

#### REHABILITATION THERAPY PATIENT AGREEMENT

Welcome to Liberty Hospital Rehabilitation Therapy. We are pleased that you have selected us as your provider of therapy. In order to best serve you, we ask that you take a moment to review and sign the following agreement. It explains our attendance and appointment cancellation policies. If you have any questions, we will be glad to answer them.

# **PUNCTUALITY**

It is important that you arrive on time for your scheduled therapy session. Your treatment times have been planned out so as to offer you optimal quality time with your therapist. Should you find that you are running late for an appointment, your appointment will end at the scheduled time so the treatment of other patients will not be negatively effected. If you are more than 15 minutes late for your appointment, we may cancel that day's treatment and reschedule you for another date and/or time.

# **APPOINTMENT CANCELLATION POLICY**

In an effort to keep our patients and staff as safe as possible, we encourage you to re-schedule your appointment if you have any signs or symptoms of illness.

We ask that you provide us at least 24 hours' notice for appointment cancellation or rescheduling of appointments. If you should have any combination of three appointment cancellations with inadequate notice and/or "no shows" for scheduled appointments, we reserve the right to cancel any remaining appointments, notify your physician and discharge you as a patient.

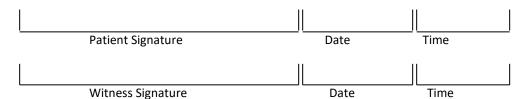
You may reach us by voicemail at your convenience during non-working hours, weekends and holidays.

#### PERSONAL BELONGINGS

Lockers may be available for you to store personal belongings. Please keep key to locker in your possession at all times. Liberty Hospital will not be responsible for items that are lost or stolen.

# **CHILDREN**

If children must accompany you to therapy, please make sure that they remain with you for the duration of therapy. Children are not allowed unsupervised in our gym area. Please note that the presence of children may impact the focus of care for you and for other therapy clients.





Have you ever had

or been treated for:						
Frequent headaches	☐ Yes					
Neck injury/ Whiplash Other:	□ Yes	Do you have an Advance Directive (e.g. living will, durable power of attorney, or any other written instructions regarding your health care treatment decisions?   Yes  No  If <i>Yes</i> , is it current?				
Recurrent neck pain	□ Yes					
Pain radiating into: O arms, O hands, O buttocks, O legs	□ Yes	☐ Yes. Where? ☐ In your possession ☐ On file with Liberty Hospital ☐ Other:				
Numbness/tingling in: O arms O hands, O buttocks, O legs	□ Yes	□ No. Would you like for Liberty Hospital's Social Services Department to perform a consultation over the telephone? □ Yes □ No				
Neuropathy	□ Yes	Collst	intation over ti	ie telephone: $\Box$	1 cs LIN	0
Diabetes: Type 1 or Type 2	□Yes	Describe the problem for which you seek therapy:				
Lung problems, including- (please circle) Asthma / Tuberculosis / Shortness of breath/ Emphysema/ COPD/ PE	□Yes	When did these problems begin?				
Double Vision / visual problems	☐ Yes	Have you had this problem before?				
Epilepsy / seizures	☐ Yes					
Stroke or Brain Injury	☐ Yes	If yes, what did you do for the problem(s)?				
Dizziness / Vertigo/ Black outs	□ Yes					
Chest pains	□Yes	Did the problem(s) get better? ☐ Yes ☐ No; How long did the problems last?				
Heart Conditions: (please circle) Pacemaker/ Coronary Artery Disease/ Coronary Artery Bypass/ Heart Attack/ Stents	□ Yes	How are you taking care of the problem(s) now?				
High blood pressure		Do you exercise beyond normal daily activities and chores? ☐ Yes ☐ No, if yes:				
	□ Yes	Describe the exercise:				
Anemia / leukemia Cancer or Tumors	□ Yes	-				
☐ Type:	☐ Yes	On average, how many days per week do you exercise or do physical activity?				
Back problems: Please list  ☐ Bulging / herniated discs	□ Yes		•	on an average da		
□ spinal cord stimulator		Do you use (	(a): $\square$ Cane	☐ Walker	☐ Manual wh	eelchair
Carpal tunnel syndrome	□ Yes	-	☐ Glasses, h	nearing aids	Other:	
Arthritis:		With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and other(s)				
□OA □RA	□ Yes	☐ Chile	d □ Persona	l care attendant	☐ Other relativ	ve(s) (not spouse or children)
Recurrent joint pains: (please					_ = = = = = = = = = = = = = = = = = = =	c(e) (nee speeds of children)
circle) hand wrist elbow Shoulder hip knee ankle feet	☐ Yes	☐ Group	Ü	Other:		
*		Where do	you live?	☐ Private hom	ne	partment
Fracture of: (please circle)  hand wrist elbow	□ Yes	☐ Assiste	d living / grou	p care	term care facili	ty/nursing home  Other:
Shoulder hip knee ankle feet  □ other:		Does your	r home have:	☐ Stair with n	o railing 🛮 Sta	irs with a railing 🛛 Ramps 🗖 Elevator
MS	□ Yes	Please che	ck if applicable	le: 🛘 I am curr	ently pregnant.	
Parkinson's Disease	☐ Yes	☐ I have 1	recently receiv	ed home health se	ervices provide	d by
Abdominal pain	□ Yes	1	J		1	·
Hepatitis / liver/ kidney disease	□ Yes	Dysarthria	□ Yes	Frequent falls	☐ Yes	
Tendonitis / bursitis	□ Yes	Dysphagia	□ Yes	MRSA	□ Yes	
Psychiatric Disorders:		) / (		D1 11 /D 1		
☐ Bi-polar ☐ Depression	☐ Yes	Memory Problems	☐ Yes	Bladder/Bowel control	□ Yes	
□Other						
Osteoporosis	☐ Yes	Voice problems	☐ Yes	DVT(blood clot)	□ Yes	
Alzheimer's/ Dementia	☐ Yes	Tuberculosis	☐ Yes	Other	☐ Yes	



Please li	ist the	following:	☐See list

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Previous surgeries and the date	Current <b>prescribed</b> and prescribed medication	e e e e e e e e e e e e e e e e e e e
If currently off work due to injury  Education: Please check the highest le  □Elementary □High School □So	evel of education completed.  ome college/ tech school	any packs per day?
	eeing, or have you recently seen a	-
☐ Acupuncturist		
☐ Home health	☐ Massage Therapist	□ Neurologist
☐ Orthopedist	☐ Osteopath	□ Podiatrist
Patient Signature		Time Reviewed/Updated Date/Time
Therapist Signature	Date	Time
Therapist Signature	Date	Time