WELCOME TO TRI-REHAB, INC.
WE LOOK FORWARD TO WORKING WITH YOU!

DATE:________________ REFERRING DOCTOR:______________________

PATIENT'S NAME (LAST) (FIRST) (M.I.) (MAIDEN)

ADDRESS CITY STATE ZIP

HOME PHONE WORK PHONE CELL PHONE E-MAIL

SEX BIRTHDATE MARITAL STATUS SOCIAL SECURITY #

OCCUPATION PATIENT'S EMPLOYER EMPLOYER'S ADDRESS

SPOUSE'S NAME (LAST) (FIRST) (M.I.)

SPOUSE'S ADDRESS CITY STATE ZIP

EMERGENCY CONTACT PHONE #

HOW DID YOU HEAR ABOUT TRI-REHAB, INC.?

MEDICAL HISTORY

_____ **High Blood Pressure**

_____ **Heart Murmur**

_____ **Other Heart Problems**

_____ **Asthma**

_____ **Epilepsy/Seizures**

_____ **Fainting**

_____ **Allergies**

_____ **Chronic Headaches**

_____ **Pacemaker**

_____ **Diabetes**

_____ **Tuberculosis**

_____ **Jaundice**

_____ **Are You Pregnant Y 0r N**

_____ **Venereal Disease**

_____ **AIDS/HIV** (+)

_____ **Nervous Disorders**

_____ **Implants**

_____ **Previous Back Pain**

_____ **Hepatitis**

_____ **Cancer**

Have you ever had physical therapy before?_____ If so, when and for what? _____

____________________________________ Did the physical therapy help? ________

History of Present Illness/Injury:____

____

Past Surgeries/Dates?____

____

Medications: ____

____

www.trirehab.com
2330 Monroe St, Suite A, Dearborn, MI 48124 (313) 593-1703, (313) 593-1939 fax
45610 Cherry Hill Road, Canton, MI 48187 (734) 981-1500, (734) 981-1515 fax

ATTENDANCE POLICY

You have been referred to Tri-Rehab, Inc. due to a physical problem or disability. The maximal benefits of rehabilitation can only be achieved if you are very serious about *your* program and follow the instructions you are given.

Attendance at rehabilitation is mandatory unless severe circumstances (illness, etc.) prevent you from making your appointment.

In the event that you must miss an appointment, it is your responsibility to call our office in advance to avoid no show status. Our office will kindly reschedule your appointment within your current prescription.

If you do not show for a scheduled appointment, it is your responsibility to reschedule the appointment at your next visit or by telephone. In the unlikely event that three appointments are missed within the current doctor's prescription, your physician and insurance representative/employer will be notified. Excessive cancellations and no shows will result in discharge from services at Tri-Rehab, Inc.

While attending your rehabilitation sessions, only patients are permitted in the treatment area or on the equipment.

* PATIENT RESPONSIBILITY *

You will be held responsible for your insurance coverage, co-pays and deductibles. Tri-Rehab encourages all patients to call their insurance carrier and request a quote of their physical rehabilitation benefits.

I have read and understand the attendance and patient responsibility information above.

Patient signature____ Date______________________

Guardian signature_____________________________________ Date______________________

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ADMISSION CONSENT

CONSENT TO TREATMENT: I consent to rehabilitation and incidental medical services at **TRI-REHAB,INC.** I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation.

LIABILITY: I know and agree that **TRI-REHAB, INC**. is not responsible for loss or damage to personal valuables.

RELEASE OF INFORMATION: I understand that **TRI- REHAB, INC.** may give information related to me to any third party payer or insurance company which may be responsible in whole or part for paying my bill and to companies hired by these third parties to monitor utilization of rehabilitation services and to any health care facility or physician by which I am referred.

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to **TRI-REHAB, INC.** and also authorize release of any medical records necessary to process claims. I understand fully that if my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment.
In the event someone other than myself is responsible for payment, I understand that their information and signature will be necessary for treatment.
I HAVE READ AND UNDERSTAND THE ABOVE:

___________________________________ ___________________________________
Patient's Signature Date Witness Signature Date

___________________________________ ___________________________________
Print Patient Name Print Witness Name

If the patient is a minor or legally incapacitated, please obtain the signature of a parent or guardian.
PERSON RESPONSIBLE FOR PAYMENT OF TREATMENT
(If other than yourself)

Name:_________________________________ Phone Number:_____________________

Address:____

Signature:_________________________________ Date:____________________________

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