Complete Physical Rehabilitation

Name:_____

List any medication Allergies:_____ **Are you latex sensitive?** Yes No

Have you declared the Advanced Clinical Directive of Do Not resuscitate? Yes No

Have you EVER been diagnosed as having any of the following conditions?

Yes	NO	Cancer. **IF YES, which type?** _____						
Yes	NO	Diabetes	Yes	NO	Multiple Sclerosis	Yes	NO	Epilepsy
Yes	NO	Heart Problems	Yes	NO	Rheumatoid Arthritis	Yes	NO	Anemia
Yes	NO	High Blood Pressure	Yes	NO	Other arthritic conditions	Yes	NO	Stroke
Yes	NO	Circulation Problems	Yes	NO	Depression	Yes	NO	Kidney Disease
Yes	NO	Asthma	Yes	NO	Hepatitis	Yes	NO	Other
Yes	NO	Emphysema/Bronchitis	Yes	NO	Tuberculosis	Yes	NO	Thyroid Problems
Yes	NO	HIV	Yes	NO	Chemical Dependency	Yes	NO	Osteoporosis

Have you recently been feeling down, depressed or hopeless?	Yes	NO
Recently have you been bothered by having little interest or pleasure in doing things?	Yes	NO
Do you feel unsafe at home or has anyone hit you or tried to injure you in any way?	Yes	NO
FOR WOMEN: Are you currently pregnant or think you might be pregnant?	Yes	NO

Please list any **OVER-THE-COUNTER** & **PRESCRIPTION** medications **taken in the last week**:

_____

Have you recently noted:

YES	NO	Weight loss/gain	YES	NO	Fatigue	YES	NO	Numbness/Tingling
YES	NO	Nausea/vomiting	YES	NO	Fever/chills/sweats			

Patient Signature: _____ Date: _____

Complete Physical Rehabilitation, PC.
Assignment of Benefits

1. I, the undersigned, hereafter referred to as “the patient” do hereby assign all of my right and interests to Complete Physical Rehabilitation, hereafter referred to as “the medical provider” to pursue and obtain payment on my behalf. This assignment shall include but is not limited to, all rights available to me pursuant to the Personal Injury Statues of the State of New Jersey.
2. I, assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me. If it is determined that more than one insurance company is responsible for payment of my medical bills I hereby authorize and give the medical provider power of attorney to sign any documents on my behalf to pursue a claim for personal injury protection benefits. However, upon consent of both parties, same shall be revocable.
3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.
4. I, the patient, authorize my bodily injury attorney (if applicable), to pay directly to the medical provider any monies due on my account, or, have same deducted from any settlement on my behalf.
5. I, the patient, do hereby direct my health insurance carrier and/or other insurance carrier to issue payment on my behalf directly to the medical provider. The check should be made payable to the medical provider. Further, in the event that the health carrier and/or other insurance carrier fails to forward the check to the medical provider, I will endorse and sign the check to the medical provider within (5) days of receipt of same or provide the provider with a personal payment of an amount equal to the insurance carrier check, with refusal to do so resulting in my account being forwarded to a medical bill collections agency.
6. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider’s medical bills unless I am requested to do so by the medical provider. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

Signed: _____ _____Patient Name: _____

Date:_____/ _____ / _____