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
www.AlliedRehab.net

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 ❑ M ❑ F

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:

____

____

____

____

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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
______Asthma/Bronchitis/Emphysema
______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
______Foot/Ankle Injury/Surgery
______Gout
______Hand/Wrist Injury/Surgery
______Heart Attack or Heart Surgery
______Hernia
______ High Blood Pressure
______ Hip Injury/Surgery
______ Infectious Diseases
______ Joint Replacement
______ Knee Injury/Surgery
______ Neck Injury/Surgery
______ Numbness or Tingling
______ Osteoporosis
______ Pacemaker
______ 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 benefited 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: _____/_____/_____