

# **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.

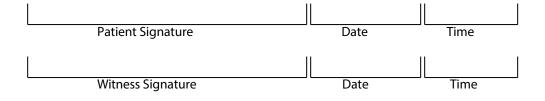
You may reach us by voicemail at your convenience during non-working hours, weekends and holidays.

### 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	$\Box$ Yes. Where? $\Box$ In your possession $\Box$ On file with Liberty Hospital $\Box$ Other:					
Numbness/tingling in: O arms O hands, O buttocks, O legs	□ Yes	<ul> <li>□ No. Would you like for Liberty Hospital's Social Services Department to perform a consultation over the telephone? □ Yes □ No</li> </ul>					
Neuropathy	□ Yes						
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? $\Box$ Yes $\Box$ No, if yes:					
Anemia / leukemia	□ Yes □ Yes	Describe the exercise:					
Cancer or Tumors		On average, how many days per week do you exercise or do physical activity?					
Back problems: Please list Bulging / herniated discs spinal cord stimulator	□ Yes	For how many minutes, on an average day?      Do you use (a):    Cane      □ Glasses, hearing aids    □ Other:					
Carpal tunnel syndrome	□ Yes		-	e			
Arthritis: DOA DRA	□ Yes	With whom do you live? $\Box$ Alone $\Box$ Spouse only $\Box$ Spouse and other(s)					
Recurrent joint pains: (please circle) <i>hand wrist elbow</i> Shoulder hip knee ankle feet	□ Yes	<ul> <li>□ Child □ Personal care attendant □ Other relative(s) (not spouse or children)</li> <li>□ Group setting □ Other:</li></ul>					
Fracture of: (please circle) hand wrist elbow Shoulder hip knee ankle feet □ other:	□ Yes	☐ Assisted Does your	d living / grou home have:	□ Stair with no	o railing 🗖 St	ity/nursing home □ Other: airs with a railing □ Ramps □ Eleva	
MS	□ Yes	Please che	ck if applicab	le: 🛛 I am curre	ently pregnant		
Parkinson's Disease	□ Yes	□ I have recently received home health services provided by					
Abdominal pain	□ Yes	ļ				_	
Hepatitis / liver/ kidney disease	□ Yes	Dysarthria	□ Yes	Frequent falls	□ Yes		
Tendonitis / bursitis Psychiatric Disorders: Bi-polar Depression Other	□ Yes	Dysphagia Memory Problems	□ Yes	MRSA Bladder/Bowel control	□ Yes		
Other		Voice problems	□ Yes	DVT(blood clot)	□ Yes	-	
Osteoporosis	□ Yes	Voice probleme			I YAC		



Please list the following:	□See list							
Previous surgeries and the date	Current <b>prescribed</b> and <b>non-</b> <b>prescribed</b> medication	Allergies Are you allergic to latex/rubber?						
Employment/Work       Occupation:         Working full time       Working part time       Homemaker       Retired       Student       Unemployed         If currently off work due to injury, what is your anticipated date of return?								
Education: Please check the highest level of education completed. □Elementary □High School □Some college/ tech school □College □Graduate School/Advanced degree								
Social Habits: Do you currently smoke?  Yes Ves Ves No If yes: How many packs per day?								
In the past year, have you had any of the following? Please circle all that apply. Bone scan CT scan MRI X-ray EEG, EKG, EMG Myelogram Stress Test Were any of these tests performed at Liberty Hospital? □ Yes □ No								
Are you currently seeing, or have you recently seen anyone else for this problem?								
□ Acupuncturist	_	□ Chiropractor						
□ Home health	□ Massage Therapist	□ Neurologist						
□ Orthopedist	□ Osteopath	Podiatrist						
Patient Signature	Date T	Time Reviewed/Updated Date/Time						
Therapist Signature	Date 7	lime						
Therapist Signature	Date 1	Time						