hospital bill. I understand that I may be billed separately for these services.**

Patient initials:_____

## NOTICE OF PATIENT RIGHTS AND RESPONSIBILITIES

I acknowledge I have been offered a copy of a Statement of Patient Rights and Responsibilities ensuring that I am treated with respect and dignity and without discrimination or distinction based on age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, medical condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

I received a copy of the Patient Bill of Rights. _____Patient initials

I declined a copy of the Patient Bill of Rights. _____Patient initials

## NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been offered the hospital's Notice of Privacy Practices which describes the ways in which the hospital may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures and I understand that I may contact the hospital's Privacy Officer, designated on the notice, if I have a question or complaint.

I received a copy of the Notice of Privacy Practices. _____Patient initials

I declined a copy of the Notice of Privacy Practices. _____Patient initials

## PATIENT DIRECTORY

**Emergency Department (ED) or Inpatient ONLY:** In order to assist family members and other visitors in locating you while you are in the Hospital, we maintain a patient directory that includes your name and room number. We will disclose this information to someone who asks for you by name, unless you instruct us not to.

I opt out of the ED/Inpatient Directory. Patient initials:_____

## PERSONAL BELONGINGS

I understand and agree that the Wickenburg Community Hospital and Community Hospital Clinic shall not be liable for the loss or damage to any money, jewelry, glasses, dentures or other articles of financial or personal value.

Patient initials:_____

## FINANCIAL AGREEMENT

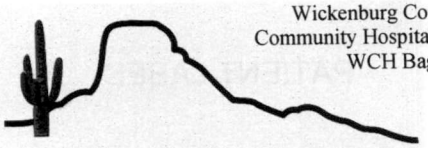
I agree that for the services provided to the patient by hospital, clinic and other health care providers, I will pay the account balance of the patient or make financial arrangements satisfactory to the hospital, clinic or any other providers, prior to discharge.

I understand the hospital is required to provide a screening examination to all patients who are seeking medical services to determine if there is an emergency medical condition, without regard to the patient's ability to pay. If there is an emergency medical condition, the hospital will provide stabilizing treatment within its capacity. I understand the hospital has a financial assistance policy and the financial responsibility for these services may be reduced or waived for those who qualify.

I understand that should my account become delinquent, it may bear interest at the legal rate and if my account is referred to an attorney for collection, I am responsible to pay reasonable attorney fees and collection expenses.

Patient initials:_____

Wickenburg Community Hospital, 520 Rose Lane, Wickenburg, AZ 85390
Community Hospital Clinic, Surgeons, 519 Rose Lane, Wickenburg, AZ 85390
WCH Bagdad Physical Therapy, 700 Palo Verde, Bagdad, AZ 86321



Wickenburg Community Hospital

PATIENT LABEL

## RELEASE OF INFORMATION

In consideration for the treatment to be given by Wickenburg Community Hospital and Community Hospital Clinics, I hereby agree to the confidentiality of medical records relating to this service including, without limitation, any psychiatric treatment. For the time period of this service, I agree, understand and authorize all records generated by this treatment and/or admission to the hospital (or treatment for whom the undersigned has legal authority to execute this consent form) can be reviewed by any person or organization authorized by law. I also authorize that these records can be reviewed by and released to a third party payer who may provide insurance payment to the hospital or clinic. Provider may release any and all parts of the patient's medical records to persons or entities engaged in the activities stated below:

A. Insurance and Quality Review: Persons or corporations (including insurance companies, worker's compensation payers, hospital or medical service corporations, welfare governmental agencies, or the patient's employer), or their designees, which may be liable under contract to the Provider, other party, patient, family member, or employer of the patient, for the purposes of securing payment for all or part of a Provider's charges, quality assurance, accrediting agencies, and provider/ physician liability insurance carriers to enable them to carry out their functions.
B. Billing and Collections: Agents or employees of the Provider that process or duplicate medical records for billing and reimbursement purposes.
C. Medical Audit: Persons or entities authorized by the Provider for purposes of conduction medical audit activities.
D. Other Providers: Physicians and personnel involved in the patient's care to provide and manage the patient's health care. Also, information may be given to other health care providers to assure continuity of care.
E. State or Regional Health Information Exchange, currently the Health Information Network of Arizona.

Patient initials:_____

This authorization may include disclosure of information relating to **DRUG, ALCOHOL** and **SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION** (except psychotherapy notes), **CONFIDENTIAL HIV/AIDS-RELATED INFORMATION**, and **GENETIC INFORMATION** only if I place my initials on the appropriate lines below.

Patient initials:_____

## ASSIGNMENT OF BENEFITS

I irrevocably assign and transfer to the hospital all rights, benefits, and other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include allocating and authorizing direct payment to the hospital of all insurance and health plan benefits payable for hospitalization or for outpatient services. I agree that the insurer or plan's payment to the hospital pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by this hospital to perfect, confirm, or validate this assignment.

Patient initials:_____

**For Medicare/Medicaid Beneficiaries Only:** I certify that the information given by me in applying for payment under Titles XVIII & XIX under the Social Security Act is correct. I request that payment of authorized benefits be made on my behalf for any service furnished to me by, or in Wickenburg Community Hospital and Community Hospital Clinics, including physician services. I authorize any holder of medical or other personal information to release any information necessary to determine these benefits or related services to the health care financing administration and agents.

Patient initials:_____

## PATIENT/GUARANTOR SIGNATURE

I, the undersigned, as the Patient, Patient Representative, or legal guardian of a minor/incapacitated Patient, hereby certify I have read, and fully understand this Conditions of Admission and Authorization for Medical treatment, and that I have signed this Conditions of Admission and Authorization for Medical Treatment knowingly, freely, voluntarily and agree to be bound by its terms.

| | |
|---|---|
| Patient | Patient Name / MR# |
| Witness | Guarantors |
| Date | Relationship to Patient |