Allied Rehab
Speech, Occupational & Physical Therapy

900 S. Franklin Street, Suite #201
Wake Forest, NC 27587
(Corner of Hwy 98-Bypass & S. Franklin Street)

Office: 919-556-1700
Fax: 919-556-1245

PATIENT REGISTRATION INFORMATION (PAGE 1)

Date____/____/____

Patient Name _____
(Last) (First) (Middle)

Mailing Address_____

City_____State_____Zip Code _____

Phone Numbers: Home ( )_____Work ( )_____Cell ( ) _____

Date of Birth_____Age_____ Gender ☐ F ☐ M

E-Mail Address _____

Referring Physician_____Phone # ( )_____

Diagnosis_____ Follow-up appointment scheduled for____/____/____

Primary Care Physician_____Phone # ( )_____

Employer_____Occupation _____

Emergency Contact Name_____Relationship _____

Daytime Phone Number_____Cell #: ( ) _____

Who will assist you in your care? _____

What injury/ailment are we treating today? _____

Date of injury or onset of symptoms? _____

Are you allergic to any drugs/medications/supplies? If so list: _____

Are you taking any medications? ☐ Yes ☐ No If yes, please list medications and dosage:

How did you hear about us?

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PATIENT REGISTRATION INFORMATION (PAGE 2)

Name:_____Date of Birth:_____Age:_____

Have you seen a doctor or had any of the following medical studies/treatments relating to this injury or episode?

	Yes		Yes		Yes
Primary Care Provider	☐	ER Visit	☐	Ultrasound	☐
Orthopedist	☐	Other Specialist	☐	Steroid Shot	☐
Neurologist/Neurosurgeon	☐	X -Ray	☐	Myelogram	☐
Podiatrist	☐	MRI	☐	Swallowing Test	☐
Rheumatologist	☐	CT Scan	☐		

Have you seen any of the following professionals this calendar year?

	Yes		Yes
Home Health PT, OT, ST	☐	Chiropractor	☐
Out-Patient PT, OT, ST	☐	Massage Therapy	☐

Where did you go?_____How long in therapy?_____

Do you currently have, or have you ever had, any of the following?

_____ Allergies
_____ Anemia
_____ Any Pins or Metal Implants
_____ Arthritis/Swollen Joints
_____ Back Injury/Surgery
_____ Blood Clot/Emboli
_____ Bowel or Bladder Problems
_____ Cancer/Chemo/Radiation
_____ Coronary Heart Disease/Angina
_____ Diabetes
_____ Dizziness or Fainting
_____ Elbow Injury/Surgery
_____ Emotional/Psychological Problem
_____ Epilepsy/Seizures
_____ Fibromyalgia
_____ Foot/Ankle Injury/Surgery
_____ Gout
_____ Hand/Wrist Injury/Surgery
_____ Heart Attack or Heart Surgery
_____ Hernia
_____ High Blood Pressure
_____ Hip Injury/Surgery
_____ Infectious Disease
_____ Joint Replacement
_____ Knee Injury/Surgery
_____ Neck Injury/Surgery
_____ Numbness or Tingling
_____ Osteoporosis
_____ Pacemaker
_____ Parkinson's
_____ Pregnant currently
_____ Severe or Frequent Headaches
_____ Shortness of Breath/Chest Pain
_____ Shoulder Injury/Surgery
_____ Sleeping Problems
_____ Stroke/TIA
_____ Thyroid Trouble/Goiter
_____ Varicose Veins
_____ Vision or Hearing Difficulties
_____ Weakness
_____ Weight Loss/Energy Loss

Please list any hospitalization or surgeries you have had in the last 12 months

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POLICIES OF ALLIED REHAB (PAGE 3)

Treatment Consent
I consent to therapy considered necessary in diagnosing and/or treating my condition.

Authorization and Release
I authorize Allied Rehab to bill and receive payments from my insurance company. I also permit the release of necessary information, including medical records, to my insurance company.

Financial Policy
Payment of all co-pays, deductibles and any portion not covered by my insurance company is due at time of service. ALLIED REHAB WILL BILL MY INSURANCE CARRIER AS A COURTESY TO ME. Allied Rehab CANNOT guarantee insurance benefits given by the insurance company to be 100% accurate. The information Allied Rehab receives IS NOT A GUARANTEE of payment from the insurance company. It is recommended that I call and verify benefits prior to my scheduled appointment. I understand that I am responsible for any portion not covered by my insurance company and prompt payment is required. An 8% interest fee will incur on any balance greater than 30 days. Accounts sent to collections will incur additional fees.

No-Show Policy

It is important that I keep all scheduled appointments to obtain maximum benefit from my rehabilitation program. Being on time for these appointments is IMPERATIVE! The therapist has blocked this time especially for me. Not showing or giving less than 24 hrs notice to cancel, takes time away from other patients who would have benefitted from this appointment. A $50 fee will be charged to my account for a no-show or late cancellation.

PLEASE INITIAL THAT YOU HAVE READ OUR POLICY OF A $50.00 NO SHOW FEE _____

I have read, understood and accepted the above policies as indicated by my signature below.

Name:_____

Signature: _____

Witness:_____Date: _____

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Patient Information Consent Form
Verification of Notice of Privacy Practices

I have read and fully understand Allied Rehab's current "**Notice of Privacy Practices**".
I understand that Allied Rehab may use or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my PHI is used and disclosed for treatment, payment and administrative operation if I notify the practice. I also understand that Allied Rehab will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my PHI for purposes as noted in Allied Rehab's "**Notice of Privacy Practices**". I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Signature Date

Print Name