REVO REHAB, INC.
Revolve. Revitalize. Revolutionize.

ARRIVE 10 Minutes EARLY for this Evaluation !!!
BRING this PAPERWORK back COMPLETED
along with your ID, INS CARDS, & List of MEDS

1317 Ebenezer Rd Rock Hill, SC 29732 **803-207-8177**

Name: _____ Date of Birth: _____

Address: _____

Phone Numbers:

Home _____

Mobile _____

Email: _____

CIRCLE WHICH # IS BEST TO REACH YOU AT

Pick ONE way to be reminded of appointments on the number you circled above ?

Call / Text / Email

PRIMARY Insurance :_____ Member Number: _____

Responsible Party: Self _____ Spouse _____Child _____

Responsible Party's Name : _____ & Date of Birth : _____/_____/_____

SECONDARY Insurance : (if applicable):_____ Member Number: _____

Responsible Party: Self _____ Spouse _____Child _____

Responsible Party's Name : _____ & Date of Birth : _____/_____/_____

Emergency Contact:

Name : _____ Number : _____

Consent to Therapy Treatment

I hereby consent to the treatment of my condition by a licensed therapist. I understand that I will receive an initial evaluation which will now be followed by one or several treatment sessions. These sessions may include one or more of the following: physical therapy, Joint mobilization, manipulation, soft tissue work, manual therapy, electrical stimulation, ultrasound, heat / ice, mechanical / manual traction, passive / active range of motion, strengthening, stretching, exercise, activities of daily living modification, and/or speech therapy.

Release of Information

I hereby authorize release of information necessary to file claims with my insurance company and information to my physician/s. I permit a copy of this authorization to be used in place of the original.

Receipt of Privacy Practice

I have received a copy of The Notice of Privacy Practices and have had an opportunity to ask questions.

Patient Signature: _____ **Date:** _____

Patient Name: _____ Date: _____

What is your chief complaint? _____

Date of onset of injury or illness: _____ Height: _____ Weight: _____

Did you have surgery? Yes / No What surgery? _____ Surgery Date: _____

Have you ever had a previous injury or occurrence to this area? Yes / No

Have you been treated for this in the past? Yes / No

Are you having any difficult: Balancing? Yes / No Walking? Yes / No Lifting? Yes / No

Scale of 0 to 10 (0 is no pain and 10 is the worst pain imaginable)

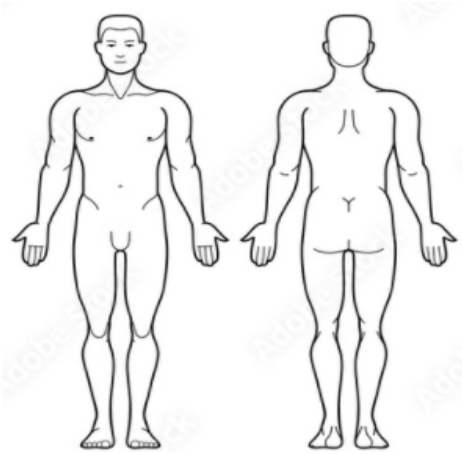
Current level of pain: 1 2 3 4 5 6 7 8 9 10

Least amount of pain over the last week: 1 2 3 4 5 6 7 8 9 10

Highest level of pain over the last week: 1 2 3 4 5 6 7 8 9 10

What increases your pain? _____

What decreases your pain?_____



On This Diagram
Circle Where You Are Having Pain

How Would You Describe Your Pain?
Sharp Aching
Dull Stabbing
Burning Throbbing

Please check the appropriate box for YOUR medical history High blood pressure___ Diabetes___ Arthritis___ COPD/Asthma___ Smoker___ Cancer___ Heart Problems___ Pacemaker___

Surgical History: _____

If female, Are you currently pregnant? Yes / No

Primary Physician: _____ Referring Physician:_____
Do you have any medication allergies? Yes / No If so, what? _____
List your current medications, including any over the counter medications. List name, dosage, and how often taken. OR please attach a list of your current medications.

_____

_____

REVO
REHAB, INC.
Revolve. Revitalize. Revolutionize.

Cancellation/Attendance/Late Policy

We take pride in providing quality rehabilitation service to our patients. In order to receive maximum benefit from your therapy treatments, we ask a few things of our patients:

- We ask that you arrive on time for your therapy appointments. If you arrive 15 minutes late, we reserve the right to reschedule your appointment.

- If you are unable to keep your appointment, we ask that you notify us by 10:00 am the day prior to your appointment at 803-207-8177

- If we do not receive at least 24hr advance notice from you, you will be charged a $25.00 cancellation fee prior to receiving your next scheduled treatment.

- In the event of three (3) appointments that have been missed with or without notification, we reserve the right to discharge you from your rehabilitation services.

- We ask that you perform your HEP (Home Exercise Program) as prescribed.

Insurance Verification

We will gladly file your insurance claim for you; however, Revo Rehab, INC does not guarantee payment by the insurance company for services rendered. In the case that your claim or a portion there of is denied, you will be responsible for payment of the remaining balance.

Medicare Beneficiaries:

We are required, by law to inform you that Medicare Part B will cover 80% of the cost of therapy. The remaining balance may be covered by supplemental insurance coverage or may be paid out-of-pocket. After the claim is initially filed, you will receive a letter of denial from Medicare. We will receive the same letter of denial, and at that time Revo Rehab, INC will bill the remaining claim with the supplemental insurance, if applicable.

Please Direct Any Therapy Concerns to Dr. Ashley Fann &

Any Billing Concerns to Kim Huddleston

at 803.207.8177 or revorehab2018@gmail.com

I give permission for rehabilitative services to be performed by Revo Rehab, Inc. I will be responsible for payment for services, if the insurance company does not pay.

Assignment of Benefits and Insurance Proceeds

I hereby authorize payment from my insurance company of medical benefits for services provided in Out Patient Therapy by an assignment of benefits. The completion of insurance forms and the assignment of insurance benefits do not relieve the undersigned of the obligation to pay the amount owed for Therapy.

Patient Signature: _____ **Date:** _____