PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at all……Mildly optimistic……Fairly……Very optimistic……..Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		
			Total:

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian):_____ Date: _____

INSURANCE ASSIGNMENT OF BENEFITS

Patient Full Name_____ ❑ Single ❑ Married

Referring Physician:_____ PH_____ FAX_____

Are You Currently Enrolled in Home Health? Yes No

CALL THE NUMBER ON THE BACK OF YOUR INSURANCE CARD AND FIND OUT WHAT YOUR OUTPATIENT PHYSICAL THERAPY BENEFITS ARE:

POLICY #1:

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Address (if different than patient):_____

Relationship to patient: ❑ Spouse ❑ Parent ❑ Other:_____

Employer_____ PH_____ Claim#_____

Employer address._____

POLICY #2 (if applicable)

Plan Benefit Verification: ❑ Deductible $_____ ❑ Coinsurance $_____ ❑ Co-pay $____ ❑ Maximums:_____

Policy Name:_____ Policy#_____ Group# (if applicable)_____

Policy Holder Name (If other than patient):_____ DOB_____ SSN_____

Declaration to Insurance Company

I hereby instruct and direct _____ insurance company to pay by check made out to the "Healthcare Provider" named below and mailed to the address below. If my current policy prohibits direct payment to the doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the "Healthcare Provider" for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Conditions Required in Order for "Healthcare Provider" to Accept This Assignment

If any boxes are left unchecked, clinic reserves the right to refuse this assignment and patient must pay out-of-pocket for services.

- ☐ A photo copy of this assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance claims.
- ☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.
- ☐ This is a direct assignment of my rights and benefits under this policy.

DATE: _____/_____/20_____

Signature of Patient/Claimant_____

(If applicable) Signature of Policy Holder if not same as patient_____