PATIENT INFORMATION AND CONSENT

Last Name:_____ **First Name:**_____ **Middle Initial:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Cell Phone:** _____ **Male** ☐ **Female** ☐

Date of Birth:_____ **Age:**_____ **Marital Status: S M D W (circle one)**

Social Security Number:_____ **Occupation:** _____

Left Handed ☐ **Right Handed** ☐ **Height:**_____ **Weight:** _____

EMERGENCY CONTACT INFORMATION:

Name:_____ **Phone:**_____ **Relationship:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

EMPLOYER: Job Related Injury? Yes ☐ **No** ☐

Company:_____ **Contact Person:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone:_____**Ext.**_____ **Fax:**_____

INSURANCE INFORMATION:

Payer:_____ **Claim #:** _____

Case Manager:_____

Payer Address:_____ **City:**_____ **State:**_____ **Zip:**_____

The Physical, Occupational and Speech Therapy Program has been prescribed by your physician. Your signature gives us permission to implement this treatment. I authorize the staff at Regional Therapy Services to discuss protected health information with caregivers involved in treatment of the above listed patient. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act, other applicable federal and state acts, or other insurance policies is correct. I authorize to release to any insurance company or their agent, any information needed for this or related claim. I request payment of authorized benefits be made on my behalf directly to Regional Therapy Services, Inc. for any past or future services rendered to me. We will verify insurance coverage upon evaluation; however, this is not a guarantee of payment. You are responsible for reviewing your insurance plan and knowing your coverage limitations for therapy services. I understand that I will be responsible for payment of services rendered.

_____

Signature **Date**

_____

Relationship (if signer is not patient)

This provider of Medical Services is an equal opportunity employer and does not discriminate in its professional or employment practices of the basis of race, creed, color, sex, national origin, age, or handicap.

INJURY INFORMATION:

Your job title at time of injury:_____

Full Time ☐ **Part Time** ☐

Are you currently working?

No ☐ **(If no, last date worked:**_____**)** **Yes** ☐ **Full Duty** ☐ **Light Duty** ☐ **Hours:**_____

Date of Injury:_____ **Date(s) of Surgery:**_____

What was your injury (part of body)?:_____

Please list your prescribed medications:

Medication	Dosage	How Often Taken

Do you have any of the following?

Diabetes ☐ **Heart Problems** ☐ **High Blood Pressure** ☐ **Circulatory/Vascular Disease** ☐

Please list any restrictions from your doctor or other medical information you wish to share:

_____

_____

_____

_____

FCE Informed Consent

Your treating physician has referred you for a Functional Capacity Evaluation or Work Capacity Evaluation. This is a voluntary test designed to measure your ability to work. It takes 3-5 hours and we need your permission to perform it. The testing consists of questionnaires, an interview, and numerous tests to measure your strength, flexibility, and ability to perform various work-related tasks such as sitting, standing, walking, stair-climbing, balancing, lifting, carrying, pushing, and pulling. You may also be asked to perform a simulation of your job. Each test will be explained to you before testing.

Do your best on *every* trial during testing in order for the results to indicate your true ability on that task. You may be asked to perform tasks that you are not used to, and your pain may increase at times during the evaluation. Because pain is so subjective and is different for every person, you will have to decide to continue or stop any particular test. We do not expect to perform activities that increase your pain to a level that you feel is unsafe for you. We will stop you if we see you doing anything that we think is unsafe for you.

This testing becomes a part of your legal medical record. Your full effort is important in order to establish your true physical capacity and what affect your injury has on your ability to work. The tests are designed to tell us if you are giving full effort within you pain tolerance, and there are indicators to determine if you are exaggerating your pain. This information will be included in the written report sent to your doctor and employer/insurance carrier (if you are here because of a work-related injury). Give your best effort at all times and do not exaggerate your pain.

We may include your picture with the report and document some of the testing with photos or videotaping for added clarity.

I understand all of the above and agree to participate in this Functional Capacity Evaluation/Work Capacity Evaluation to the best of my ability.

_____

Signature Date

_____

Witness Date

Authorization for Release of Medical Information

This form is kept on file until the patient requests to release their medical information to a specified person/company.

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Information Released From: _____

Information Released To: _____

Relationship to Patient: _____

List any tests performed in the last year (MRI, X-Ray, etc.): _____

_____

_____

Purpose for Release: _____

_____

Signature of Patient or Representative of Patient Date

_____

Signature of Agency Date