COMMUNITY SPORTS & THERAPY CENTER

WEB www.cstcenter.com PHONE 419-678-OHIO

SERVING OUR COMMUNITY SINCE 1980

a proud partner of Mercer Health

New Pediatric Patient Intake Form

Name: ______________________________ Date of Birth: ____________ Age: ____ Date: __________

Are you presently receiving ANY type of home health care services from ANY home health agency or hospice? Examples: Mercer Health Home Health or Celina Visiting Nurses ☐ Yes ☐ No

Have you received ANY other therapy services throughout the year from another therapy agency?
☐ Yes ☐ No

Are you currently being treated by another physician or health care practitioner (chiropractor, physical therapist, etc.)? ☐ Yes ☐ No If yes, who? ______________________________

For what? ______________________________

What diagnosis/injury has brought you to therapy? ______________________________

____

When did it start? ______________________________

What is your goal(s) to accomplish in therapy? ______________________________

____

Birth History (Full-term, NICU, Apgar Score, Natural Birth Vs. C-Section)? ______________________________

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Current and Past Medical History *(Check all that apply.)*

- ☐ Anemia
- ☐ Angina/Chest Pain
- ☐ Arrhythmia
- ☐ Asthma/Emphysema/COPD
- ☐ Bleeding Disorder
- ☐ Blood Clots
- ☐ CAD (Coronary Heart Disease)
- ☐ Cancer
- ☐ Congenital Heart Defect
- ☐ Depression
- ☐ Diabetes
- ☐ Drug/Alcohol Abuse
- ☐ Fractures
- ☐ GERD
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Health Issues
- ☐ MI/Heart Attack
- ☐ Migraines/Headaches
- ☐ Neurological Diseases
- ☐ Obstructive Sleep Apnea
- ☐ Renal Disease
- ☐ Seizures
- ☐ Sickle Cell
- ☐ Stroke/CVA/TIA
- ☐ Vascular Disease

If you checked any of the above, please explain: ______________________________

____

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Patient Name: ______________________________ Date: ______________

List all surgeries: ____

____

Do you have any allergies? □ Yes □ No If yes, please list: ______________________________

____

If you are obtaining therapy without a physician referral, please list a physician in which we can share your therapy information/notes.

Physician: ______________________________

Medicare Patients – in order to bill Medicare we require a physician referral due to physician certification and recertification requirements by Medicare.**

Please check any of the following treatments you have had in the past.

□ Physical therapy ______________ □ Psychologist ______________

□ Occupational therapy ______________ □ Chiropractor ______________

□ Pain program ______________ □ Nerve block ______________

□ Back school ______________ □ TENS ______________

□ Other ______________

Do you have any religious or cultural considerations we need to know about before you start our program?

□ Yes □ No If yes, please explain: ______________________________

____

____

Are you in a situation with someone who is physically, emotionally, or sexually hurting you? □ Yes □ No

Please feel free to ask our staff any questions you may have regarding our services or any billing/price information. We will be glad to assist you in any way we can.

<u>Several insurance companies require you to contact them before you receive therapy services. It is your responsibility to see that this is done but our staff will assist you as much as possible</u>. Insurance coverage varies from company to company. It is the patient's ultimate responsibility to verify insurance coverage for services received. Please note that we are a hospital-based facility, not a free-standing facility, and our billing at all locations is completed through Mercer Health hospital.

Revised 5/3/18

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Patient Name: ____ Date: ____________________

Our goal is to provide you with the highest quality professional service in an efficient manner. We have allocated sufficient time to properly meet your needs. <u>If for any reason you cannot make your therapy appointment, please notify us at least 8 hours before the scheduled appointment. If you fail to do so, we reserve the right to charge a missed appointment charge that insurance usually does not cover.</u>

We are a clinical education site for multiple universities and professional schools. There are times we have therapy students in our department. They may observe and at times perform your treatment program in aspects of your care that they have been determined to be competent in and with proper supervision. May we have your permission for students to perform and/or observe your treatment? If at any time you feel uncomfortable with this you may let us know and we will make other arrangements.

□ **Yes, students may perform, participate and/or observe my treatment with proper supervision.**
□ **Yes, students may observe and participate in my treatment, but not perform any treatment.**
□ **No, students may not perform, participate and/or observe my treatment.**

There are also volunteers in our department observing this field of the medical environment in further medical education. Volunteers by policy do not perform treatment in our department.
□ Yes, volunteers **may** observe my treatment.
□ No, volunteers **may not** observe my treatment.

How did you hear about us? *(Check all that apply.)*

□ Doctor □ Newspaper Ad □ Radio Ad □ Social Media

□ Friend/Relative □ Website/Internet □ Previous Experience

□ Other: ____

Email Address: ____

TO THE BEST OF MY KNOWLEDGE, INFORMATION PROVIDED HEREIN IS CORRECT.
I, the patient have also reviewed the Rehabilitative Services Department's Patient Bill of Rights and Responsibilities statement and I am committed to cooperating and participating at my fullest capacity. A copy of the hospital Patient Bill of Rights and Responsibilities (Policy #A-3) that addresses the rights and responsibilities of patients is also available upon request.

____ ____________________
Signature of Patient/Legal Guardian Date