LAKESIDE
COMPREHENSIVE REHABILITATION
& FAMILY FITNESS

To the patients and families of Lakeside Comprehensive Rehabilitation Inc.,

Thank you for choosing our rehab staff to provide your therapy services.

It is our goal to provide you a customized therapy program in collaboration with your referring physician.

During your initial visit:

- You will be evaluated.
- You will gain a care plan with goals.
- You will have a follow-up appointment scheduled with a therapist that you will continue to see throughout the duration of your care.

The clinic will communicate in writing with your referring physician to provide results of your evaluation and the care plan.

Please remember:

- Your appointment time is reserved for you; plan to arrive a few minutes prior to your scheduled time.
- If you cannot make the scheduled appointment time, please call 24 hours in advance.
- The frequency of your visits and length of treatment is guided by your condition, physician and insurance benefits.
- You will receive a Home Exercise Program from your therapist.
- You will receive a Free 30 day membership to Lakeside Family Fitness & Wellness Center upon successful discharge from your therapy program.
- Your feedback is important to the therapists. Please communicate your questions, level of pain and concerns.

If you would like to speak to me, please ask a staff member to contact me or your may call me at (231) 873-3577. Thank you!

Sincerely,

Erica Fenton
Director of Operations
Lakeside Comprehensive Rehabilitation, Inc.

FACILITY POLICY

A. **PATIENTS ARE TO BE AWARE OF THEIR INSURANCE COVERAGE PRIOR TO RECEIVING SEVICES. (IF YOU NEED ASSISTANCE WITH THIS PLEASE INFORM THE FRONT OFFICE)**

B. COPY(S) OF INSURANCE COVERAGE AND I.D. ARE REQUIRED UPON ADMISSION.

C. **COPAYS OR COINSURANCES ARE TO BE PAID PRIOR EACH TREATMENT SESSION**

D. LCR ACCEPTS CHECKS WITH PROPER I.D. A $25 FEE WILL BE APPLIED FOR RETURNED CHECKS

E. ALL BALANCES ARE DUE WITHIN 30 DAYS UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN MADE WITH THE BILLING DEPARTMENT.

F. **STREET SHOES** ARE NOT PERMITTED IN THE GYM AND POOL AREAS. SHOES SHOULD BE CLEAN AND DRY.

G. **FOOD AND DRINK** ARE NOT PERMITTED IN THE GYM AND POOL AREAS.

H. **PATIENTS HAVE TO SIGN ALL LCR ADMISSION FORMS PRIOR TO THEIR FIRST TREATMENT.**

I. PATIENTS ARE TO CALL 24 HOURS IN ADVANCE WHEN CANCELING AN APPOINTMENT TO AVOID A $25 CHARGE FOR RETURN VISITS OR $50 FOR INITIAL EVALUATIONS.

J. ALL PATIENTS UNDER THE AGE OF 18 HAVE TO BE ACCOMPANIED BY A PARENT/GUARDIAN UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE.

K. We are committed to professionalism and expect the same from our clients. We will not tolerate **any** inappropriate acts.

By signing below I understand that the nature of therapy services is for the purpose of health improvement and rehabilitation. I have stated all known medical conditions and will inform and update my therapist of any changes to my medical health as necessary. I understand that my session will be terminated due to any form of inappropriate behavior. I have read the above terms and agree to comply with the LCR facility policies.

PATIENT SIGNATURE_____DATE_____

PARENT/GUARDIAN
SIGNATURE_____RELATIONSHIP_____

Patient Information:

Name:_____ **DOB**_____ **SSN**_____

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

Sex:_____ **Age:**_____ **Marital Status:**_____ **Referring Physician**_____

Phone_____ **Email**_____

Emergency Contact: _____ **Emergency Contact Phone#**_____

Employment Information:

Employed: F/T_____ **P/T**____ **On Leave** ____ **Retired**____ **Disabled**_____ **Not Employed**____

Employer's Name:_____ **Phone #**_____

Employer's Address:_____

Insurance Coverage Information:

Is this a **Workmen's Compensation** Claim? **Yes**_____ **No**_____
Is this an **Automobile Insurance/Accident** Claim? **Yes**_____ **No**_____

If <u>yes</u> was answered to either question above please fill in the information below:

Date of Injury:__/___/___ State Accident Occurred In:_____ Claim #_____

Insurance Company Name:_____

Address:_____

Case Manager/Adjusters Name:_____ Phone#_____

Primary Insurance:_____ **Contract/ID#**_____

Subscriber's Name:_____ Date of Birth____/____/____

Secondary Insurance:_____ **Contract/ID#**_____

Subscriber's Name:_____ Date of Birth____/____/____

*****(Please make sure the front office has copies of your Insurance Cards.)*****

Do you have a **Health Savings Account (HSA)?** Yes____ No____ Unsure____

Do you have a **Flexible Spending Account (FSA)?** Yes ____ No____ Unsure____

CHIEF COMPLAINT-What is the main reason for your visit today?: _____

Have you received services from Lakeside Comprehensive Rehab before? Yes____ No____

Have you received Physical, Occupational, Speech or Medical Massage Therapy elsewhere this calendar year?_____

If yes, when and where:_____

Have you received Chiropractic Services? Yes____ No_____ If yes, When?_____

How did you hear about us? ____Physician ____Friend/Family ____Radio ___TV ____Newspaper ___Billboard

History of Present Illness:

Where is the problem?_____

Does anything make the problem better/worse? Yes_____ No_____

If yes, Explain:_____

When did you first notice it?_____

How long does it last?_____Does it interfere with your normal function? Yes_____ No_____

If yes, Explain:_____

On a scale from 1-10 (10 being the most severe) what would you rate the severity of your pain?:_____

Health History:

What Medicines are you allergic to? _____

List your Medications; dose and frequency:_____

_____

List any previous Surgeries:_____

List any serious medical problems (high blood pressure, diabetes, heart attacks, strokes, etc.):

_____

Do you have a Pacemaker? Yes____ No____ Are you taking any Blood Thinners? Yes____ No_____

Do you have Metal Implants? Yes____ No____ If so, where?_____

Are you (or are you trying to become) pregnant? Yes____ No____ Do you take birth control pills? Yes____No____

Do you smoke? Yes_____ No_____ Do you drink alcohol? Yes_____ No_____

Do you have a history of:

Cancer:	Yes____ No____	Kidney Failure:	Yes____ No____
Kidney Stones:	Yes____ No____	Heart Disease:	Yes____ No____
Diabetes:	Yes____ No____	Claustrophobia:	Yes____ No____
Hepatitis B:	Yes____ No____	HIV:	Yes____ No____
Tuberculosis:	Yes____ No____	Depression:	Yes____ No____
Headaches	Yes____ No____	Skin Rashes	Yes____ No____

AUTHORIZATION FOR THERAPY TREATMENT, ASSIGNMENT OF BENEFITS, PAYMENT RESPONSIBILTIY AND NOTICE OF PRIVACY PRACTICES

Authorization for Treatment: The undersigned hereby authorizes Lakeside Comprehensive Rehabilitation Inc., and/or their contactors (collectively referred to as "Provider"), to render to the patient Physical Therapy, Occupational Therapy, Massage Therapy or other related services (collectively referred to as Therapy Services) that the provider and/or patient's Physician determine to be necessary or advisable. The undersigned agrees to cooperate with all reasonable requests of the Provider in connection with Provider's rendition of therapy services. All patients under the age of 18 have to be accompanied by a parent/guardian unless other arrangements have been made.

Assignment of Benefits: The undersigned hereby assigns and transfers to Provider the right to any third party payments to which the undersigned may be or become entitled to for therapy services rendered by the provider. The undersigned hereby authorizes the Provider to apply and file for all such benefit payments on behalf of the patient and direct such payments to be made directly to the Provider. Any insurance benefit payments received by the undersigned for services rendered by the Provider shall be paid to Provider.

Payment Responsibility: The undersigned shall be financially responsible for any portion of the Provider's invoice that is not paid, except those charges that are denied due to insurance rules and daily maximums. The undersigned agrees to execute any and all documents and perform any acts that the Provider may reasonably request to ensure all third party benefits for Therapy services are paid to the Provider. Further, the undersigned accepts financial responsibility for professional fees not covered by the patients existing and current health insurance policy. A $25 fee may be charged to the patient if a patient does not show for a scheduled appointment. **As a reminder, the undersigned hereby takes responsibility to know the coverage limits and benefits of their health plan(s) in order to avoid any billing confusion. All co-pays or coinsurances are due at the time of service unless other arrangements have been made.**

Notice of Privacy Practices: The undersigned hereby acknowledges having had an opportunity to review and/or review a copy of the Provider's Notice of Privacy Practices. The undersigned gives consent to call the Patient's home or other designated location and leave a message on an answering machine, voicemail or with a person referencing any items that assist in carrying out their healthcare services. These being appointment reminders, insurance injuries and information related to their clinical care. The Provider may also mail documents to their home or other designated location. These items may be appointment reminders, new admission documents, test results as long as they are marked "confidential". Lastly, the Provider may email my home or other designated location any items that assist in carrying out my healthcare services. The undersigned is in agreement with how the Provider will use or disclose personal health information. The undersigned further has given consent to the above operations of the Providers Privacy Practices.

PRINT NAME _____ SIGNATURE _____

RELATIONSHIP TO PATIENT (IF UNABLE TO SIGN) _____ DATE _____

**********PERSONAL WAIVER**********

PARTICIPANT AGREEMENT, RELEASE, AND ACKNOWLEDGEMENT OF RISK

In consideration of the services of **Lakeside Comprehensive Rehabilitation Inc.**, their agents, owners, officers, volunteers, participants, employees, and all other persons or entities acting in capacity on their behalf (hereinafter collectively referred to a "LCR"), I hereby agree to release and discharge Lakeside Rehab, on behalf of myself, my children, my parents, my heirs, assig personal representative and estate as follows:

1. I acknowledge that LCR entails known and unanticipated risks which could result in physical or emotional injury, paralysis, death or damage to myself, to property, or to third parties. I understand that such risks simply cannot be eliminated without jeopardizing the essential qualities of the activity.
2. I expressly agree and promise to accept and assume all of the risks existing in this activity. My participation in this activity is voluntary and I elect to participate in spite of the risks.
3. I hereby voluntarily release, discharge, and agree to hold harmless from any and all claims, demands, or causes of action, which are in any way connected to my use of LCR's equipment or facilities, including such claims which allege negligent of LCR or others.
4. Should LCR or anyone acting on their behalf be required to incur attorney's fees and costs to enforce this agreement, I agree to indemnify and hold them harmless for all such fees and costs. If I am to file a lawsuit against LCR I will do so in the State of which LCR operates and all laws of that state will be assessed.
5. I certify that I have adequate insurance to cover any injury or damage I may cause or suffer while participating or else I agree to bear the cost of such injury or damage myself. I further certify that I have no medical or physical conditions which could interfere with my safety in this activity, or else I am willing to assume and bear the costs of all risks that may be created, directly or indirectly, by any such condition.
6. I agree that if any portion of this agreement is found to be void or unenforceable, the remaining portion shall remain in full force and affect.

By signing this document, I agree that if anyone is hurt or property is damaged during my participation in this activity, I may be found to have waived my right to maintain a lawsuit against LCR on the basis of any claim from which I have released them herein.
I have had sufficient opportunity to read this entire document. I have read, understood, and agree to be bound by these terms.

Signature of Participant or Parent/Guardian _____

Print Name_____ **Date**_____

PARENT'S OR GUARDIAN'S ADDITION INDEMNIFICATION

In consideration of the Minor(s) being permitted by LCR to participate in its activities and to use its equipment and facilities. I further agree to indemnify and hold harmless from any and all Claims which are brought by, or on behalf of Minor(s), and which are in any way connected with such use or participation by Minor(s) listed below.

Minor(s) Printed Names _____ _____

_____ _____

EMERGANCY INFORMATION

If injured, to which hospital would you like to be transported?_____

If you are found to be in cardiac arrest would you like to be resuscitated? ☐**Yes** ☐**No**

PATIENT PARTICIPATION AGREEMENT

The staff at Lakeside Comprehensive Rehabilitation (LCR) appreciates you giving us the opportunity to work with you to address your rehabilitation needs. Our clinicians promise to devote their energy and skills to maximize your recovery. We share with you, both the goal of achieving an optimal outcome as well as the responsibility of doing what is necessary to obtain that goal.

Lakeside Comprehensive Rehabilitation, Inc. maintains a **ZERO Tolerance** to **"No-Shows"**, i.e. patients who fail to attend their scheduled appointments will be taken off of the department's schedule until you personally speak via telephone with your attending therapist regarding your adherence to an agreed upon schedule. There is a **$25 charge** for each appointment No-Show. Repeat occurrences or not attending your scheduled appointments will result in your discharge from Rehabilitation Services. _____ **(Patient Initials)**

Your active participation i.e. attendance in the rehabilitation process is a vital component of our treatment plan. Working together as a team, clinician and patient, is a requirement to successfully achieve your goals.

Patient (Guardian) Signature _____ Date_____

Printed Name: _____ Date_____

PATIENT MEDICAL EMERGENCY FORM

Name: _____ DOB: _____

Emergency Contact_____

Phone Number: _____ Cell Phone #:_____

Medical Illness's:_____

_____

_____

List of Current Medication:

_____

_____

_____

EMERGENCY TREATMENT:

In the event of an emergency would you like us to perform the following intervention: (Please Check all that apply)

_____ AED- Defibrillator

_____ CPR Resuscitation

_____ First Aid

_____ Transported to a Hospital

Name of Hospital Preferred _____