

Authorization to pay THE ROSE CENTER

I hereby authorize my insurance benefits to be paid directly to THE ROSE CENTER. I understand that I am financially responsible for co-pays, deductibles, and non-covered services. I also understand that if I am receiving home health services of any kind, that outpatient physical therapy will not be covered by Medicare and I will be responsible for my entire bill.

I authorize THE ROSE CENTER to release any information needed to process this claim.

*When out-patient physical therapy will be denied by Medicare and most insurance companies:

- Physical Therapy at two clinics on the same day
- Home health services currently in progress - nursing, PT, speech, OT, bathing assistance

Please only sign on one line

Sign: _____	Date: _____
Sign: _____	Date: _____
Sign: _____	Date: _____
Sign: _____	Date: _____

Authorization for Treatment

and to be called at your home regarding my appointments.

I authorize THE ROSE CENTER and it's licensed/certified staff to provide treatment as per my plan of care.

Please only sign on one line

Sign: _____	Date: _____
Sign: _____	Date: _____
Sign: _____	Date: _____
Sign: _____	Date: _____

Authorization for Release of Medical Information

Name: _____ Date of Birth: _____

To disclose information

I hereby authorize **THE ROSE CENTER FOR REHABILITATION, HOPE AND WELLNESS** at 3278 Bechelli lane, Redding, CA, 96002 to disclose information from my records and appointment information to :

Spouse: _____ Family Member: _____

Caregiver: _____ Transportation: _____

Vendor: _____ Other: _____

This information is needed for the following reason:

- Evaluation and progress notes Prescription for PT or assistive devices
 Other _____

Release of records from another company (please check any that apply)

I here by authorize:

- MDImaging Open Imaging
 Advanced Imaging Mercy Medical Center
 Shasta Regional Medical Center Other Dr _____

To release my records of:

- X-Rays C-Tscans
 MRI Reports

to **THE ROSE CENTER FOR REHABILITATION, HOPE AND WELLNESS**

3278 Bechelli lane, Redding, CA, 96002 to disclose information from my records

Consent Signature

I understand I may revoke this consent at any time, except where information has already been released

Signature

Date

Witness

Date

Patient Information Consent Form

I have read and fully understand The Rose Center for Rehabilitation, Hope and Wellness' NOTICE OF INFORMATION PRACITCES. I understand The Rose Center may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that The Rose Center will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in The Rose Center's NOTICE OF INFORMATION PRACTICES. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature

Date

The Rose Center for Rehabilitation, Hope, & Wellness

APPOINTMENT POLICY

We would like to inform you of our policy for missed appointments. Due to the no show/no call missed appointments and cancellations; we are changing our guidelines for appointments.

- 1) Please allow for one hour for your appointment.
- 2) If you need to cancel or reschedule your appointment, please give a 24 hour notice.
- 3) If you do miss your appointment and you did not call, we will be charging you \$35.00 for that hour that you missed.

By signing this appointment policy, you are saying that you have fully read and understand the above information. Thank you for your cooperation.

Signature

Date



The Rose Center

for
Rehabilitation, Hope & Wellness

Patient Name: _____ Acct #: _____

Date of birth: _____

PAST MEDICAL HISTORY

Today's Date: _____ Referring Physician: _____

1. Please check if you have ever had:

- | | | |
|---|--|--|
| <input type="checkbox"/> Arthritis/gout | <input type="checkbox"/> Low blood sugar | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Broken bone/fracture | <input type="checkbox"/> Head injury | <input type="checkbox"/> Repeated infections |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Metal implant | <input type="checkbox"/> Neurological (Stroke, Parkinson, etc) |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Developmental or growth problems |
| <input type="checkbox"/> Seizure/ Epilepsy | <input type="checkbox"/> Skin diseases | <input type="checkbox"/> Circulation/vascular problems |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Diabetes/high blood pressure |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Ulcer/stomach problems |
| <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Infectious disease | |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Surgical Intervention on Neck or Back | |

Please explain any box checked above: _____

2. Within the past 6 months, have you had any of the following symptoms? (Check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Difficulty walking | <input type="checkbox"/> Fever/chills/sweats |
| <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Joint pain/swelling | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Pain at night | <input type="checkbox"/> Hearing problems |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Vision problems |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dizziness or blackouts | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Coordination problems | <input type="checkbox"/> Bowel problems | <input type="checkbox"/> Unexplained weight loss |
| <input type="checkbox"/> Weakness in arms or legs | <input type="checkbox"/> Sudden weight loss | |
| <input type="checkbox"/> Loss of balance/falls | <input type="checkbox"/> Urinary problems | |

3. Have you ever had surgery? **Yes No** If yes, please describe and include dates: _____

4. Please provide a list of your medications or any dietary supplements (ie calcium). _____

5. List any allergies, including medications. _____

6. Have you had any testing, x-rays, MRI, blood work, etc.?

Circle one: **YES NO**

7. Have you had any illness within the last three weeks? (cold, flu, fever, etc.) _____

8. Do you have any sores that have not healed or any change in size, shape, or color of a wart or mole? _____

9. Do you have discomfort, shortness of breath, or pain with exercise? _____

10. Do you smoke? _____ If yes, how much? _____

11. Do you exercise regularly? _____ What type and how often? _____

12. What is your occupation? Or retired from? _____

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