Orthopaedic Team Rehabilitation
PHYSICAL THERAPY

28001 Schoenherr Road, Suite 6, Warren, MI 48088 | Phone: 586-999-8330 | Fax: 586-999-8331

Admission Questionnaire

Referred by: ☐ **Physician** _____ ☐ **Friend** ☐ **Online** ☐ **Other**

Name (Last, First) _____

Date of Birth: _____

Address: _____

Please Check One: ☐ **Male** ☐ **Female** **Social Security #:** ___ – ___ – ___

Home #: _____ May we leave a message? ☐ Yes ☐ No

Cell#: _____ May we leave a message? ☐ Yes ☐ No

Work#: _____ May we leave a message? ☐ Yes ☐ No

Email Address: _____

If under 18: Parent/Guardian Name: _____

Emergency Contact: _____ **Phone:** _____

Relationship: _____

Medical History (check all that apply):

☐ Seizures ☐ Dizziness/Vertigo ☐ Latex Allergy Other: _____

Change of Insurance:

I agree to inform Orthopaedic Team Rehabilitation of any insurance changes that occur during my treatment.

Signature: _____ **Date:** _____

GENERAL CONSENT TO TREATMENT

CONSENT: I consent to physical therapy treatments as deemed necessary by my doctor and physical therapist. I understand that while in Orthopaedic Team Rehabilitations clinic I am under the care of my doctor and my therapist and that my therapist and any staff assisting him or her will follow a plan of care approved by my doctor.

PAYMENT BY HEALTH INSURANCE: Orthopaedic Team Rehabilitation. Orthopaedic Team Rehabilitation participates with most insurances. Orthopaedic Team Rehabilitation will bill your health insurance. Payment is based on each individual contract. We will verify your benefits prior to physical therapy.

VERIFICATION OF BENEFITS: I certify that the information I have provided to Orthopaedic Team Rehabilitation to verify my health insurance or Medicare benefits is accurate and complete to the best of my knowledge.

PRIVACY OF MY HEALTH CARE INFORMATION: Orthopaedic Team Rehabilitation makes every effort to comply with State and Federal law on the privacy of health care information. I acknowledge that upon my request I was given a copy of Orthopaedic Team Rehabilitation's HIPP A policy and have had time to read it and ask for further information if needed.

PERSONAL PROPERTY: Orthopaedic Team Rehabilitation is not responsible for loss or damage to any of my personal property while I am in the clinic.

Signature of Patient/Parent: **Date:**

_____ _____

Witness: **Date:**

_____ _____