Morris County Hospital

MCH REHAB CENTER
Physical, Occupational, & Speech Therapy

Marital Status:____________________

Patient Name:______________________________Address:____
Street City State Zip

Home Phone:_______-_______-________Cell Phone:________-_________-_________Work:_______-________-__________

As a courtesy we will send you a text or voice call reminder 24 hours prior to your next scheduled appointment, please circle which reminder you would prefer.

Text Voice Call

Birthdate:______________________________Sex:___________Email Address:______________________________________

Emergency Contact:__________________________Relationship:__________________Phone Number:______-_______-______

Employer:____Position:____

PRESENT ILLNESS AND MEDICAL HISTORY

Please circle

Auto Accident: YES NO **Work injury**: YES NO **Other:**______________**Injury Date**____________**Surgery Date**_________

Based on your awareness, what is your rehabilitation expectations/goals while in this program?

____

____

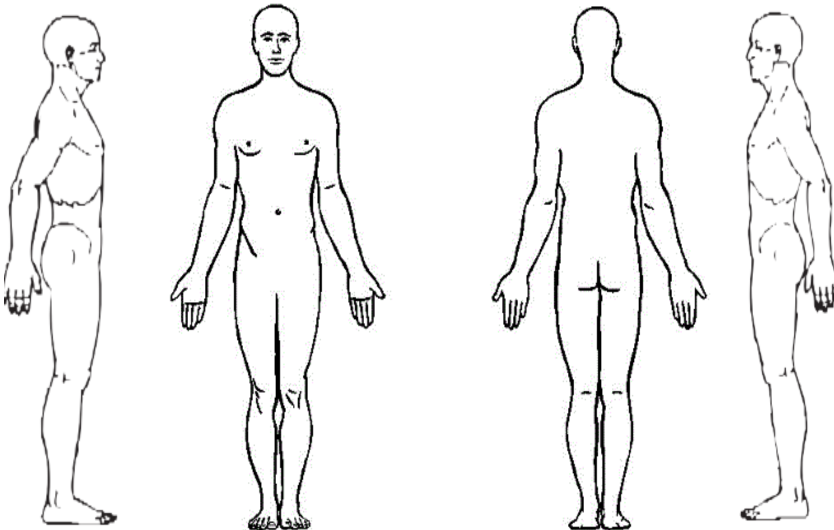
Do you now have or have you ever had and of the following? Please mark with an (X)

____Cardiovascular Disease ____Stroke/TIA ____ History of Cancer ____Immunosuppression ____Depression/Anxiety
____Heart Attack ____Diabetes ____Cancer ____Epilepsy/Seizures ____ Currently pregnant
____Pacemaker ____Parkinson's ____Osteoarthritis ____Current Infection ____ High Blood Pressure
____Alzheimer's ____Fibromyalgia ____Rheumatoid Arthritis ____Traumatic Brain Injury ____Suspected Fracture
____Recent Surgery ____Fracture
Other(please list):____

Have you had any of the following medical services for this injury?

_____X-Ray _____MRI _____CT Scan _____Chiropractic _____PT/OT_____Orthopedist _____Neurologist _____Podiatrist

On the body diagram below, please mark the areas of your symptoms as they are at this moment:



Is there an attorney involved in this case? YES NO

Would you like to speak with a social worker about any aspects of Your rehabilitation program? YES NO

Are you currently taking any prescription and/or non prescription medications? YES NO

List Medications below:
(If you have a list with you please provide to office to copy list)

____

____

____

____

Are you allergic to any Medications? YES NO
List Medication Below:

____

____

____

CANCEL/NO-SHOW AGREEMENT AND POLICY

The following policies outline our position regarding cancellations and no-shows for your therapy visits at Morris County Hospital**.**

These policies are important to us, and we hope that they are important to you because it can make the difference between whether or not you succeed in your treatment goals. Usually your referring doctor and/or therapist have prescribed a frequency of treatment. **Your participation and compliance with the plan of care will be your most important job.** All you need to do is follow your therapist's instructions and together we will have the best chance of achieving your goals!

- We require 24 hours notice in the event of a cancellation**. IT IS YOUR RESPONSIBILITY TO HAVE AN ALTERNATIVE TIME IN MIND THAT WILL ENSURE YOU GET YOUR FULLY PRESCRIBED NUMBER OF TREATMENTS THAT WEEK.** (in some cases, this may not work since some forms of treatment do not work when administered sequentially)
- There is a $25 charge for any cancellation without proper notice. This charge will be your personal responsibility and not billed to your insurance.
- For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your physician and case manager or employer. **This is a mandatory policy for all our therapists and may jeopardize your claim.**
- **Please understand that your pain may increase and/or decrease as your course of treatment progresses. Neither of these conditions should serve as a reason to miss your appointment.** If you are in pain you have one of the best reasons to come in so we can address it, and if you are feeling good this is our best opportunity to make some great strides towards goal completion.
- **When you fail to show as scheduled, three people are affected**: **You**, because you do not get the treatment you need as prescribed by the doctor and/or therapist; **the therapist**, who now has a space in their schedule since the time was reserved for you personally; **and another patient**, who could have been scheduled for a therapy appointment.

****We sincerely appreciate your cooperation and compliance with these policies. Your return to good health is our common goal****

Please acknowledge that you thoroughly understand these policies by signing below:

______________________________ ______________________

Patient/Guardian Signature **Date**

NOTICE OF PATIENT'S FINANCIAL RESPONSIBILITY

MANY INSURANCE COMPANIES ARE NOW REQUIRING PRE-CERTIFICATION ON OUTPATIENT SERVICES. EACH INDIVIDUAL INSURACE COMPANY HAS THEIR POLICY REGARDING OUTPATIENT PRE-CERTIFICATION; IF YOUR INSURANCE COMPANY REQUIRES CERTAIN OUTPATIENT SERVICES TO BE PRE-CERTIFIED AND YOU RECEIVE THESE SERVICES WITHOUT THAT CERTIFICATION NUMBER BEING PROPERLY OBTAINED THEN YOU MAY BE PERSONALLY RESPONSIBLE FOR THE CHARGES INCURRED FOR THOSE SERVICES.

I HAVE READ THE INFORMATION STATED ABOVE AND I FULLY UNDERSTAND THAT I MAY BE LIABLE FOR THOSE SPECIFIC CHARGES THAT I INCURR TODAY.

______________________________ ______________________

Patient/Guardian Signature **Date**