WELCOME TO
River Region Rehab

We are pleased to have you as our patient and look forward to getting your treatment started!

Attached is your basic New Patient paperwork.
(Self assessment surveys and Insurance specific forms will be given at your first visit)

What to bring to your first visit?

*Your completed New Patient packet
*Driver's License
*Insurance Card
*List of medications and history of surgeries

What to wear?

*Something comfortable and allows access to the area being treated.
* Closed toe shoes.

Please contact us with any questions:
Luling 985 331 1001 Destrehan 985 307 0925 New Orleans 504 281 4521
Fax 985 331 1005 Fax 985 307 0826 Fax 504 281 4739

Patient Information

First Name: _____ Gender: _____

Middle Initial: _____ Date of Birth: _____ / _____ / _____

Last Name: _____ Marital Status: _____

Employer Name: _____ Nickname: _____

Other information: _____

Responsible Party

Is the patient the responsible party? _____ Yes _____ No

*If you checked off **no**:*

Relationship to patient: _____ Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____ - _____ Date of Birth: _____ / _____ / _____

Personal Information

Is your home and mailing address the same? _____ Yes _____ No

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Contact Information

Home Phone: (_____) _____ - _____ Cell Phone: (_____) _____ - _____

Email Address: _____

Do you want to receive text message or email appointment reminders? _____ Text _____Email _____ No

Emergency Information

Contact Name: _____ Relationship: _____

Phone: (_____) _____ - _____

Identification Information

Social Security Number: _____ - _____ - _____

Did a doctor send over a referral for this patient? _____ Yes _____ No

____Yes ____No Undersigned hereby authorizes the above provider to render any and all therapy services or other related services that provider feels are necessary or advisable to the patient in conjunction with physician referral.

____Yes ____No I assign payment of medical benefits directly to this provider.

____Yes ____No I authorize the release of any medical information necessary to process this claim. I also give my authorization to release my records, progress notes, and verbal reports if and when needed. I also authorize the request of an appeal or a fair hearing with my insurance or Medicare carrier if payment is denied.

Patient Signature_____ **Date**_____/_____/_____

Responsible Party Signature_____ **Date**_____/_____/_____

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

HIPPA

I have read and fully understand River Region Rehab's Notice of Information Practices. I understand that River Region Rehab may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that River Region Rehab will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in River Region Rehab's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient's Name – Printed

_____

Signature

_____

Date

RIVER REGION REHAB

12371 HWY 90 STE. D, LULING, LA 70070 • (985) 331-1001 • (985) 331-1005 FAX

1972 ORMOND BLVD., STE. D, DESTREHAN, LA 70047 • (985) 307-0925 • (985) 307-0826 FAX

10001 LAKE FOREST BLVD., STE 102, NEW ORLEANS, LA 70127 • (504) 281-4521 • (504) 281-4739 FAX

RIVER REGION PHYSICAL THERAPY REHAB

HIPPA

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____

Patient Name

_____

Patient Signature

_____

Date

RIVER REGION PHYSICAL THERAPY REHAB

MEDICAL HISTORY

Patient Name_____ Date_____

DOB: _____

DO YOU HAVE A HISTORY OF:	YES	NO	REMARKS
High Blood Pressure	_____	_____	_____
Heart Disease	_____	_____	_____
Diabetes	_____	_____	_____
Respiratory Problems	_____	_____	_____
Cancer	_____	_____	_____
Broken Bones	_____	_____	_____
Pacemaker	_____	_____	_____
Metal Implants	_____	_____	_____

PLEASE LIST ANY SURGERIES YOU HAVE HAD:_____

_____

IF YOU ARE ON ANY MEDICATION, PLEASE LIST THEM BELOW:

_____

Patient Signature:_____ Date:_____

Therapist Signature:_____ Date:_____

RIVER REGION PHYSICAL THERAPY REHAB

OCCUPATIONAL HISTORY

PATIENT'S NAME: _____ **DATE:** _____

OCCUPATION: _____

EMPLOYER: _____

JOB RESPONSIBILITIES:

_____

_____

Please list five critical demands that are performed on a daily basis and give details: (example: climbing eight foot ladders, walking/balancing on beams, sitting in front of a computer, answering phones, crawling in elevator shafts, etc.)

1. _____
2. _____
3. _____
4. _____
5. _____

Do you perform lifting activities in your job? Yes _____ No_____

If so, what is the maximum amount of weight lifted on your own? _____lbs

Thank your for your time filling out this questionnaire, it will allow us to better develop a well-rounded program for you.

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Who referred you to our facility?

___ Newspaper

___ Phonebook

___ Friend _____

___ Family _____

___ Doctor _____

___ Other _____

Have you been a patient at River Region Rehab in the past?

___ Yes ___ No

If so, when and what did we treat you for?

_____

Would you like for us to forward your evaluation to your Primary Care Physician?

___ Yes ___ No

If so, please list his/her name _____