Date: ____

Referring Physician: ___________________________________

Patient Name:

First	Middle	Last	Preferred	Maiden

Date of Birth	Social Security Number	Marital Status	M F Sex	Race

Street Address:

Zip: City: State: County:

Mailing Address:

Zip: City: State: County:

Home Phone	Work Phone	Cell Phone	Email Address

Patient's Employer: Phone:

Employer Address:

Zip: City: State: County:

Patient's Occupation:

Retirement Date:

Guarantor Name: **IF PATIENT IS A MINOR**

First	Middle	Last	Relationship to Patient

Date of Birth	Social Security Number	Cell Phone	M F Sex

Mailing Address:

Zip: City: State: County:

Guarantor's Employer: Phone:

Zip: City: State: Occupation:

Emergency Contact Name:

First	Middle	Last	Relationship

Date of Birth	Home Phone	Cell Phone	Email Address

Mailing Address:

Zip: City: State: County:

Please give ALL Insurance Cards to the Front Office for Copies

All of the information included on this Patient Information form is complete and accurate to the best of my knowledge, and I certify that I am the patient or duly authorized general agent of the patient authorized to furnish the information requested.

Signature Date

Patient Health Information Sheet

1. Have you ever been diagnosed with or currently have any of the following conditions?

____ Heart Problems
____ Pacemaker/Defibrillator
____ High Blood Pressure
____ Stroke
____ Circulatory Problems
____ Diabetes
____ Kidney Disease
____ Lung Disease
____ Cancer
____ Seizures
____ Arthritis
____ TB
____ Peptic Ulcer
____ Stomach Problems
____ HIV
____ Hepatitis
____Metal Implants

2. What is your current occupation?____

3. Are you currently off work? ____Yes____No

   If yes, how long? ____

4. Do you presently receive Home Health or Hospice? ____Yes____No

5. Do you have problems tolerating heat or cold? ____Yes____No

6. Have you fallen in the past 6 months? ____Yes____No

7. Do you take any of the following prescriptions?

   (Narcotics, High Blood Pressure Medication, Diuretics, Heart Medication) ____Yes____No

8. Do you feel dizzy when you get up from a chair or bed? ____Yes____No

9. Do you have uncorrected vision problems with reading/driving? ____Yes____No

10. Please explain the reason you are attending therapy (fell, work injury, car wreck, etc)

____

____

Date of Injury____________________

11. List any other medical conditions not mentioned here____

____

12. List medications____

____

13. List allergies (including food & medications)____

14. If Female, are you pregnant? ____

15. Name of your family physician____

16. Are there any 3rd party payers we should be aware of?____

17. Are you involved in litigation regarding this incident?____

Medicare Questionnaire

1. Are you entitled to Black Lung Medical Benefits? ____Yes____No

   Date:____________________If so, describe injury/illness:____

2. Are the services to be paid by a government research program? ____Yes____No
3. Has the Department of Veterans Affairs authorized and agreed to pay

   for your care at this facility? ____Yes____No
4. Is this a work related injury or illness? ____Yes____No
5. Is this injury/illness related to a non-work related accident? ____Yes____No

   Date of injury/illness:__________________________________
6. Do you have End Stage Renal Disease? ____Yes____No
7. Are you entitled to Medicare based on Age? ____Yes____No

   Retirement Date:____

7. Are you entitled to Medicare based on Disability? ____Yes____No

   Disability Date:____

9. Are you currently working? ____Yes____No

   If yes, Part Time? Or Full Time?______________________________
10. If you are married, is your spouse currently working? ____Yes____No

    If working, Name and Address of spouse's employer:____

    If retired, retirement date? ____
11. Are you covered by an Employer Group Health Plan through your spouse

    or any other family member's current or former employment? ____Yes____No

    If yes, provide the following information:

    Number of employees: _____1-18 _____20-99 ____100 & up

    Name and Policy number of Employer Health Plan: ____
12. **Are you in a Nursing Home? ____Yes____No**

    If yes, Name of Nursing Home:____
13. **Are you an Inpatient at a Rehab Center? ____Yes____No**

    If yes, Name of Rehab Center:____
14. **Are you receiving Home Health services? ____Yes____No**
15. **Are you receiving Hospice? ____Yes____No**

Policies, Authorization, and Assignment of Benefits

InPatient/OutPatient Condition of Admission and Consent to Medical Treatment & Notice of Patient Rights and Responsibilities

________ Initial

I certify that I have received and signed copies of Wesley Medical Center's "Notice of Patient Rights and Responsibilities" and the "InPatient/OutPatient Conditions of Admission and Consent to Medical Treatment." I have directed all questions regarding the policies of Wesley Medical Center to an Admissions Associate.

Payment Policy

________ Initial

Patients are expected to make payment in full for office services at the time of the visit. For your convenience, we accept cash, checks, VISA, Mastercard, American Express, and Discover. We understand that circumstances sometimes do not make it possible for you to pay in full. When this happens, payment arrangements will be made with Wesley Medical Center's Business Office. Patients with insurance are responsible for any co-payment or deductible at the time of service.

Cancellation Policy

________ Initial

Failure to keep your appointments at Wesley Medical Center's OutPatient Rehabilitation hinders our ability to provide the best care to our patients. Missed appointments affect the consistency of your own rehabilitation program. As a result, **3 cancellations or no-shows** will result in discontinuation of therapy. Cancellations due to illness or family emergency are excluded from this policy. We ask that you show us consideration by calling prior to your appointment if you are unable to attend. (601)268-5015

Late Arrival Policy

________ Initial

As a courtesy to our staff and other patients, appointments will be automatically cancelled **15 minutes after scheduled start time**. In special cases and when our schedule will allow, we may be able to accommodate a partial appointment. This will be at the discretion of the therapist and only with advanced notification of your late arrival.

Caregiver's Policy

________ Initial

For the safety and quality of care of your loved ones, caregivers are required to stay on the premises and must return to the department in a timely manner to pick up their loved one. In the event the caregiver has not returned in 5 minutes, a staff member will contact the caregiver at once. Please be considerate of our therapists, make sure that your loved one has any necessities with them (diapers, wipes, etc)

I understand Wesley Medical Center Outpatient Rehabilitation's Payment Policy, Cancellation Policy, Late Arrival Policy, and Caregiver's Policy. I also understand my responsibility to notify the front office of any changes to my information or if I have difficulty fulfilling my scheduled appointments.

Patient Signature: ____ ***Date:*** ________________________