LifeWork THERAPY SERVICES

Patient Information

First Name:_____MI_____Last_____DOB:_____

Physical Address:_____City:_____State:_____Zip:_____

Mailing Address: ☐Check if same_____City:_____State:_____Zip:_____

Home Phone:_____ Cell Phone:_____SSN:_____Age:_____

Email Address: _____

*by providing email address, you expressly consent to receive emails from us. We do not provide or sell you address to 3rd parties.

Marital Status (circle): S M D W Sex: ☐ Male ☐ Female Former Patient: ☐ Yes ☐ No

Occupation:_____ Work Status: ☐ Full Time ☐ Part Time ☐ Retired

Employer:_____Employer Phone:_____

Employer's Address:_____

In Case of Emergency

Name of Emergency Contact:_____Relation to Patient:_____Phone :_____

Accident Information

Is your injury a result of an accident? Yes No ☐ Motor Vehicle Accident ☐ Work Related Accident ☐ Other

Date of Injury/Accident:_____Briefly Describe:_____

_____

Is an attorney involved? ☐ Yes ☐ No Name of Attorney/Law Firm:_____

Is Workers' Comp involved? ☐ Yes ☐ No Workers' Comp Company:_____

Adjuster or Case Manager's Name & Phone #:_____

Referral Information

Referring Physician:_____ Next Scheduled Appt. with Referring Physician:_____

How did you hear about us? ☐ Doctor ☐ Employer ☐ Attorney ☐ Former Patient_____
☐ Family or Friend_____☐ Internet / Facebook ☐ Advertisement (list form)_____
☐ Drove By & Saw It ☐ Other_____

Medicare (If Applicable)

If you are a Medicare patient, are you receiving any type of Home Health (HH) Services? ☐ Yes ☐ No
If so, which HH agency?_____Date of Discharge from HH?_____

Have you received ANY previous physical, occupational, or speech therapy since January 1st of this year? ☐ Yes ☐ No
If Yes, from whom?_____How many visits?_____When was your last visit?_____

Cancellation, No-Shows, and Late Arrivals

It is our policy to notify a patient's physician and case manager/insurance company if a patient misses two (2) scheduled appointments without reasonable cause. We ask that you please provide at least 24 hours' notice should you need to reschedule or cancel an appointment. We also reserve the right to charge for any cancellations or no-shows without proper notice. Three (3) consecutive missed appointments without reasonable cause may result in cancellation of all future appointments. Patients arriving more than 15 minutes late may be asked to reschedule their appointment.

By signing this form, I attest that the above information is true to the best of my knowledge. I agree and give consent for treatment for myself, or the above named minor child, by the staff at LifeWork Therapy Services, LLC and/or as directed by my referring physician.

Patient/Guardian Signature:_____ Date:_____

Medication Log

Name_____ **Date**_____

Medication Name	Dosage/Amount	How Often	Pill/Cream/Injection	Reason for taking

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Name_____Date of Onset / Injury_____Date of Surgery_____

History of Present Condition_____

Primary/Current Complaint(s)_____

Diagnostic tests performed? ☐ X-RAYS ☐ MRI ☐ CT SCAN ☐ NERVE STUDY ☐ BONE SCAN ☐ OTHER _____

Past Medical History (please circle):

High Blood Pressure	Heart Disease	Heart Attack	Pacemaker/Defibrillator	Osteoporosis	Cancer
Asthma	Sleep Apnea	COPD/Emphysema	Pneumonia/Bronchitis	Stroke	Depression
Seizures	Concussion	Hepatitis	Currently Pregnant	Anemia	Headaches
Fractures	Diabetes	Thyroid Disease	Kidney Disease	HIV/AIDS	Tuberculosis
Rheumatoid Arthritis	Osteoarthritis	Metal Implant	Circulatory Problems	Obesity	Other

Medical Allergies_____

Previous Surgeries_____

Functional Limitations (please circle any tasks you are having difficulty performing):

Lying Down	Sleeping thru night	Sitting	Standing	Bending
Squatting	Kneeling	Walking	Running	Lifting
Reaching	Climbing Stairs	Work Demands	Coughing	Sneezing

Living Situation: ☐ Alone ☐ With family, spouse or partner ☐ Assisted Living Facility ☐ Independent Living Facility
Steps inside home or to enter home? ☐ Yes ☐ No If Yes, how many?_____

Fall History: Please indicate # of falls you've had in the past year_____
Factors which seem to make you fall_____

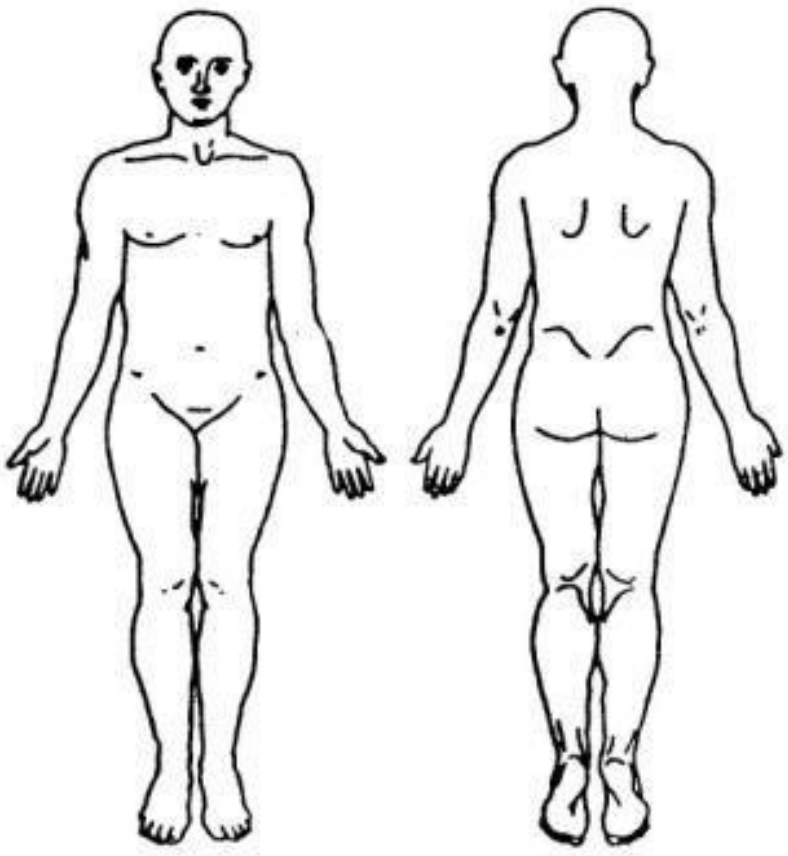
Tobacco Use: Are you a current tobacco user? ☐ Yes ☐ No

Please rate your pain **in the last 72 hours** by circling the correct numbers below:

Current Pain:	0	1	2	3	4	5	6	7	8	9	10
	No Pain					Moderate Pain					Worst Possible Pain
Least Pain:	0	1	2	3	4	5	6	7	8	9	10
	No Pain					Moderate Pain					Worst Possible Pain
Worst pain:	0	1	2	3	4	5	6	7	8	9	10
	No Pain					Moderate Pain					Worst Possible Pain

Describe Your Pain (please circle any that apply to you):

Constant	Intermittent	Sharp	Dull Ache	Burning
Numbness	Tingling	Radiates into Leg	Radiates into Arm	Muscle Soreness
Interrupts Sleep	Headaches	Stiffness	Localized	Widespread



Please indicate WHERE your symptoms are on the drawing above.

Please list your main goals for attending therapy:_____

_____

_____

_____

_____

Authorization for the Release of Medical Record Information

By signing below, I acknowledge that I have reviewed a copy of the Notice of Privacy Practices for LIFEWORK THERAPY SERVICES, LLC and I understand that I may request a copy at any time. I consent to the use and disclosure of my personal health information for the purposes of treatment, payment and healthcare operations. I also grant permission for this practice and its affiliates to obtain information from my physician and other medical professionals as it relates to my treatment.

Patient Name (print): _____ Date: _____

Patient/Guardian Signature: _____

Consent of Release to Other Persons

I hereby give my consent for LIFEWORK THERAPY SERVICES, LLC to release information regarding my account, treatment and/or healthcare to the following persons in order to facilitate and coordinate my care, treatment and/or payment of services rendered:

Name	Relationship	Phone

I understand that authorizing the release of my information to the above individual(s) is voluntary and I can revoke it by writing to LIFEWORK THERAPY SERVICES, LLC or by completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to redisclosure by the individual(s).

Patient/Guardian Signature: _____ Date: _____

Consent to Contact

I give LIFEWORK THERAPY SERVICES, LLC "express prior consent" to contact me at any and all phone numbers provided by phone call or text message for the purpose of treatment, scheduling and/or payment.

_____
Initial

LifeWork THERAPY SERVICES

Patient's Name (print): _____

FINANCIAL POLICY / ASSIGNMENT OF BENEFITS

I, the undersigned, understand that LifeWork Therapy Services, LLC will bill my insurance carrier for services rendered upon verification of benefits by my insurance company. I understand that verification of benefits is no guarantee of payment and my financial responsibility is subject to change. If my insurance company fails to render payment for services rendered, I hereby personally guarantee payment for all medical care / services rendered and understand that I will be responsible for the balance due in full.

I authorize and request that my insurance benefits be paid directly to LifeWork Therapy Services, LLC for all services rendered by this practice. If my current policy prohibits direct payment to LifeWork Therapy Services, LLC, I hereby instruct and direct my insurance carrier to make the check out in my name but send the check to LifeWork Therapy Services, LLC. If my insurance carrier makes payments to me, I agree to immediately pay over these funds to LifeWork Therapy Services, LLC and I also authorize LifeWork Therapy Services, LLC to deposit the check received on my account when made out to me.

I understand that I am responsible for payment of all co-pays, co-insurance and deductibles at the time of service. I also understand that I am responsible for any balance due after payment by my insurance company. I agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

Workers' Compensation (W/C): I authorize release of all medical information to my employer, insurance adjuster and/or case manager assigned to my W/C claim. All charges related to my claim shall be forwarded to the W/C insurance carrier and I will not be held responsible for these charges. I understand if I claim W/C benefits and are subsequently denied such benefits, I may be held responsible for the total amount of charges for services rendered.

POLICY DISCLOSURES

LifeWork Therapy Services, LLC highly recommends that you contact your health plan prior to your initial visit as it is the patient's sole responsibility to know their outpatient rehabilitation benefits. In certain circumstances, as with patients with no insurance, payment plans may be made in advance of your visit. For the convenience of our patients, we also offer select rehabilitation products to purchase for home use. Please note that we do not bill insurance for these products and we will disclose this to you prior to you accepting said product. LifeWork Therapy Services, LLC accepts cash, checks, Visa, MasterCard and Discover. There is a $35.00 fee for all returned checks.

I have read, understand, and consent to the above agreement.

Patient/Guardian Signature:_____ Date: _____

Patient/Guardian Name (please print):_____

Witness

Employee Signature:_____ Date: _____

Name: _____ Date_____

Pediatric Mood & Feeling Scale

Instructions: This form is about how you might have been feeling or acted recently. Please circle how much you have felt or acted this way in the past two weeks.

1.	**I felt miserable or unhappy.**	**Not true**	**Sometimes**	**True**
2.	**I didn't enjoy anything at all.**	**Not true**	**Sometimes**	**True**
3.	**I felt so tired I just sat around and did nothing.**	**Not true**	**Sometimes**	**True**
4.	**I was very restless.**	**Not true**	**Sometimes**	**True**
5.	**I felt I was no good anymore.**	**Not true**	**Sometimes**	**True**
6.	**I cried a lot.**	**Not true**	**Sometimes**	**True**
7.	**I found it hard to think properly or concentrate.**	**Not true**	**Sometimes**	**True**
8.	**I hated myself.**	**Not true**	**Sometimes**	**True**
9.	**I felt I was a bad person.**	**Not true**	**Sometimes**	**True**
10.	**I felt lonely.**	**Not true**	**Sometimes**	**True**
11.	**I thought nobody really loved me.**	**Not true**	**Sometimes**	**True**
12.	**I thought I would never be as good as other kids.**	**Not true**	**Sometimes**	**True**
13.	**I did everything wrong.**	**Not true**	**Sometimes**	**True**

For ages 12-17 years old.