NEW PATIENT INTAKE FORM

PennState Health
Rehabilitation Hospital
In Partnership with Select Medical

PATIENT DEMOGRAPHICS

Patient Name:		**Date of Birth (mm-dd-yyyy):**	
Address:	**City:**	**State:**	**Zip Code:**
Mobile Phone:	**SS#:**	**Sex:** ☐ Male ☐ Female	
Home Phone:	**Email:**		
Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Seperated ☐ Unknown			
Race/Ethnicity: ☐ American Indian/Alaska Native ☐ Asian/Pacific Islander ☐ Black/African American ☐ White/Caucasion ☐ Hispanic/Latino ☐ Multiracial ☐ Declined ☐ Unavailable			
Date of Injury/Onset Date:	**Auto Related:** ☐ Y ☐ N	**Work Related:** ☐ Y ☐ N	

PRIMARY INSURANCE

Insurance Company:		**Phone#:**
Policy / ID#:	**Group#:**	
Policy Holder Name:	**Policy Holder Date of Birth:**	
Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other		

SECONDARY INSURANCE

Insurance Company:		**Phone#:**
Policy / ID#:	**Group#:**	
Policy Holder Name:	**Policy Holder Date of Birth:**	
Patient's Relationship to Policy Holder: ☐ Self ☐ Spouse ☐ Child ☐ Other		

EMERGENCY CONTACT

Contact Name:	**Phone#:**
Relationship to Patient: ☐ Parent ☐ Spouse ☐ Child ☐ Sibling ☐ Other	

REFERRING/PRIMARY PHYSICIAN

Physician:	**Phone#:**	**Fax#:**	
Address:	**City:**	**State:**	**Zip Code:**

I certify that the information provided is, to the best of my knowledge, true and accurate.

Signature:	**Date:**

Patient Name: _____ Date: _____
Acct#: _____

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NOTIFICATION of PATIENT RESPONSIBILITY for CO-PAYMENTS / CO-INSURANCE % and DEDUCTIBLES

Your insurance company requires Penn State Health Rehabilitation Hospital Outpatient Center to collect your co-payment amount from you at the time of service. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment. Furthermore, we have an obligation to collect any co- insurance % or unmet deductible amounts from you that are determined to be your responsibility.

You will receive statements from us during and after your treatment for any outstanding amounts your insurance company indicates will be your financial responsibility. These statements will also include the amount billed to your insurance company and the payments received from both you and your insurance company**.**

BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this section.

I authorize Penn State Health Rehabilitation Hospital Outpatient Center to disclose my health information that is directly related to my current treatment at Penn State Health Rehabilitation Hospital Outpatient Center to the individual(s) listed below for purposes of their role in my treatment or payment or payment for the health services that I have received.

Such persons involved in your care may include: spouse, children, blood relatives, roommates, boyfriends/girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to individuals involved in my care.

NAME	RELATIONSHIP

Penn State Health Rehabilitation Hospital Outpatient Center has verified Outpatient Physical Therapy/Occupational Therapy/Speech Therapy benefits based on the information furnished to us by you. Your Insurance Company has the disclaimer that this is verification of benefits and not a guarantee of payment. Based on the information your insurance company provided to us, the estimated amount you are responsible for is:

Co-Payment_____per Visit/Discipline Co-Insurance_____**%** of allowed amount
Deductible Amount_____Amount Remaining _____
Out of Pocket Maximum _____Amount Remaining _____
Maximum Visits/Days_____per Year / Contract / Condition / Lifetime
Other Benefit Information _____

NOTE: ***ESTIMATED coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility of their account balance. The estimation is based on a negotiated contract and any remaining balance due will be billed to you after additional information is received from your insurance company***.

We are committed to Service Excellence to our patients. If you have questions or concerns about your billing, please contact our Centralized Business Office at (866) 889-9968. Thank you.

Statement of Financial Responsibility; Consent to Treatment; Authorization to Release Information

PennState Health Rehabilitation Hospital
In Partnership with Select Medical

Patient Name: _____ Date: _____ Acct#: _____

STATEMENT OF FINANCIAL RESPONSIBILITY

Penn State Health Rehabilitation Hospital Outpatient Center appreciates the confidence you have shown in choosing us to provide for your rehabilitative needs. The service you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. **However, you are ultimately responsible for the payment of your bill.**

You are responsible for payment of any co-payment at the time of service and for any deductible /coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. Payment is expected by payment due date on your Monthly Patient Statement. Payments can be made at the center, mailed to the address on your statement, or you may access our on-line bill payment option @ https://pay.instamed.com/kesslerbillpay once a statement is received from the billing office, or by calling our customer service department at 1-866-889-9968.

I have read the above policy regarding my financial responsibility to Penn State Health Rehabilitation Hospital Outpatient Center for providing rehabilitative services to the above named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Penn State Health Rehabilitation Hospital Outpatient Center. I agree to pay Penn State Health Rehabilitation Hospital Outpatient Center the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature: _____ **Date:** _____

(relationship to patient: self – guardian – other**:** _____)

AUTHORIZATION TO UTILIZE CONTACT INFORMATION

I agree that in order for Penn State Health Rehabilitation Hospital Outpatient Center to collect any amounts I may owe, Penn State Health Rehabilitation Hospital Outpatient Center may contact me by any telephone number associated with my account, including wireless telephone numbers, which could result in charges to me. We may also contact you by sending text messages or emails, using any email address I provide to Penn State Health Rehabilitation Hospital Outpatient Center. Methods of contact may include using pre- recorded/artificial voice messages and use of automatic dialing devices, as applicable.

Signature: _____ **Date:** _____

(relationship to patient: self – guardian – other**:** _____)

Statement of Financial Responsibility; Consent to Treatment; Authorization to Release Information

PennState Health Rehabilitation Hospital
In Partnership with Select Medical

Patient Name: _____ Date: _____ Acct#: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that the **Notice of Privacy Practices** and **Notice for Federal Civil Rights** is posted at the location in which I am receiving treatment and that I have read and understand the notice. I further acknowledge that I have the right to request a copy of the notice and one will be provided to me.

Signature: _____ **Date:** _____

(relationship to patient: self – guardian – other**:** _____)

CONSENT TO TREATMENT

I am aware of my diagnosis and voluntarily consent to have Penn State Health Rehabilitation Hospital Outpatient Center, through its appropriate personnel, provide evaluation and/or treatment as prescribed by my physician and/or recommended by my therapist. I understand the practice of physical, speech, and occupational therapy is not an exact science, and I acknowledge that no guarantees have been given to me regarding the successful completion or the results of the treatment provided. I understand that the treatment I receive from Penn State Health Rehabilitation Hospital Outpatient Center is limited to physical, speech, and/or occupational therapy services and that I shall seek treatment from other medical professionals for all other issues I may experience. I understand that I have the right to ask questions at any time during the course of my care.

Signature: _____ **Date:** _____

(relationship to patient: self – guardian – other**:** _____)

AUTHORIZATION TO RELEASE INFORMATION

I further authorize Penn State Health Rehabilitation Hospital Outpatient Center to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment necessary to secure payment for services provided.

Signature: _____ **Date:** _____

(relationship to patient: self – guardian – other**:** _____)

PennState Health
Rehabilitation Hospital
In Partnership with Select Medical

Outpatient Medical History / Screening Form

To Be Completed By The Patient / Family / Caregiver

Patient Name:_____ Spoken Languages:_____

Preferred language to receive healthcare information for ***patient:*** _____

Preferred language to receive healthcare information for ***legal guardian / healthcare proxy*** **:** _____

Emergency Contact:_____ Telephone # :_____

Family Physician / Internist:_____ Telephone # :_____

Religious / Cultural Needs: NO ☐ YES ☐ Please Explain:_____

Special Learning Needs: NO ☐ YES ☐ Please Explain:_____

Hearing Difficulty: NO ☐ YES ☐ Speaking / Communication Difficulty: NO ☐ YES ☐

Why are you here?_____ Date of Injury:_____

Medical Information:

	Patient		Family History	
	YES	NO	YES	NO
Diabetes	☐	☐	☐	☐
Hypertension (high blood pressure)	☐	☐	☐	☐
Heart Attack	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐
High Cholesterol	☐	☐	☐	☐
Smoking	☐	☐	☐	☐
Chest Pain / Angina	☐	☐		
Light-Headedness / Dizziness / Fainting	☐	☐		
Hypotension (low blood pressure)	☐	☐		
Shortness of Breath	☐	☐		
Ankle Swelling	☐	☐		
Night Coughing	☐	☐		
Cancer / Tumors / Growths	☐	☐	☐	☐
*Radiation / Chemotherapy Treatment	☐	☐		
Osteoporosis	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐
Rheumatic Disease	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Multiple Sclerosis	☐	☐	☐	☐
Brain Injury	☐	☐		
Spinal Cord Injury	☐	☐		
Fractures	☐	☐		

Fractures:
DATE:_____ AREA:_____
DATE:_____ AREA:_____

	YES	NO
Diminished Sensation / Numbness	☐	☐
Skin Sensitivities:	☐	☐
Latex ☐ Adhesives ☐ Temperature ☐		
History of Pressure Sores	☐	☐
Pacemaker / Defibrillator	☐	☐
Bleeding / Bruising (recent history)	☐	☐
Hypoglycemia (low blood sugar)	☐	☐
Active seizure disorder	☐	☐
Dementia / Alzheimer's	☐	☐
Kidney Disease	☐	☐
Asthma	☐	☐
* Always have inhaler with you	☐	☐
Lung Disease / Emphysema / COPD	☐	☐
* Oxygen use	☐	☐
Are You Pregnant?	☐	☐
In the past month, have you frequently been bothered by feeling down, depressed or hopeless?	☐	☐
In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things?	☐	☐
Other:	☐	☐

_____
_____

In the past three months have you experienced:

Changes or difficulty with Bowel	☐	☐
Changes or difficulty with Bladder	☐	☐
Night Sweats	☐	☐
Fever	☐	☐

Are you in pain? YES☐ NO☐

Location of pain:_____

If you answered yes to any of the above:

Are you under the care of a physician for these conditions?

YES☐ NO☐

Allergies: _____

_____

Surgery(s) within last 3 months - Include Dates: _____

What are your Rehabilitation goals?_____

Medical Information:

If you need information regarding Advanced Directives, please contact the site Patient Service Specialist. Advanced Directives are not honored in the Outpatient Setting.

FALL RISK ASSESSMENT*	YES	NO
Have you fallen within the last year? If so, how many times? _____	☐	☐
Have any of these falls resulted in an injury within the last year?	☐	☐
Are you afraid of falling?	☐	☐
Have you recently felt unsteady on your feet or in your wheelchair?	☐	☐
Do you experience dizziness or vertigo?	☐	☐
Do you have vision problems that are not corrected by glasses?	☐	☐
Do you use sedatives that affect your level of alertness during the day?	☐	☐
Do you have memory / cognitive difficulties?	☐	☐
Do you have a lower extremity disability that affects walking?	☐	☐

AS PER CMS FALL SCREENING CRITERIA
***Patient is considered a fall risk if patient has fallen two or more times in the past year**
***Patient is considered a fall risk if patient has fallen one time with resulting injury in the past year**

NUTRITIONAL SCREENING	YES	NO
Unexplained weight loss (>5% in last 30 days)	☐	☐
Recent loss of appetite / aversion to food?	☐	☐
Do you have difficulty swallowing?	☐	☐
Decrease in food intake? (<50% for 3 days or more)	☐	☐
Are you under the care of a physician for these conditions?	☐	☐

CURRENT MEDICATION (List below)

I provided separate list of medications: ☐

I am currently not taking any over the counter or prescribed medications / herbals: ☐

Are all meds prescribed by a physician? YES ☐ NO ☐

** **FALL RISK** - Patient is considered a fall risk if they answer yes to three or more fall risk assessment questions, if they meet CMS screening criteria for fall risk, or if therapist judgment indicates. Clinician should refer to the Fall Prevention Policy in the OP PSHR P&P manual (PC OP 1018).*

Please inform your therapist of any changes in medications, medical conditions or surgeries so this summary list can be updated as you progress in your treatment.

PATIENT SIGNATURE:_____DATE:_____

UPDATES:

Please list changes to medication:

Please list changes to medical condition / surgeries:

PATIENT SIGNATURE:_____NEW DATE:_____

This information will be used as a guide to your treatment plan. If you need any medical follow-up, please contact your physician.

To Be Completed By Evaluating Therapist

Patient has been identified as a fall risk : YES ☐ NO ☐

Patient has been identified as a nutrition risk : YES ☐ NO ☐ (If yes, notify MD)

Patient would benefit from a Social Services referral: YES ☐ NO ☐ (yes if therapist feels patient life is threatened / patient is a threat to others)

Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**
Therapist Signature:	**Date:**	**Time:**

(Therapist has reviewed medical history form with patient)

MEDICARE SECONDARY PAYOR (MSP) QUESTIONNAIRE

PennState Health Rehabilitation Hospital
In Partnership with Select Medical

Patient Name: Date:

Account #: Medicare ID#:

Office Use Only:		
PSS Name:	Contact Person at HHA:	Discharged from HH? ☐ Yes ☐ No
Facility Phone: 717-833-5300	Phone:	Discharge Date:

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

1. Have you received Home Health (HH) services in the last 60 days? ☐ YES ☐ NO

If Yes:	If No:
Name of HH Agency:	Proceed to Next Question
Agency Phone #:	
Type of HH Services:	
Last Date of Service:	

2. Are you currently residing in a Skilled Nursing Facility? ☐ YES ☐ NO

If Yes:	If No:
Name of Facility:	Proceed to Next Question
Facility Phone #:	
Are you on/in the "Medicare Unit"? ☐ Yes ☐ No	

3. Are you entitled to benefits under the Black Lung Program, Department of Veteran Affairs (VA), or other government program? ☐ YES ☐ NO

If Yes: This Program is Primary to Medicare	If No:
Program Name:	Proceed to Next Question
Address:	
Phone #:	

4. Is your accident/injury work-related, a motor vehicle accident, or an accident on a property other than your own? ☐ YES ☐ NO

If Yes: Date of Accident: _____			If No:
Select one: ☐ Work-Related	☐ Motor Vehicle Accident	☐ Accident on Property	Proceed to Next Question
Insurance Name:			
Address:			
Phone #:	Contact Name:		

Continue on next page

5. Do you feel you have the right to be compensated by a party who may have caused the injury or illness? ☐ YES ☐ NO

If Yes:	If No:
Do you intend to file a liability claim or lawsuit in connection with this injury or illness? ☐ Yes ☐ No	Proceed to Next Question
If Yes: Provide Attorney information below:	
Attorney Name:	
Name of Law Firm:	
Address:	
Phone:	

6. Have you received a kidney transplant or currently receiving dialysis for End Stage Renal Disease? ☐ YES ☐ NO

If Yes:	If No:
Date of kidney transplant or start of dialysis:	Proceed to Next Question
Note: If the date is less than 30 months ago: Are you currently covered under group insurance provided by your or a family member's employer? ☐ Yes - Group Insurance is Primary ☐ No - Medicare is Primary	

7. Are you currently employed? ☐ YES ☐ NO

If Yes:	If No:	
Does your employer employ more than 20 employees? ☐ Yes ☐ No	Date of Retirement:	☐ Never Employed

Is your spouse currently employed? ☐ YES ☐ NO

If Yes:	If No:	
Does your **spouse's** employer employ more than 20 employees? ☐ Yes ☐ No	Date of Retirement:	☐ Never Employed

Note: If both patient and spouse are not currently emplyed, then Medicare is primary.

8. If none of the above applies to you, and your Medicare coverage is due to age or disability, do you have group insurance overage through another family member's current employer?
☐ YES - Group Insurance is Primary
☐ NO - Medicare is Primary

9. Do you have any benefits though Tricare (formerly Champus?) ☐ YES ☐ NO

10. If you answered YES to questions 7,8,or 9, provide the group insurance information for proper billing of your account:

Insurance Name:	☐ Not Applicable (Medicare is Primary)
Address:	
Phone:	
Employer:	
Insured's Name:	
Policy Number:	

I certify that the information provided is, to the best of my knowledge, true and accurate.

Signature:	**Date:**

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