

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 PRACTICES. 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 and Wellness
Seating and Mobility Patient Questionnaire

Dear Client,

Please answer the following questions to the best of your ability. This will help us process your equipment request accurately and efficiently. If you are unsure of any questions, please leave blank and the PT can assist you during your appointment. Thank you.

I. Medical history

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: _____

II. Why did your physician refer you for a seating and/or mobility evaluation? (YES/NO)

Falls? _____ How many in last 6 months? _____ Why do you think you fall? _____

Pain? _____ Where? 1) _____ 2) _____ 3) _____ How severe, scale of 1-10 _____

Are you able to walk at home? _____ Do you use a walker? _____ Cane? _____ Manual push chair? _____

Skin breakdown? Date wound started _____ Specific location of wound _____

Do you have a physician that manages your wound? Who? _____ Why do you think this wound started? _____

Please provide previous wound history _____

What is your height? _____ What is your weight? _____

Is the doctor that referred you here your primary doctor? _____ If not, name of primary MD: _____

Other physicians involved in your care _____

What is your medical diagnosis? _____

III. What type of equipment do you feel you need to be evaluated for? (Check all that apply)

Standard wheelchair _____ Lightweight _____ Titanium _____ Aluminum _____ Rigid _____ Folding _____

Power wheelchair _____ Invacare _____ Permobil _____ Quickie _____ Pride _____

Scooter _____

New seating components: Cushion _____ Back support _____

Standing Frame _____

Transfer device: Hoyer lift _____ Ceiling track lift _____ Other _____

3278 Bechelli Lane, Redding CA. PHONE: 530 223-9474; FAX : 223 6937



**The Rose Center for Rehabilitation, Hope and Wellness
Seating and Mobility Patient Questionnaire**

Pressure mapping _____

IV. Vendor questions

What company issued your current equipment? _____

What vendor would you like to use for **THIS** equipment order? (Please Check)

Northern Rehab and Respiratory _____ New West Medical _____ Western Rehab _____ Everything Medical _____

Other: _____

Do we have your permission to forward your information to this vendor? Yes _____

The vendor will be contacting you in regards to our equipment request, is this agreeable to you? Yes _____

Please list **date of issue** (approx) of last: manual wheelchair _____ Power Chair _____ Cushion _____

Other _____

Is there a specific product you are interested in seeing? _____

Have you already tried a specific product with your vendor? _____

V. Previous Equipment Likes/ Dislikes (skip this section if this is your first wheelchair)

What type of chair base do you have now? _____ When issued? _____

Likes? _____ Problems/Dislikes? _____

What type of cushion do you have now? _____ When issued? _____

Likes? _____ Problems/Dislikes? _____

What type of back support do you have now? _____ When issued? _____

Likes? _____ Problems/Dislikes? _____

VI. Functional Status (proceed to next section if fully dependent for care)

Are you able to walk in your house? _____ Are you able to drive? _____ Can you walk in a store? _____

How do you transfer? Stand step _____ Bent pivot _____ Slide board _____ Hoyer _____ Sit to stand _____ Does a caregiver lift you? _____ Who? _____ Other _____

Do you shower independently? _____ With assistance/ describe _____

Do you get dressed independently? _____ With assistance/describe _____

Do you cook for yourself? _____ with assistance/ describe _____

Do you drive? _____ Vehicle modifications/ describe _____

Do you work? _____ Are you currently seeking employment? _____

IV. Pressure relief (check all that apply)

How do you currently relieve pressure?

Forward or lateral weight shifts _____ How often? _____

Depression lift _____ How often? _____ Standing _____ How often? _____

Manual tilt _____ How often? _____ How Far? _____

Power Tilt in space _____ how often? _____ To what angle? _____



The Rose Center for Rehabilitation, Hope and Wellness
Seating and Mobility Patient Questionnaire

Power recline ___ how often? ___ How far? ___
 Do you feel excessive: moisture/ wetness is a problem for you? ___ Friction? ___
 Trauma from bumping hitting objects during transfers? ___

VII. Funding sources (Check all that apply)

Do you have Medicare? ___ Number _____

Do you have Medi- Cal? ___ Date of issue _____ Number _____
 Case manager name? _____

Private Insurance? ___ Name/ Number _____

Are you a Far Northern Regional Center Client? ___ Case manager _____

Department of Rehab? ___ Case manager _____

ALS/ MS society contribution candidate? ___ Contact name _____

Redding Rancheria? ___ Contact name _____

Other/ Charity _____

If needed, are you or other family members able to pay for denied items or special features? _____

Are there special features you would you like to see or have installed on this new equipment?

How did you hear about The Rose Center Seating and Mobility department?

Physician ___ Vendor ___ Friend ___ Walk- In ___ Other _____

Additional comments you feel are relevant to this evaluation:

