REQUEST FOR TREATMENT

NAME: _____

ACCOUNT #: _____

MAJOR COMPLAINT: _____

_____

HOW DID THE CONDITION DEVELOP? _____

WHEN WAS THE VERY FIRST TIME YOU WERE AWARE OF THIS PROBLEM? _____

_____

HAVE YOU HAD THIS PROBLEM OR SIMILAR PROBLEM BEFORE? **YES** **NO**

IF YES, EXPLAIN: _____

HAVE YOU EVER RECEIVED TREATMENT FOR THIS? **YES** **NO**

IF YES, WHERE, WHEN AND MONTH: _____

_____

HAS THIS PROBLEM IMPROVED? **YES** **NO** WORSENED? **YES** **NO** STAYED THE SAME? **YES** **NO**

IS THERE ANYTHING THAT MAKES THIS PROBLEM WORSE? **YES** **NO**

IF YES, PLEASE EXPLAIN: _____

_____

HAVE YOU EVER BEEN IN AN AUTO ACCIDENT? PAST YEAR **YES** **NO** PAST 5 YRS. **YES** **NO** OVER 5 YRS. **YES** **NO**

DESCRIBE ANY SURGERIES: _____

ARE YOU PREGNANT? **YES** **NO**

DRUGS CURRENTLY TAKING: **PAIN MEDS** **BLOOD PRESSURE MEDS** **MUSCLE RELAXANTS** **INSULIN** **BIRTH CONTROL** **ANTI-DEPRESSANTS** **OTHERS** (LIST): _____

HAVE YOU EVER SUFFERED FROM: **DIZZINESS** **BACKACHES** **NUMBNESS** **HEART TROUBLE** **TUBERCULOSIS** **SINUS TROUBLE** **NERVOUSNESS** **DIGESTIVE DISORDER** **RHEUMATIC FEVER** **ANEMIA** **CANCER** **ARTHRITIS** **NEURITIS** **ASTHMA** **DIABETES** **OTHER** (LIST): _____

I UNDERSTAND AND AGREE THAT HEALTH, AUTOMOBILE, AND OTHER ACCIDENT INSURANCE POLICIES ARE AN ARRANGEMENT BETWEEN AN INSURANCE CARRIER AND MYSELF. FURTHERMORE I UNDERSTAND THAT **DOUGLAS RAPID REHAB, P.A.** OR ITS WHOLLY OWNED SUBSIDIARIES WILL PREPARE ANY NECESSARY REPORTS AND FORMS TO ASSIST ME IN MAKING COLLECTIONS FROM THE RESPONSIBLE INSURANCE COMPANY AND THAT ANY AMOUNT AUTHORIZED TO BE PAID DIRECTLY TO **DOUGLAS RAPID REHAB, P.A.** AND ITS WHOLLY OWNED SUBSIDIARIES WILL BE CREDITED TO MY ACCOUNT ON RECEIPT. I CLEARLY UNDERSTAND AND AGREE THAT ANY SERVICES RENDERED TO ME ARE CHARGED DIRECTLY TO ME AND THAT I AM PERSONALLY RESPONSIBLE FOR PAYMENT AND THAT IN EXTENDING ANY CREDIT, PAYMENT PLAN, OR DEFERRED PAYMENT. I AUTHORIZE **DOUGLAS RAPID REHAB, P.A.** OR ITS WHOLLY OWED SUBSIDIARIES. I ALSO UNDERSTAND THAT IF I SUSPEND OR TERMINATE ANY TREATMENT, ALL FEES FOE PROFESSIONAL SERVICES RENDERED ME WILL BE IMMEDIATELY DUE AND PAYABLE. I WAS NOT SOLICITED OR PERSUADED BY ANY PERSON TO SEEK SERVICES BY **DOUGLAS RAPID REHAB, P.A.**

DATE: _____

PATIENT SIGNATURE: _____ SOCIAL SECURITY #: _____

CONSENT TO MEDICAL CARE

UNDERSTAND THAT I HAVE A CONDITION THAT REQUIRES MEDICAL TREATMENT.

DOCTOR(S) AT **DOUGLAS RAPID REHAB, P.A.** TO DETERMINE WHAT KIND OF DIAGNOSTIC PROCEDURES (TEST) MUST BE DONE IN ORDER TO LEARN MORE ABOUT MY CONDITION. THESE MAY INCLUDE X-RAYS, BLOOD PRESSURE TESTS, OR OTHER ROUTINE TESTS, I UNDERSTAND THAT IF MY PROVIDER ADVISES A MORE COMPLEX TEST, OR ONE WHICH HAS SPECIAL RISKS, THAT IT WILL PERSONNEL AT **DOUGLAS RAPID REHAB, P.A.** TO ASSIST IN GIVING, OR TO GIVE, THE TESTS WHICH MY PROVIDER WILL.

I ALSO AUTHORIZE MY PROVIDER TO DETERMINE WHAT KIND OF TREATMENT IS TO BE GIVEN AND TO PERFORM SUCH PROCEDURES AS HE/SHE MAY DEEM PROFESSIONAL JUDGEMENT TO PRESERVE MY HEALTH.
ADDITIONALLY, I AUTHORIZE THE PERSONNEL OF **DOUGLAS RAPID REHAB, P.A.** TO ASSIST IN THE GIVING, OR TO GIVE, THE THERAPY WHICH MY PROVIDER WILL ORDER I FULLY UNDERSTAND THAT MEDICAL TESTS OR TREATMENTS MAY INVOLVE. IF PART OF MY TREATMENT IS VERY COMPLEX OR CARRIES SPECIAL RISKS, IT WILL BE EXPLAINED.
I UNDERSTAND THAT THE PRACTICE OF MEDICINE AND SURGERY ARE NOT EXACT SCIENCES, AND ACKNOWLEDGE THAT NO GUARANTEE OR ASSURANCE HAS BEEN THE RESULTS OF TREATMENT OR EXAMINATIONS. I CERTIFY THAT I HAVE READ THIS FORM, AND HAVE HAD IT EXPLAINED TO ME, AND I CERTIFY THAT I FULLY UNDERSTAND ITS CONTENTS. I WAS NOT SOLICITED OR PERSUADED BY ANY PERSONS TO SEEK SERVICES BY INJURY TREATMENT **DOUGLAS RAPID REHAB, P.A.**

DATE: _____

PATIENT SIGNATURE: _____ SOCIAL SECURITY #: _____

PRINT NAME OF WITNESS: _____ FOR PATIENT UNABLE TO SIGN:

PRINT NAME: _____

REPRESENTIVE: _____

DMLR 02_REV 7/8/14 _____