Date: _____ **Date of Injury or Surgery:** _____

Occupation_____ **Right Handed**_____ **Left Handed**_____

Why are you being seen for therapy today? _____

Diagnostic test(s) results: X−ray / MRI / CT Scan _____

Previous therapy or medical interventions _____

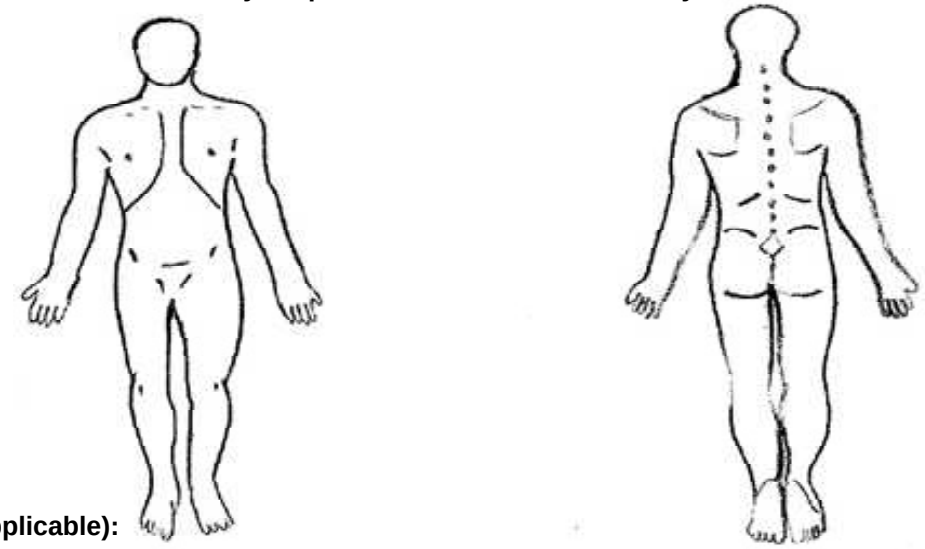
Check which of the following applies to you:

_____ Pain _____ Decreased Motion _____ Swelling/edema _____Stiffness _____ Loss of function

Indicate the nature of your pain and symptoms (Check all that apply):

___Sharp ___Dull ___Piercing ___ Shooting ___Aching ___ Deep ___Superficial ___ Tingling ___ Numbness ___ Intermittent

___ Burning ___ Stabbing **Where is your problem? Indicate on the body chart**



Current Pain Level (if applicable):

No Pain 0 1 2 3 4 5 6 7 8 9 10 Worst Pain Imaginable

Are your symptoms worse in the: _____ Morning _____Afternoon _____Evening

Are your symptoms: _____ Worse _____ Same _____ Better

Medical History (Check all that apply):

❑ Arthritis
❑ Cancer
❑ Diabetes
❑ Depression/Anxiety
❑ Other (Please Describe): _____

❑ High Blood Pressure
❑ Fever/Chills/Sweats
❑ Heart Condition

❑ Pacemaker
❑ Stroke
❑ Unexplained Weight Loss
❑ History of Drug/Alcohol Abuse

❑ Fibromyalgia
❑ Osteoporosis

❑ Blood Clot
❑ Shortness of Breath
❑ HIV/Hepatitis
❑ Allergy _____

Are you pregnant? ❑ Yes: _____ months ❑ No

Current Medication(s): _____

OUTPATIENT REHAB MEDICAL HISTORY INTAKE FORM

EvergreenHealth Monroe
P.O. BOX 646
14701 179th AVENUE S.E.
MONROE, WA 98272−0646
(360) 794−7497

ADM

FINANCIAL AGREEMENT & CONSENT FOR DISCLOSURE

By signing below, I agree:

1. That EvergreenHealth Monroe may share any financial information I provide to facilitate payment.
2. To pay EvergreenHealth Monroe for balances remaining after insurance benefits are paid, unless prohibited by law or contract.
3. To notify EvergreenHealth Monroe of changes to my insurance coverage and/or address.
4. That EvergreenHealth Monroe may impose reasonable interest, late charges, costs and/or reasonable attorney's fees should my account become delinquent.
5. To notify EvergreenHealth Monroe if I am not able to pay my balance due within 30 days of receipt.
6. To apply to other financial programs that I may qualify for as requested by EvergreenHealth Monroe, should I be unable to pay my account.
7. That any lawsuit for collection of my account may be brought in Snohomish County, Washington.
8. That EvergreenHealth Monroe may, at its discretion, disclose to appropriate parties my medical records or information from my records for treatment, payment and health care operation purposes.

I understand that:

- Each EvergreenHealth Monroe entity bills separately for their services.
- Patients who receive services at EvergreenHealth Monroe generally receive two bills: one bill from the physician or other provider (for the costs of the professional services) and one bill from the hospital (for the facility costs, i.e. building, equipment, supplies, staff time). Each of these bills may incur a co−payment or co−insurance responsibility, depending on my insurance coverage. The exact amount of the co−insurance or co−payment will depend upon the actual services provided and the coverage provisions of any insurance I have. At my request, EHM staff will provide me with an estimate of the billed charges for services I am likely to receive.
- EvergreenHealth Monroe requests and, if I provide it, will use my Social Security Number to facilitate access to any potential federal or state health care benefits, to verify my identity, or to facilitate discharge
- planning. Providing my Social Security Number is voluntary except when applying for state and federal health care benefits.
- My Consumer Credit Report information may be accessed for the following reasons: to make determination of available financial assistance, assistance in managing the payment process, or if I report that my identity has been stolen.

Statement to Permit Payment of Medicare or Insurance Benefits to Provider

I request payment of authorized Medicare or insurance benefits for any services furnished to me by EvergreenHealth Monroe. I authorize any holder of medical and other information about me to release to Medicare [and its agents] or other insurance providers any information needed to determine these benefits for related services.

SIGNATURE (Patient or person authorized to give authorization)	PRINT NAME	DATE & TIME	WITNESS INITIALS

IF SIGNED BY PERSON OTHER THAN PATIENT, SPECIFY SURROGATE'S RELATIONSHIP TO PATIENT:

❑ GUARDIAN ❑ HEALTH CARE POWER OF ATTORNEY ❑ PARENT

❑ HUSBAND / WIFE ❑ ADULT CHILD ❑ ADULT BROTHER / SISTER

INTERPRETER PROVIDED: ❑ YES ❑ NO

GENERAL CONSENT TO REHABILITATION SERVICES TREATMENT

This undersigned patient or patient's authorized legal representative hereby consents to admission to EvergreenHealth Monroe Rehabilitation Services for diagnostic tests, procedures, care and treatment. I am aware that the practice of medicine is not an exact science and acknowledge that no guarantees or promises have been made as to the result of the procedures, care or treatment provided. I consent to and authorize the following:

Medical Consent: I consent to Evergreen Health Monroe Rehabilitation Services procedures and therapy performed or prescribed by the attending provider or his/her designees or assistants.

Advance Directive: I understand that I have an opportunity to make known my wishes, in writing, regarding my health care and/or end of life decisions. Upon my request, I will be provided with information about a Living Will and/or a Durable Power of Attorney for Health Care.

Patient's Rights and Responsibilities: I acknowledge receiving the Patient's Rights and Responsibilities pamphlet.

Release of Confidential Information: I authorize EvergreenHealth Monroe and/or the attending physician/provider to release any information, including information from my medical record necessary to facilitate health care claims processing and payments. This release may include specific information related to the testing, diagnosis and/or treatment of sexually transmitted diseases (including HIV), alcohol or drug abuse, and mental health/psychiatric disorders. I also consent to the release of any information as needed for post−discharge care or transfer of care to other health care facilities or agencies as I direct or as required by law. (If refused, please draw a line through this section and initial).

Personal Valuables: EvergreenHealth Monroe shall not be held liable for the loss of or damage to any money or other valuables even if deposited for safekeeping, which is provided as a service only; and shall not be held liable for loss or damage to any other personal property.

Cancellation/Attendance: I understand that if I am unable to keep a scheduled appoinment I will make notification at least 24 hours in advance. Failure to provide notification of the cancellation of 2 or more appointments may result in discharge from the rehabilitation service. I understand that appointment times are held for 10 minutes only, and if I am late my appointment may be re−scheduled for a different day.

I acknowledge that this form has been fully explained to me and that I have read and understand its contents (including the information as detailed on the back side of this form). I also acknowledge receipt of a copy of this form. I certify that as the patient, his/her representative or legal guardian, I accept the terms of this document. I further acknowledge receipt of EvergreenHealth Monroe's *Notice of Privacy Practice*, and that EHM may acknowledge my presence, location, and condition to callers and/or visitors, as noted below.

SIGNATURE (Patient or person authorized to give authorization)	PRINT NAME	DATE & TIME	WITNESS INITIALS

IF SIGNED BY PERSON OTHER THAN PATIENT, SPECIFY SURROGATE'S RELATIONSHIP TO PATIENT:

❑ GUARDIAN ❑ HEALTH CARE POWER OF ATTORNEY ❑ PARENT

❑ HUSBAND / WIFE ❑ ADULT CHILD ❑ ADULT BROTHER / SISTER

INTERPRETER PROVIDED: ❑ YES ❑ NO

GENERAL CONSENT TO REHABILITATION SERVICES TREATMENT

Patient Complaints: Patients may file a complaint regarding any concerns about care or services received at the hospital by contacting any staff member or by contacting the Patient Advocate at 360−794−1403. At any time, a patient may also file a complaint by contacting the Washington State Department of Health at 1−800−633−6828, HSQAComplaintIntake@doh.wa.gov, or the DNV at 1−866−523−6842, hospitalcomplaint@dnv.com. The filing of a complaint will not compromise a patient's care or future access to care.

PATIENT INFORMATION RELEASE AUTHORIZATION

I understand that my health care information is protected and I have received a copy of the Notice of Privacy Practices.

The name(s) listed below is / are family members or friends to whom I wish to grant access to my health care information. I will rely on the professional judgement of my provider and his / her designee to share such information, as they deem necessary.

I understand that information is limited to verbal discussions, and that no paper copies of my protected health care information will be provided without my signature on a Release of Information form.

I understand that some information is considered "sensitive." I understand that I must check the specific box(es) in order for my provider or his/her designee to release any "sensitive" information:

- ❑ Mental health / psychiatric disorders (including depression)
- ❑ Chemical dependency (drug and / or alcohol abuse / treatment)
- ❑ HIV / AIDS virus
- ❑ Sexually transmitted diseases

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time.

List in order:

NAME	RELATIONSHIP
1.	
2.	
3.	
4.	
5.	

❑ All family members are granted access.