MOSSY CREEK REHAB

Patient Registration and Health History

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions

Mailing Address

Address | City | State | Zip

Telephone (home) | (work) | Referred by

Age | Birthdate | * Social Security # xxx-xx- | *must have last four numbers for ins.

Occupation | Employer

Marital Status | Spouse's Name | Spouse's DOB | Spouse's SS# xxx-xx-

Spouse's Employer | Emergency Contact | Phone

Current Complaints

Nature of Injury or complaint: ☐ Automobile * ☐ Work ☐ Other

Please describe:

Date of injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractor care? ○ No ○ Yes Are you **currently** being seen by Home Health? ○ No ○ Yes

Insurance Information

Name of party responsible for payment | Phone

Address | Relationship to Patient

Do you have health insurance? ○ No ○ Yes Name of Company

Primary Policy Holder's Name | DOB | SS# xxx-xx-

***If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone | Claim #

Signature of Patient /Representative/Parent or Legal Guardian of Minor – Consent to Treat

X_____ Date _____

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Have you ever had:	**Briefly Explain:**
Broken Bones? O No O Yes	
Been in an Auto Accident? O No O Yes When? _____	
Sprains/Strains? O No O Yes	
Stroke? O No O Yes	
Cancer? O No O Yes	
Other? O No O Yes	

Do you have an Advance Directive/Living Will □Yes □ No If yes, please supply this office with a copy for our files.

Do you have?

Arthritis? O No O Yes
Diabetes? O No O Yes
Heart Disease? O No O Yes
Cancer? O No O Yes

Please list any allergies you may have:

_____

Pain Questions: Please rate your current pain (1-10) *10 being the worse*

_____

Do you experience pain every day? O No O Yes
Do your symptoms interfere with daily life? O No O Yes
Does pain wake you up at night? O No O Yes
Are symptoms worse during certain times of the day? O No O Yes
Do changes in the weather affect your symptoms? O No O Yes
What activities aggravate your symptoms? _____

Medications	**Prescribed for?**

PATIENT AUTHORIZATION

MCR FINANANCIAL POLICY

As a courtesy, Mossy Creek Rehab (MCR) will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance.

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

I authorize my insurer to pay benefits directly to MCR. I authorize MCR to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. I understand that I am financially responsible for all charges incurred at MCR. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my MCR visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with the insurer.

HIPAA NOTICE OF PRIVACY PRACTICES

I understand that MCR and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that: I understand that MCR may use and disclose my protected health information for treatment, billing to obtain payments, and for related health care operations. A copy of HIPAA is available upon request.

X _____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date