12880 Northline Rd, Southgate MI 48192
P: 734-486-7080 F: 734-486-7090

Patient Information

Name _____ Date of Birth _____

Social Security # _____-_____-_____ Address _____

Primary Phone Number: _____ Sex: Male_____ Female _____

Marital Status: Single_____ Married_____ Divorced_____ Separated_____ Widowed_____

Referring Doctor/PCP Name _____ Referring Doctor/PCP phone number_____

Employment

Current Status [ ] Working [ ] Not Working

Employer _____

Insurance Information

Primary Insurance_____

Contract Number _____ Group Number _____

Subscriber Name_____ DOB of subscriber___/___/___

Secondary Insurance _____

Contract Number _____ Group Number _____

Subscriber Name _____ DOB of subscriber ___/___/___

How did you hear about us?

[]MD | [] Instagram | [] Facebook | [] Friend | [] Website | [] Promo | [] Staff | [] Other:

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Physical Therapy Admission Information

Name _____

Height _____ **Weight** _____ **Age** _____

[ ] Right handed [ ] Left handed

Date of Injury onset _____

Is this a work related injury [ ] Yes [ ] No

Where do you live?

[ ] Single level Home [ ] Multi Level Home/ 2 or more levels

[ ] Mobile Home [ ] Apartment

[ ] Assisted Living [ ] Long Term Care

With whom do you live with? Check all that apply

[ ] Alone [ ] Children

[ ] Spouse [ ] Group Setting

[ ] Parents

Do you use:

[ ] Cane [ ] Manual Wheelchair

[ ] Walker [ ] Motorized Wheelchair

Have you fallen 1 or more times in the past year? [ ] Yes [ ] No

Have you had physical therapy, Home Health or Chiropractic care this year? [ ] Yes [ ] No

If yes, when:

Health Habits

Do you use tobacco? [ ] Yes [ ] No If so, how many packs per day ___

Do you drink alcohol? [ ] Yes [ ] No If so, how many drinks in a week ___

Do you exercise regularly? [ ] Yes [ ] No

If yes, how often and what type of activities? _____

Any Medication allergies [ ] Yes [ ] No If yes, what?_____

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History of current problems?

When did the problem begin? _____

Explain how this occurred:

_____
_____
_____

Have you had and recent X-rays, CT scans, MRI's, or other diagnostic testing for your current problem?

If known, what were the results:

_____
_____
_____

What activities are you not able to do now that you could do before this current problem?

_____
_____
_____
_____

What are your goals for Physical Therapy?

_____
_____
_____
_____

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Consent to treatment
I consent to rehabilitation and related services at: Rehab by Design
In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touch, and/or direct contact of a sensitive nature.

Initials: _____

Liability
I know and agree that Rehab by Design is not responsible for loss or damage to personal valuables

Initials: _____

Waiver and Release
I hereby release, discharge and acquit: Rehab by Design, its agents, representatives, affiliates, employees, or assigns of and from any and all liability, claim, demand, cause of action, or loss of any kind of arising. This is resulting from my refusal to accept, receive or allow emergency/medical services including but not limited to ambulance service, emergency medical technician, physician, or urgent care services

Initial: _____

Financial Policy
I understand fully that in the event my insurance company or financial responsibility party does not pay for the services I receive, I will be financially responsible for payment. To assist in establishing your account, please supply all necessary information for accurate billing of your claim: including your insurance card, drivers license, employer information, and demographic information. Satisfy all insurance co-payments, co-insurance, deductibles and non-covered services on the day services are rendered. Provide your insurance company and us with any additional information requested to complete the processing of claims filed on your behalf

Initials: _____

Authorization of Payment
I hereby assign all benefits directly to: Rehab by Design. I also authorize release of any medical records to healthcare providers as necessary to facilitate my treatment and to other third parties as necessary to process medical clams and otherwise permitted or required in the Notice of Privacy.

Initials: _____

Notice of Privacy/Patient Bill of Rights
I acknowledge receipt of Notice of Privacy Practice
I acknowledge receipt of the Statement of Patient Rights

Initials: _____

I certify that all of the information provided is true and correct

Patient/Guardian Signature _____ Witness Signature _____ Date __/__/____

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Automobile/MotorCycle Insurance Coverage

Is this injury covered by automobile accident insurance? **[ ]** Yes **[ ]** No

Date of accident __/__/____

Insurance Carrier _____ Claim Number _____

Carrier Address _____

Name of Insured_____ Adjustor_____

Adjustor Phone Number____-____-_____

Workers Compensation

Is this injury covered by Workers Compensation? **[ ]** Yes **[ ]** No

Insurance Carrier_____

Carrier Address _____

Adjustor_____ Adjustor Phone Number____-____-_____

Do you have an attorney for this injury/claim? **[ ]** Yes **[ ]** No

Name of Attorney_____

Address _____

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Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligation for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment.

If an appointment is not canceled at least 24 hours in advance you will be charged a fifty dollar ($50) fee; this will not be covered by your insurance company.

_____	_____	_____
Print Patient's Name	Patient/Guardian Signature	Date

(Office Use Only)

Patient Account:_____
Patient MRN: _____

REHAB BY DESIGN

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Pain Rating

I would **currently** rate my pain as:

No Pain	Weak Pain		Moderate Pain		Strong	Very Strong		Very, Very Strong		Emergency
0	1	2	3	4	5	6	7	8	9	10

The **least** amount of pain I have had in the **last 30 days** is:

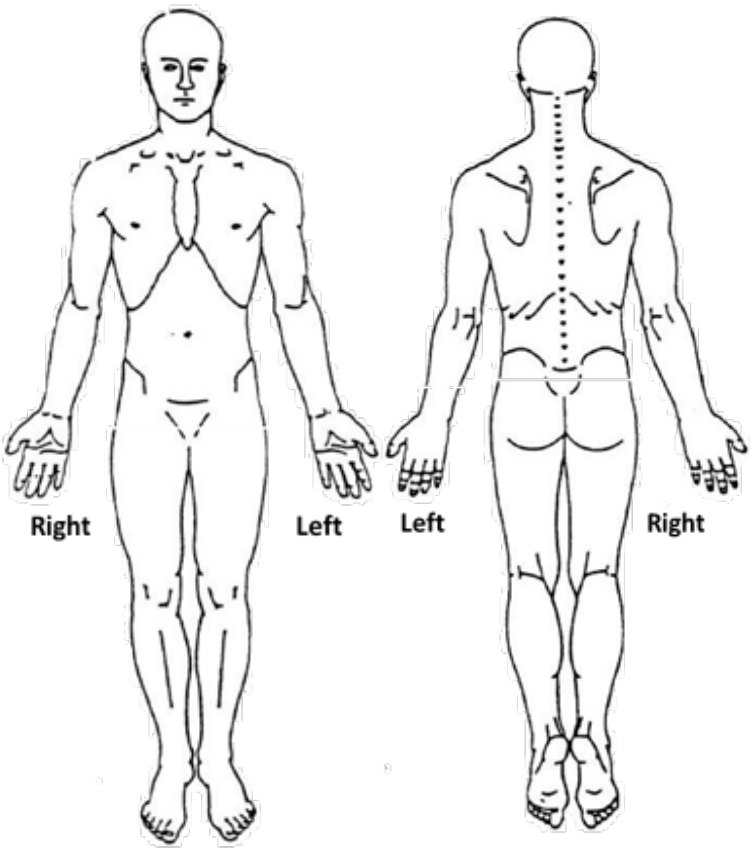
No Pain	Weak Pain		Moderate Pain		Strong	Very Strong		Very, Very Strong		Emergency
0	1	2	3	4	5	6	7	8	9	10

The **worst** amount of pain I have had in the **last 30 days** is:

No Pain	Weak Pain		Moderate Pain		Strong	Very Strong		Very, Very Strong		Emergency
0	1	2	3	4	5	6	7	8	9	10

Pain Drawing

Please shade all areas of discomfort caused by your current injury



Since your injury condition began, your symptoms are ?

[ ] Better [ ] Same [ ] Worse

Over a full day how often you have symptoms?

[ ]Occasional	[ ] Intermittent	[ ] Frequent	[ ] Constant
10-25 %	26-50%	51-80%	81-100%

How is your sleep?

[ ] Good	[ ]Moderate	[ ] Difficult	[ ] With Medications
Position	[ ] Back	[ ] Side	[ ] Stomach

What makes your injury feel Better (B), Same (S), or Worse (W)? Check each column.

Action	B	S	W	Action	B	S	W
Nothing				Twisting			
Sitting				Laying down			
Standing				Sleeping			
Walking				Rest			
Running				Sneezing			
Movement				Coughing			
Bending				Medication			
Exercise				Writing			
Kneeling				Computer			
Lifting				Other:			
Stairs							

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PATIENT FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Patient Name: Date:

		INSTRUCTIONS: Circle the level of difficulty for each activity.	0 = Absolute no difficulty	1 = Able to do with little difficulty	2 = Able to do w litmod difficulty	3 = Able to do w mod difficulty	4 = Able to do w modsignif difficulty	5 = Able to do w signif difficulty	6 = Unable to do at all	Not applicable
MOBILITY/WALKING	1	Walking short distances	0	1	2	3	4	5	6	n/a
	2	Walking long distances	0	1	2	3	4	5	6	n/a
	3	Walking outdoors	0	1	2	3	4	5	6	n/a
	4	Climbing stairs	0	1	2	3	4	5	6	n/a
	5	Hopping	0	1	2	3	4	5	6	n/a
	6	Running	0	1	2	3	4	5	6	n/a
CHANGE/MAINTAIN BODY POSITION	1	Rolling over	0	1	2	3	4	5	6	n/a
	2	Moving - lying to sitting	0	1	2	3	4	5	6	n/a
	3	Sitting	0	1	2	3	4	5	6	n/a
	4	Bending/Stooping	0	1	2	3	4	5	6	n/a
	5	Kneeling	0	1	2	3	4	5	6	n/a
	6	Standing	0	1	2	3	4	5	6	n/a
CARRY/MOVE/ HANDLE OBJECTS	1	Pushing	0	1	2	3	4	5	6	n/a
	2	Pulling	0	1	2	3	4	5	6	n/a
	3	Reaching	0	1	2	3	4	5	6	n/a
	4	Grasping	0	1	2	3	4	5	6	n/a
	5	Lifting	0	1	2	3	4	5	6	n/a
	6	Carrying	0	1	2	3	4	5	6	n/a
SELF CARE	1	Dressing/Clasp b/h back	0	1	2	3	4	5	6	n/a
	2	Doing light housework	0	1	2	3	4	5	6	n/a
	3	Prep meals/kitchen tasks	0	1	2	3	4	5	6	n/a
	4	Bathroom activities	0	1	2	3	4	5	6	n/a
	5	Sleeping Ability	0	1	2	3	4	5	6	n/a
	6	Hygiene (comb hair/brush teeth)	0	1	2	3	4	5	6	n/a

PATIENT SIGNATURE **DATE**

REVIEWED BY THERAPIST / CREDENTIALS **DATE**

Patient Rights:

Rehab By Design has adopted the following statement of patient rights. This list shall include, but not be limited to, the patient's right to:

1. Become informed of his or her rights as a patient in advance of, or when discontinuing, the provision of care. The patient may appoint a representative to receive this information should he or she so desire.
2. Exercise these rights without regard to sex or cultural, economic, educational or religious background or the source of payment for care.
3. Considerate and respectful care, provided in a safe environment, free from all forms of abuse, neglect, harassment and/or exploitation.
4. Access protective and advocacy services or have these services accessed on the patient's behalf.
5. Appropriate pain and symptom management.
6. Remain free from seclusion or restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
7. Knowledge of the name of the physician who has primary responsibility for coordinating his/her care and the names and professional relationships of other physicians and healthcare providers who will see him/her.
8. Receive information from his/her physician about his/her illness, course of treatment, outcomes of care (including unanticipated outcomes), and his/her prospects for recovery in terms that he/she can understand.
9. Receive as much information about any proposed treatment as he/she may need in order to give informed consent or to refuse the course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in the treatment, alternative courses of treatment or non-treatment and the risks involved in each and the name of the person who will carry out the procedure or treatment.
10. Participate in the development and implementation of his or her plan of care and actively participate in decisions regarding his/her medical care. To the extent permitted by law, this includes the right to request and/or refuse treatment.
11. Formulate advance directives regarding his/her healthcare, and to have facility staff and practitioners who provide care in the facility comply with these directives (to the extent provided by the state laws and regulations).
12. Full consideration of privacy concerning his/her medical care program. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. The patient has the right to be advised as to the reason for the presence of any individual involved in his or her healthcare.
13. Confidential treatment of all communications and records pertaining to his/her care and his/her stay at the facility. His/her written permission will be obtained before his/her medical records can be made available to anyone not directly concerned with his/her care.
14. Realase of records to designated
15. Realease
16. Receive information in a manner that he/she understands. Communications with the patient will be effective and provided in a manner that facilitates understanding by the patient. Written information provided will be appropriate to the age, understanding and, as appropriate, the language of the patient. As appropriate, communications specific to the vision, speech, hearing cognitive and language impaired patient will be appropriate to the impairment.
17. Access information contained in his or her medical record within a reasonable time frame.
18. May obtain or inspect his/her medical records and a third party shall not be given a copy without authorization of the patient except as required by law and third-party contract (usually within 30 days of the request and a nominal fee may apply).
19. Reasonable responses to any reasonable request he/she may make for service.
20. Leave the facility even against the advice of his/her physician.
21. Reasonable continuity of care.
22. Be advised of the facility's grievance process, should he or she wish to communicate a concern regarding the quality of the care he or she receives. Notification of the grievance process includes: whom to contact to file a grievance, and that he or she will be provided with a written notice of the grievance determination that contains the name of the facility's contact person, the steps taken on his or her behalf to investigate the grievance, the results of the grievance and the grievance completion date.
23. Be advised if facility/personal physician proposes to engage in or perform human experimentation affecting his/her care or treatment. The patient has the right to refuse to participate in such research projects. Refusal to participate or discontinuation of participation will not compromise the patient's right to access care, treatment or services.
24. Full support and respect of all patient rights should the patient choose to participate in research, investigation and/or clinical trials. This includes the patient's right to a full informed consent process as it relates to the research, investigation and/or clinical trial. All information provided to subjects will be contained in the medical record or research file, along with the consent form(s).
25. Be informed by his/her physician or a delegate of his/her physician of the continuing healthcare requirements following his/her discharge from the facility.
26. Examine and receive an explanation of his/her bill regardless of source of payment.
27. Know which facility rules and policies apply to his/her conduct while a patient.
28. Have all patient's rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
29. May request another provider if another qualified provider is available.
30. Will not be discharged, harassed, retaliated or discriminated against because a patient has exercised rights protected by law.
31. Know if physician has any ownership in the practice.

All facility personnel, medical staff members and contracted agency personnel performing patient care activities shall observe these patients' rights.

Patient Responsibilities:

The care a patient receives depends partially on the patient. Therefore, in addition to these rights, a patient has certain responsibilities as well. These responsibilities should be presented to the patient in the spirit of mutual trust and respect:

1. The patient has the responsibility to provide accurate and complete information concerning his/her current complaints, allergies to environment, food and medication(s) and current and past illnesses, hospitalizations, medications and other matters relating to his/her health.
2. The patient is responsible for reporting perceived risks in his or her care and unexpected changes in his/her condition to the responsible practitioner.
3. The patient and family are responsible for asking questions when they do not understand what they have been told about the patient's care or what they are expected to do.

Patient Responsibilities Cont'd:

4. The patient is responsible for following the treatment plan established by his/her practitioner, including the instructions of nurses and other health professionals as they carry out orders.
5. The patient is responsible for his/her actions should he/she refuse treatment or not follow his/her physician's orders.
6. The patient is responsible for fulfilling financial obligations of his/her care as promptly as possible.
7. The patient is responsible for following facility policies and procedures.
8. The patient is responsible for being considerate of the rights of other patients and facility personnel.
9. The patient is responsible for being respectful of his/her personal property and that of other persons in the facility.
10. The patient is responsible for notifying the physician, in writing, of any living will, medical power of attorney, or other directive that could affect the patient's care.

If you think that we may have violated your patient rights, or you disagree with a decision we made, you may file a written complaint with:

Rehab By Design - Clinical Director

2300 Biddle Ave STE 100

Wyandotte MI 48192

You may also call us to voice a grievance or complaint at: 734-246-5705

If you believe your concerns have not been adequately addressed, you may contact:

Michigan Department of Licensing and Regulatory Affairs Bureau of Health Care Systems
Complaint Investigation Unit
P.O. Box 30664
Lansing, MI 48909
www.michigan.gov/bhcs, toll-free complaint hotline at 800-882-6006

Visit www.medicare.gov and select "Ombudsman" under "Help & Support" to get information about how your Medicare questions and complaints are handled, or call 1-800-MEDICARE (1-800-633-4227)

Patient Printed Name

Patient Signature Date

Witness

Date

Reviewed: 11.3.2023 CE