Neuro Rehab Partners

neurorehabpartners.com

6133 Bristol Parkway Suite 200
Culver City, CA 90230
Phone: 310.337.7600
Fax: 310.337.7607

6345 Balboa Boulevard Suite 120
Encino, CA 91316
Phone: 818.881.7600
Fax: 818.881.7608

Patient Information

Name: _____ Date of Birth: _____ Age: _____

Address: _____ City: _____

State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Referred By: _____ Primary Care Physician: _____ Phone #: _____

Emergency Contact not living with you:

Name: _____ Relationship: _____ Phone #: _____

Insurance Information

Do you have LEGAL REPRESENTATION associated with your injury? ☐ **YES** / ☐ **NO**

Are you currently receiving ANY type of HOME HEALTH CARE? ☐ **YES** / ☐ **NO**

Primary Ins. Co: _____ ID #: _____

**If you are not the primary insurance holder, please provide the following:*

Insured's Name: _____ *DOB:* _____ *Relationship:* _____

Secondary Ins. Co: _____ ID #: _____

**If you are not the primary insurance holder, please provide the following:*

Insured's Name: _____ *DOB:* _____ *Relationship:* _____

Patient Authorization ***Please Read Carefully***

CARE AND CONSENT

I do hereby agree and give my consent to NEURO REHAB PARTNERS LLC and all its healthcare professionals to provide my care and treatment as prescribed by my physician **INITIALS:** _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical benefits to which I am entitled, including Medicare, Private Insurance, and Third party payers to NEURO REHAB PARTNERS LLC. I hereby authorize said assignee to release all information including medical records necessary to secure payment. **INITIALS:** _____

FINANCIAL POLICY STATEMENT

NEURO REHAB PARTNERS LLC bills your insurance solely as a courtesy to you. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full by you. In the event your insurance carrier requests a refund of payments made, you will be responsible for monies owed. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to NRP. I understand and agree that if I fail to make payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed. **INITIALS:** _____

HOME HEALTH CARE

Please be advised that any services needing the use of a home health agency will result in the loss of your Medicare Outpatient benefits. In the event that you do not notify us at the start of a Home Health Episode you will be solely responsible for any treatments rendered by NEURO REHAB PARTNERS LLC. **INITIALS:** _____

If you agree to all above statements, please sign below.

Signature: _____ **Date:** _____

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Patient Name:_____ **DOB:**_____ **Age:**_____

To the best of your knowledge, do you now or have your ever had any of the following?

High Blood Pressure	Yes ☐	No ☐	Cancer	Yes ☐	No ☐
Congestive Heart Failure	Yes ☐	No ☐	Arthritis	Yes ☐	No ☐
Angina/Heart Attack *(circle)*	Yes ☐	No ☐	Osteoporosis	Yes ☐	No ☐
Heart Disorder/Pacemaker *(circle)*	Yes ☐	No ☐	Joint Replacement	Yes ☐	No ☐
Shortness of Breath	Yes ☐	No ☐	Fractures	Yes ☐	No ☐
Allergies/Asthma/COPD *(circle)*	Yes ☐	No ☐	Unusual Weight Gain/Loss *(circle)*	Yes ☐	No ☐
Diabetes	Yes ☐	No ☐	Bowel/Bladder Incontinence *(circle)*	Yes ☐	No ☐
Kidney Failure/Dialysis	Yes ☐	No ☐	Abnormal Vision	Yes ☐	No ☐
Stroke	Yes ☐	No ☐	Impaired Hearing	Yes ☐	No ☐
Seizures	Yes ☐	No ☐	Impaired Cognitive Status: *(circle)* Confusion, Dementia, Decreased Memory	Yes ☐	No ☐
Falls in the past 12 months? # of falls: ___ Injury:_____	Yes ☐	No ☐	Psychological Issues*: (circle)* Depression, Anxiety, Decreased Insight, Decreased Judgment	Yes ☐	No ☐
Falls in past 3 months? ____	Yes ☐	No ☐	Impaired mobility	Yes ☐	No ☐
Do you have pain that affects your function? **Rate the pain**: ____ **out of 10** *(0 = none, 10 = worst possible)*	Yes ☐	No ☐	Environmental Hazards: *(circle)* Uneven floor surfaces, pets, clutter, throw rugs, etc.	Yes ☐	No ☐

Main complaint/Diagnosis:_____

Pertinent history for this therapy visit: _____

Other past medical history. Please list any diagnoses, surgeries/hospitalizations/injuries and provide procedures and dates when possible:_____

Please list recent diagnostic studies (i.e. CAT scan, MRI, X-Rays):_____

Have you had any therapy in the past? Yes ☐ No ☐ If yes, please indicate where, when, and for what problem:_____

What are your goals for therapy?_____

FOR OFFICE USE ONLY: HEIGHT: WEIGHT: BMI CALCULATION: