HEALTHSOUTH®

OUTPATIENT INFORMATION RECORD/HISTORY ASSESSMENT

GENERAL INFORMATION

Name ______________________

Sex ☐ M ☐ F   Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Daytime phone __________ Alternate/cell phone __________

Home phone ______________________

Address ______________________

City __________ State ______ Zip ______

Name of parent/guardian/caregiver ______________________

Relationship __________ Home/work phone __________

Primary care physician ______________________

Phone __________ Fax __________

Emergency contact ______________________

Relationship __________ Home/work phone __________

Known allergies: ☐ None ☐ Yes ______________________

Adverse reactions to medications: ☐ None ☐ Yes ______________________

To be completed by therapists on subsequent visits as change occurs.

UPDATES with therapists initials/date/time	UPDATES with therapists initials/date/time

Primary language spoken __________ Caregiver language spoken __________ Date of birth: ______ Age: ______

Level of education ☐ 0-7 ☐ 8-12 ☐ College   Caregiver ☐ 0-7 ☐ 8-12 ☐ College

Is your condition due to the ☐ Auto accident ☐ Fall ☐ Work injury ☐ Other __________ Date of onset __________

If this is a work injury, where were you working when the injury occurred? ______________________

Employer __________ Occupation __________ Last day worked __________

Employer address __________ Phone __________

If your primary insurance is Medicare and you have sustained an injury, please describe in detail how and where this injury occurred

____

What is the problem that brings you to therapy? ______________________

Are there any cultural or religions beliefs that may impact your care? ☐ Yes ☐ No Please explain: ______________________

At the present time, would you say that your health is (choose one of the following) ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Is there anything we need to know that is not covered on this form? Comments: ☐ No If so, please explain: ______________________

What are your goals for therapy: ______________________

©2011 HealthSouth Corporation

OUTPATIENT INFORMATION RECORD/HISTORY ASSESSMENT

CURRENT MEDICATIONS ☐ NONE ☐ SEE ATTACHED LIST			
		To be completed by therapists on subsequent visits as change occurs.	
PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS/OTC DRUGS	DOSAGE/FREQUENCY	UPDATED PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS OTC DRUGS/DOSAGE/FREQUENCY Initials/date/time	UPDATED PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS OTC DRUGS/DOSAGE/FREQUENCY Initials/date/time

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist. If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients. We are obligated to record all cancellations and no shows in your medical record. If you are covered by worker's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier.

☐ **Patient/caregiver unable to complete form; information reviewed and completed by therapist.** ______________ **Initials**

Name of person completing form: ______________________ Date: ____________

Clinical signature/title/initials ______________ Date/time ______________ Clinical signature/title/initials ______________ Date/time ______________

Clinical signature/title/initials ______________ Date/time ______________ Clinical signature/title/initials ______________ Date/time ______________

©2011 HealthSouth Corporation REORDER # HLS-FM-304

HEALTHSOUTH®

OUTPATIENT INFORMATION RECORD/HISTORY ASSESSMENT

GENERAL INFORMATION

Name ______

Sex ☐ M ☐ F Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Daytime phone ______ Alternate/cell phone ______

Home phone ______

Address ______

City ______ State ______ Zip ______

Name of parent/guardian/caregiver ______

Relationship ______ Home/work phone ______

Primary care physician ______

Phone ______ Fax ______

Emergency contact ______

Relationship ______ Home/work phone ______

Known allergies: ☐ None ☐ Yes ______

Adverse reactions to medications: ☐ None ☐ Yes ______

To be completed by therapists on subsequent visits as change occurs.

UPDATES with therapists initials/date/time	UPDATES with therapists initials/date/time

Primary language spoken ______ Caregiver language spoken ______ Date of birth: ______ Age: ______

Level of education ☐ 0-7 ☐ 8-12 ☐ College Caregiver ☐ 0-7 ☐ 8-12 ☐ College

Is your condition due to the ☐ Auto accident ☐ Fall ☐ Work injury ☐ Other ______ Date of onset ______

If this is a work injury, where were you working when the injury occurred? ______

Employer ______ Occupation ______ Last day worked ______

Employer address ______ Phone ______

If your primary insurance is Medicare and you have sustained an injury, please describe in detail how and where this injury occurred

______

What is the problem that brings you to therapy? ______

Are there any cultural or religions beliefs that may impact your care? ☐ Yes ☐ No Please explain: ______

At the present time, would you say that your health is (choose one of the following) ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Is there anything we need to know that is not covered on this form? Comments: ☐ No If so, please explain: ______

What are your goals for therapy: ______

©2011 HealthSouth Corporation

HEALTHSOUTH®

OUTPATIENT INFORMATION RECORD/HISTORY ASSESSMENT

Surgeries/hospitalizations (include dates)

CURRENT PROBLEM

	YES	NO	COMMENTS	** To be completed by therapists on subsequent visits as change occurs. **	
				UPDATES with therapists initials/date/time	UPDATES with therapists initials/date/time
Bowel/bladder					
Headaches					
Blurry/double vision/dizziness					
Shortness of breath					
Smoking/alcohol/street drugs					
Sleeping/fatigue					
Weight loss/gain					
Nausea/vomiting					
Skin/swelling					
Chest pain					
Falls/near falls					
Other					

MEDICAL/SURGICAL HISTORY

	YES	NO	COMMENTS	To be completed by therapists on subsequent visits as change occurs.	
				UPDATES with therapists initials/date/time	UPDATES with therapists initials/date/time
Respiratory: COPD, asthma/TB					
High/low blood pressure					
Heart disease/heart attack/pacemaker					
Circulation/vascular					
Arthritis/osteoporosis/joint replacement					
Pregnancy					
Diabetes mellitus					
Cancer					
Kidney/urinary/intestinal trauma					
Epilepsy/seizures					
Stomach/gastrointestinal					
Neurological conditions/stroke					
Head or spinal cord injury					
Psychiatric history/depression					
Other					

©2011 HealthSouth Corporation REORDER # HLS-FM-304

OUTPATIENT INFORMATION RECORD/HISTORY ASSESSMENT

CURRENT MEDICATIONS ☐ NONE ☐ SEE ATTACHED LIST

		To be completed by therapists on subsequent visits as change occurs.	
PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS/OTC DRUGS	**DOSAGE/FREQUENCY**	**UPDATED PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS OTC DRUGS/DOSAGE/FREQUENCY** Initials/date/time	**UPDATED PRESCRIPTION DRUGS/HERBAL SUPPLEMENTS OTC DRUGS/DOSAGE/FREQUENCY** Initials/date/time

In order to reach your optimum rehabilitation, it is essential that you follow your physician's prescribed treatment and the treatment plan established by your therapist. If you must cancel an appointment, please notify us as soon as possible so that we can reschedule your missed appointment within the week. We appreciate notification of cancellations 24 hours prior to scheduled appointments; this allows us to utilize your appointment time for other patients. We are obligated to record all cancellations and no shows in your medical record. If you are covered by worker's compensation, we are obligated to report cancelled and "no show" appointments to your insurance carrier.

☐ **Patient/caregiver unable to complete form; information reviewed and completed by therapist.** ____________ **Initials**

Name of person completing form: ______________________ Date: __________

Clinical signature/title/initials ______________ Date/time ______ Clinical signature/title/initials ______________ Date/time ______

Clinical signature/title/initials ______________ Date/time ______ Clinical signature/title/initials ______________ Date/time ______

©2011 HealthSouth Corporation REORDER # HLS-FM-304

HEALTHSOUTH®

OUTPATIENT INFORMATION RECORD/HISTORY ASSESSMENT

Patient's additional information:

Date	Therapist's notes/updates:	Initial/date/time

©2011 HealthSouth Corporation REORDER # HLS-FM-304

HEALTHSOUTH®

CONSENT TO TREAT AND CONDITIONS OF ADMISSION

Patient Identification

Patient Name:________________________________ M.R.# ______________

Dear Patient: Welcome! This form is designed to make sure you have the information you need to make an informed decision about being admitted to this hospital. Our admitting staff, case managers, and other administrators will be happy to help you get all the information you need in order to enable you to provide us with your informed consent to be treated as a patient at our hospital.

I. Consent to Medical Treatment. As patient, agent of patient or guarantor, I hereby consent to being admitted and treated at HealthSouth (the "Hospital"). I authorize two categories of individuals to treat me while I am a patient:

1. **Employees of the hospital:** These individuals include nurses, therapists and other clinicians who work under the clinical supervision of qualified and licensed clinicians who are employed by the hospital.
2. **Independent practitioners:** These individuals include physicians, nurse practitioners, physicians assistants, and other health care professionals, all of whom are independent members of Hospital's Medical Staff or who have been otherwise granted privileges to treat patients at the Hospital. In addition, this category includes any clinical students, residents or fellows under the supervision of these independent licensed health care practitioners. These independent practitioners are independently licensed by the state and operate according to their professional judgment and skills in the delivery of medical care to their patients and oversight to students.

The treatment I am authorizing includes administering such examinations, treatments and/or diagnostic procedures under the direction of a physician as may be necessary for my medical care at the Hospital, whether provided on an inpatient and/or outpatient basis and/or by practitioners from a distant site via electronic communications and including, without limitation, general and rehabilitative nursing care, minor procedures, laboratory and other diagnostic procedures, radiological examinations (e.g., X-rays), blood draws, specialized therapies, pain management, and other treatments and interventions under the general and specific instructions of a practitioner(s).

I further consent to the presence of medical, nursing, and other healthcare personnel who may not be directly involved in my medical treatment and care but who serve in educational or training functions. I acknowledge that I have the right to select any Practitioner who has privileges to practice at the Hospital to provide me with medical care and/or treatment, if he or she agrees to accept me as a patient; provided, however, that in the event of an emergency, or if specialized treatment is required, I consent to treatment by any available Practitioner who has privileges or authorization to practice at the Hospital. I acknowledge that I may be required to sign additional consent forms for certain specific medical treatments or procedures as a way of insuring that I have received all the information I need to make an informed decision.

2. **Independent Status of Medical Staff and Practitioners.** I understand that all practitioners described above who are not employees of the Hospital practice independently under their state license and privileges granted by the hospital. Their medical services are not controlled by the hospital or its employees, so these practitioners maintain sole responsibility for their medical judgment and professionalism.

I understand and agree that in most cases the practitioners who render professional services to me will bill and collect for their services independently from the Hospital. I understand that the bills from any practitioners billing in such manner may be separate and apart from the Hospital's billing and collections (see Paragraph 4 below).

3. **No Guaranteed Outcome.** I understand that the practice of medicine and the delivery of health care services are not exact sciences, and I acknowledge that no guarantee has been made to me as to the effect, result, or outcome of any examination or treatment I may receive at the Hospital. I acknowledge that the Hospital is not responsible if I do not follow the instructions of the Independent Practitioners or Hospital Employees providing me with treatment during the course of my medical care at the Hospital.

©2014 HealthSouth Corporation

Patient Identification

4. **Financial Agreement.** I understand that I am obligated to pay the Hospital's usual and customary charges for all services received by me during my medical treatment and care at the Hospital. I understand that failure to pay these charges within 120 days of receipt of the bill may result in a referral to an agency or attorney for collection. If my account is referred to a collection agency or attorney, I agree to pay reasonable attorney fees and collection expenses. I understand that I may be asked to sign a separate financial agreement for all amounts not covered under an insurance policy, healthcare service plan, and managed care program or by any third party payor not a party to this agreement. I also understand that I may receive a bill directly from my independent physicians. If I receive a separate bill from these individuals, I understand that these charges will not be included on the separate bill I receive from the hospital. I understand that my physicians may not be a part of my health plan and that it is my responsibility to verify insurance coverage for these physicians. I also understand that it is my responsibility to pursue resolutions for benefit reductions or non-payment.

I acknowledge that, if I am a member of a healthcare service plan or covered under a managed care plan, it is my responsibility to provide to the Hospital the name of the plan, my primary care physician's name and telephone number, and confirmation of eligibility.

5. **Assignment of Benefits.** I hereby irrevocably assign and transfer directly to the Hospital all rights of any insurance or third party payor benefits for services rendered to by the hospital. I understand that I am responsible for providing the Hospital with information necessary to allow the Hospital to bill my insurance carrier or provider of medical benefits. I understand I may be financially responsible for payment of any charges not paid by insurance or other third party even if I have no insurance or coverage is denied. I further understand the Hospital does not accept responsibility for collecting my insurance claim or negotiating a settlement on a disputed claim, and that I may be responsible for the timely payment of my account(s). I certify that the information given by me in applying for, or assigning, payment to all payers, including Medicare or Medicaid, is correct. I request payment from all payers, including authorized Medicare or Medicaid benefits, be paid to the Hospital on my behalf for services furnished to me. I authorize the Hospital to release information about me that is necessary to act on this request for payment.

6. **Consent to Testing.** I understand that the law may allow for testing in the event of accidental exposure of a healthcare worker to blood or bodily fluids to ensure that the healthcare worker has not been put at risk for a communicable disease for which he or she may need treatment. If a healthcare worker is exposed, I consent to have the Hospital team members draw my blood and run tests for communicable diseases. I understand that the cost of this testing will not be charged to my bill and I can determine whether or not I want to be informed of the test results.

7. **Patient Valuables.** While the Hospital will use its best efforts to protect the valuables of its patients, I understand that the Hospital is not liable for damage to, or loss or theft of, any money, documents, or any other personal property of mine.

I hereby acknowledge that prior to my admission to or my receiving treatment at the Hospital, I have read and understand this Consent to Treatment. By my signature below, I accept all terms and conditions. If I am executing this document on behalf of this patient, I certify that I have the authority to execute this form on behalf of the patient.

_________________________ Patient

_________________________ Witness

_________________________ Personal Representative/Family Member

_________________________ Print Name of Personal Representative

_________________________ Witness

Date_______________ Time__________

HEALTHSOUTH
Valley of the Sun Rehabilitation Hospital

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES*

You may refuse to sign this acknowledgement

HealthSouth Valley of The Sun Rehabilitation Hospital will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for the other health care operations. Healthcare operations generally include those activities we perform to improve the quality of care.

We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies about your personal health information. The terms of the notice may change with time and we will always post the current notice at our hospitals and have copies for distribution.

I, ______________________________, have received a copy of this hospital's Notice of Privacy Practices.

____
Please Print Name

____
Signature

____
Relationship to Patient

____
Date/Time

For Office Use Only

I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but the acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify) ______________________________

____

____

______________________________ ______________
Signature Date/Time

THE PATIENT IS ENTITLED TO A COPY OF THIS ACKNOWLEDGEMENT

Include completed acknowledgement in the patient's Medical Record

©2013 HealthSouth Corporation

CMP – 704

Attachment G

Opportunity to Agree, Object, or Restrict

Hospital Directory HealthSouth patients have the opportunity to agree or object to the practice of sharing "directory information", i.e., the patient's name, room number, general condition and religious affiliation (with clergy only), with other individuals who are not involved in the patient's treatment, payment for said treatment, hospital operations or those activities allowed by federal and state law.

Check one of the following:

___ I agree to have my "directory information" shared with individuals who ask for me by name.
☐ No Code ☐ A ☐ B ☐ E ☐ P

___ I object to sharing "directory information" with individuals who ask for me by name.
☐ N ☐ C

I am identifying the following individual to be my lay caregiver:

Name: ______________________________

Address: ______________________________

Phone Number: ______________________________

___ I allow HealthSouth to share my protected health information with my lay caregiver.

___ I DO NOT allow HealthSouth to share my protected health information with my lay caregiver.

___ I decline to identify a lay caregiver.

Individual/Family Member/Personal Representative
HIPAA allows HealthSouth to share patient's Protected Health Information (PHI) with their personal representatives including, but not limited to, family members, close friends and those individuals who have Durable Power of Attorney for the patient's healthcare decisions. To clarify with whom HealthSouth may share your PHI, please list below the names of those individuals. HealthSouth will share with the below individuals only PHI surrounding your HealthSouth hospital stay.

___I hereby allow my health information to be shared with the following individual(s):

____________________ ____________________ ____________________

Health Plan HIPAA allows the patient an opportunity to restrict the use/disclosure of health information to a current health plan for medical services or products paid for in full as "out of pocket" expenses.

___I hereby request a restriction on the use/disclosure of my health information to my current health plan. I understand that this request requires payment for medical services in full as an "out of pocket" expense.

☐ I

Description of Specific Protected Health Information to be Restricted:

____

Name of Health Plan Restricted from Use/Disclosure: ______________________________

Name of Subscriber and Subscriber Number:

____

______________________________ ____________________
Signature of patient/patient representative Date/Time

______________________________ ____________________
Signature of Witness Date/Time

No Code - No alert	**A** - Administrator	**B** - HealthSouth Board of Director	**C** - Celebrity
E - Employee	**N** - No release of info	**P** - Physician/Physician Family	**I** - No release of info to insurance

©2013 HealthSouth Corporation