Lansing Rehabilitation Services – Known as LRS

Please print clearly, if you require assistance with writing, or reading see front desk

Today's Date: ____________________

Last Name:	First Name:
Nickname:	Pronoun(S) Used:
Date of birth:	Male ◯ Female ◯
Address:	
Address: Billing if different	
Mobile #:	Secondary #:
Emergency Contact Name & Phone:	
Email: check if you would like email appointment reminders ◯	
Employer Name & Phone:	
Social Security #: **For Military-Tricare patients**	

Start of required insurance information; **Please note If you are NOT the primary insurance policy holder all information below will need to be completed in order to ensure proper billing and avoid unnecessary charges to you the patient.**

Primary Insurance Company Name:			
Policy Holder Name:			
Relationship To Policy Holder:			
Policy Holder Address:			
Policy Holder Phone:			
Policy Holder Date of Birth:	**Month**	**Day**	**Year**

Secondary Insurance Company Name:			
Policy Holder Name:			
Relationship To Policy Holder:			
Policy Holder Address:			
Policy Holder Phone:			
Policy Holder Date of birth:	**Month**	**Day**	**Year**

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lansingrehab@gmail.com

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To ensure proper billing LRS will need to verify that your claim is open and billable, therefore accurate information below is needed.

Auto – PIP claims / Workers Compensation Claims
Insurance Company Name:
Adjusters Name:
Adjusters Phone number:
Claim #:
Date of Injury – **Month/day/Year**
Employers name: **{workers comp only}**
Employers address: **{workers comp only}**

What Days and Times best fit your schedule? {Check all that apply below}

Morning = 7:00 am to 11:00 am / Afternoon = 12:00 pm to 4:00 pm / Evening = 5:00 pm to 6:00 pm

Monday	Tuesday	Wednesday	Thursday	Friday	Morning	Afternoon	Evening

Minor {Under 18 years of age} Consent Requests if applicable:

- ✓ Do You prefer a to have a ***Female clinician*** ◯ ***- Male clinician*** ◯ ***- No preference*** ◯
- ✓ Do you need a chaperone in the room with you? **Yes** ◯ **No** ◯
- ✓ Do you need or require special accommodations? If yes please explain below:
  Yes ◯ **No** ◯

____

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Please; Read and Initial Each Bullet Point
If you require assistance a staff member can assist.

1. ___ **Consent for Care & Treatment,**
   The term "Informed Consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition. I have been given on opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent form. In the event of a change in medical status, I understand that my treatment may be modified, stopped, or referred out to the proper practitioner. I reserve the right to withdraw at any time.
2. ___ **HIPAA,**
   The *Health Insurance Portability and Accountability Act of 1996* (HIPAA) is a federal law that required the creation of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge.
   A BROCHURE OF YOUR RIGHTS AND COVERAGE IS AVAILABLE UPON REQUEST, YOU ARE CERTIFIYING THIS WAS OFFERED.
3. ___ **Consent to Bill Insurance,**
   By providing a copy of your Health Insurance(s) you are agreeing that your policies are **Current & Active**. LRS will bill your insurance(s) for all applicable fees associated with your care***. However, by checking this box you agree that any fees known as Deductible, Co-Pay, Co-Ins. AND / OR any other non-covered charges detailed by your insurance CO. when associated with your care will be covered by you known as the 'Patient' Or 'Guarantor' to patient. Fees are due at the time of service unless prior arrangements are made.*** It is your responsibility to know what your policy covers, LRS will kindly do a preliminary benefit check and may provide you with those details if requested.
4. ___ **Attendance Agreement,**
   LRS strives to provide our patients with excellent one on one care, due to this philosophy and specialized care our office will provide an appointment schedule in advance. If you are unable to make an appointment, we do require twenty-four (24) notice. If you will be more than fifteen (15) minutes late, we reserve the right to reschedule. If at any time you do not call and cancel and your appointment shows as a 'No-call/No-show' you will be assessed a $35.00 dollar fee at your next attended appointment.
5. ___ **Release of HIPAA c/o Billing, appointments & or medical treatments,**
   List up to two (2) individuals whom you give permission to LRS to speak to on your behalf regarding billing, appointments schedules, & or treatments

____

Name & Relationship

____

Name & Relationship

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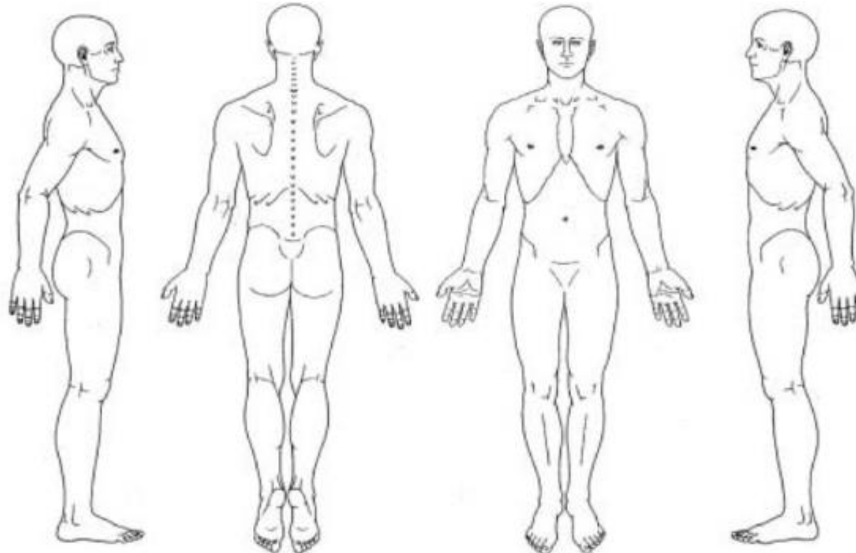
Symptoms – History Intake:



1. My symptoms are, {check one} **Constant** ◯ **Frequent** ◯ **Intermittent** ◯
2. Circle your current pain level, 0 = no pain / 10 = worst pain imaginable

   0 1 2 3 4 5 6 7 8 9 10
3. Best to your knowledge date of injury or onset of symptoms? _________________
4. Since the start of symptoms do you, **feel Better** ◯ **No change** ◯ **Worse** ◯
5. Since the start of your symptoms have you or are you currently receiving physical therapy elsewhere, including massage therapy or chiropractic care? **Yes** ◯ **No** ◯
6. Since the start of your symptoms have you had any of the following?
   check all that apply **MRI** ◯ **CT scan** ◯ **X-Ray** ◯ **Other** ◯
7. What daily functions do you struggle with? _______________________________
   ____
8. What activities, movements make your symptoms worse? _________________
   ____
9. Does anything help your symptoms? ____________________________________
   ____
10. Does your pain disrupt your sleep? **Yes** ◯ **No** ◯
11. Have you had a fall recently or prone to falling? **Yes** ◯ **No** ◯

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Surgical History – List Year and Procedure
1.
2.
3.
4.

Medications	
1.	5.
2.	6.
3.	7.
4.	8.

Past Medical History – Check any that apply

Allergies	◯	Epilepsy/Seizures	◯	Osteoporosis Osteopenia	◯
Autoimmune Disorder	◯	Headaches/migraines	◯	Pacemaker	◯
Black Outs	◯	Hearing Impairment	◯	Pain w/ Coughing/Sneezing	◯
Cardiac Problems	◯	Hepatitis/HIV/AIDS	◯	Bowel or Bladder Problems	◯
Cigarette Use	◯	High Blood Pressure	◯	Recent unintentional weight loss	◯
Concussion/Traumatic Brain Injury	◯	Female - are you pregnant	◯	Respiratory/Breathing issues	◯
Depression/Anxiety Panic Disorders	◯	Neurological Diseases	◯	Rheumatoid Arthritis	◯
Diabetes	◯	Numbness/Tingling	◯	Ringing in Ears	◯
Dizziness/Vertigo	◯	Osteo-Arthritis	◯	Sleep Apnea	◯
Spinal Pain		Stroke/TIAs/Head Injury	◯	Visual Impairment	◯

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