Central Nebraska Rehabilitation Services

Date:

PATIENT INFORMATION

Date of Birth:	Last Name:	First Name:	
Preferred Name:	Middle Name:	SSN:	Maiden Name:
Gender (Circle One): Male / Female / Other / Prefer Not to Say		**Marital Status (Circle One):** Married / Single / Divorced / Widowed	
Mailing Address:		City:	
State:		Zip Code:	
Home Phone:	Work Phone:	Cell Phone:	
Email:		Would you like appointment reminders? (Circle One): Email Text	
Employer:		Preferred Spoken Language:	

EMERGENCY CONTACT

Name & Relationship:	Phone:

REASON FOR VISIT

Have you had any Speech, Occupational, or Physical Therapy this calendar year? Y / N

Any Chiropractic visits this year? Y / N At which facility? _____

What area are we treating today? (ex. back, knee, elbow, etc.):	Date of Injury/ Day Symptoms Began?

Accident Related: Y / N Accident Type (circle one): Home Work Auto State of Accident: _____

Referring Doctor: Date of Surgery, If applicable?

INSURANCE INFORMATION *If patient is <u>not</u> the policyholder, please complete the information below*

Primary Insurance:

Subscriber Name: Birth Date:

Subscriber Address (If different from patient's):

Relationship to Patient:

Secondary Insurance:

Subscriber Name: Birth Date:

Subscriber Address (If different from patient's):

Relationship to Patient:

Updated 11-5-21 (Label)

Central Nebraska Rehabilitation Services

RESPONSIBLE PARTY INFORMATION (IF PATIENT IS UNDER 19)

Please populate all fields. If the field does not apply to you, please mark with NA.

Primary Guarantor Information		
Primary Guarantor Name:		
Relationship to Patient:		
Address (If different from patient's):		
City:	State:	ZIP Code:
SSN:	Birth Date:	Cell Phone:
Primary Guarantor email address:		

Secondary Guarantor Information		
Secondary Guarantor Name:		
Relationship to Patient:		
Address (If different from patient's):		
City:	State:	ZIP Code:
SSN:	Birth Date:	Cell Phone:
Secondary Guarantor email address:		

Signature of person completing paperwork: _____

Date:_____

Central Nebraska Rehabilitation Services, LLC
Registration Consent Form

Label

AUTHORIZATION of Assignment of Benefits/Insurance Appeals:

I hereby give authorization for payment of insurance benefits to be made directly to Central Nebraska Rehabilitation Services, LLC, for services rendered here. I understand that I am financially responsible for all charges whether or not they are covered by insurance.
I authorize any information pertaining to any medical claim, grievance, or appeal, including any external review rights, filed by Central Nebraska Rehabilitation Services, LLC on my behalf be released or received by Central Nebraska Rehabilitation Services, LLC. I authorize Central Nebraska Rehabilitation Services, LLC to act as my Authorized Representative regarding claims, grievances and appeals for services rendered by Central Nebraska Rehabilitation Services, LLC for as long as I, or the patient, is treated at, or have outstanding claims with, Central Nebraska Rehabilitation Services, LLC.

Patient Signature: _____ Date: _____
(Signature of Patient, Parent, or Guardian)

Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney

VISIT LIMITS and SUPPLIES:

I understand that my insurance company may have a calendar year limit as to how many therapy visits, they will allow, and this may also include any chiropractor visits or osteopathic physiotherapy visits. Although as a courtesy Central Nebraska Rehabilitation Services, LLC, will track the visits I have here, they are unable to track any treatment outside their facility. I may be responsible for any visits that go over my covered limit. I understand that if my health insurance carrier does not cover a supply, I am responsible for payment in full for the supply. **Initial:** _____

Photo Release:

I hereby grant Central Nebraska Rehabilitation Services and its entities permission to the rights of photographs and/or video recordings of me without payment or any other consideration. I understand that my image or video may be edited, copied, exhibited, published, or distributed and waive the right to inspect or approve the finished product wherein my likeness appears. Additionally, I waive any right to royalties or other compensation arising or related to the use of my image or recording. By signing this release, I understand this permission signifies that photographic or video recordings of me may be electronically displayed in any format and for any purpose. I hereby hold harmless, release, and forever discharge CNRS from any and all claims, demands, and causes of action without limitation which I, my heirs, representatives, executors, administrators, or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this authorization. By signing this form, I acknowledge that I have completely read and fully understand the above release and agree to be bound thereby. I hereby release any and all claims against any person or organization utilizing this material. I also hereby agree to allow CNRS the use of comments made within patient records systems for publicity and marketing purposes.

Signed _____ Date _____ I Decline _____ (initial)

If individual photographed/recorded is under nineteen (19) years old, the following section must be completed: I have read, and I understand this document. I understand and agree that it is binding on me, my child (named above), our heirs, assigns and personal representatives. I acknowledge that I am nineteen (19) years old or more and that I am the parent or guardian of the child named above.

Signature of Patient or Responsible Party _____ Relationship to Patient_____ Date_____

FINANCIAL AGREEMENT

In the event of default, I agree to pay all costs of collections, and reasonable attorney fees. I hereby authorize Central Nebraska Rehabilitation Services, LLC, to release all information to insurance companies, attorney, or other physicians to secure the payment of benefits; and agree that a photocopy of this form shall be valid as the original. I understand the minimum monthly payment requirement on any balances due is 5% of the total balance or $50, whichever is greater, and that my balance must be paid in full within 6 months. If I am unable to pay in full within 6 months, approval is guaranteed through the Union Bank and Trust patient financing program. (Inquire for details.)

HIPAA PRIVACY NOTICE:

The signature below acknowledges I was offered a copy of Central Nebraska Rehabilitation Services LLC notice of privacy practices.

Permission to release medical information to:_____(optional)

CONSENT OF MEDICAL TREATMENT:

Knowing that I have (or the patient listed above has) a condition requiring diagnosis and medical treatment, do hereby voluntarily consent to such diagnostic procedures and to such medical treatment rendered by Central Nebraska Rehabilitation Services, LLC.

Patient Signature: _____ (Signature of Patient, Parent, or Guardian) Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Power of Attorney	Date

Children's REHAB CENTER

General Information				Date_____
Patient Name	Nickname	Gender ❑ M ❑ F	Birthdate__/__/___	Age

Mother's Name	Father's Name
Who does the child live with?	
If child does not live with parents, how does child refer to caregiver (Ex: grandma, grandpa, etc.)?	

Is child in foster care?	❑ Y	❑ N	
Is child adopted?	❑ Y	❑ N	If yes, at what age was child placed with this family?
Languages spoken in home:			
Preferred language of primary caregiver for instructional materials:			

Sibling's Names	Age	Gender		List ALL patient medications currently taking and reason
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	
		❑ M	❑ F	

Describe reason for evaluation and areas of concern:

Pregnancy and Birth History

List any complications, illnesses, injuries, hospitalizations, bleeding, or fetal drug/alcohol exposure during this pregnancy:

Gestational age or list due date:

Delivery	❑ Vaginal ❑ suction/vacuum ❑ forceps ❑ none	❑ C-section ❑ planned ❑ unplanned ❑ emergency

Weight:	Length:	Apgar score:

Was child born blue?	Y N	Was cord around neck	❑ Y How many times:	❑ N

Oxygen or respiratory assistance	❑ Y Type and for how long:	❑ N

Length of hospital stay:

NICU	❑ Y Number of days spent in NICU:	❑ N

❑ Breast-fed	❑ Bottle-fed Formula:	❑ Both

Describe any feeding difficulties including latching, sucking, reflux/GERD, sensitivities, etc.:

School History

Children's REHAB CENTER

School Name:				Grade:
Services child receives through school or Early Developmental Network (check all that apply)	❑ physical therapy	❑ occupational therapy	❑ speech therapy	❑ other:

Describe child's performance in school	Strengths:	Weaknesses:

Describe any behaviors at home or school that concern you:

Medical History

Has your child ever had any of the following:			Comments (specify condition, specialists following care, dates, etc):
Heart conditions	❑ Y	❑ N	
Respiratory conditions	❑ Y	❑ N	
Seizures	❑ Y	❑ N	
Frequent ear infections	❑ Y	❑ N	Tubes in ears ❑ Y ❑ N
Chicken pox	❑ Y	❑ N	
Fevers over 101 degrees	❑ Y	❑ N	
Excessive vomiting or reflux	❑ Y	❑ N	
Latex allergy	❑ Y	❑ N	
Food allergies	❑ Y	❑ N	
Other allergies	❑ Y	❑ N	
Asthma	❑ Y	❑ N	
Hearing problems	❑ Y	❑ N	
Wears hearing aids	❑ Y	❑ N	
Vision problems	❑ Y	❑ N	
Wears corrective lenses	❑ Y	❑ N	
Fallen and hit head	❑ Y	❑ N	
Knocked unconscious	❑ Y	❑ N	
Been intubated	❑ Y	❑ N	
Feeding tube (NG tube, G-button, PEG tube, etc.)	❑ Y	❑ N	
Most recent eye exam	Date:		
Most recent physical/well-check	Date:		
Special tests (hearing test, swallow study, x-ray, CT scan, MRI, ultrasound, genetics, etc.)	Date(s), reason(s), & results:		
Hospitalizations	Date(s) & reason(s):		

Children's REHAB CENTER

Surgeries	Date(s) & type(s):			
Upcoming medical appointments, follow-ups, surgeries	Date(s) & type(s):			
Current restrictions by doctor				
Previous outpatient therapy	Speech	❑ This clinic	❑ Other	Date & reason:
	OT	❑ This clinic	❑ Other	Date & reason:
	PT	❑ This clinic	❑ Other	Date & reason:

Additional medical information not otherwise mentioned:				
Medical/therapy equipment used by child (braces, standers, wheelchairs, adaptive equipment, switches, communication devices etc.)				
Does your child enjoy movement?	❑ Y	❑ N	Was your child a fussy baby?	❑ Y ❑ N
Describe any recent loss of function due to illness or injury:				

Growth and Development

List age child was able to:	
Roll over and over	Completely toilet trained
Pivot on tummy	Speak first real words
Sit alone	Speak first real sentences
Crawl on hands and knees	Brush teeth
Stand alone	Feed self finger foods
Walk without help	Feed self with utensils

Preferred hand (hand dominance):	❑ Right	❑ Left	❑ Unsure	Age began showing preference:

Developmental Milestones for Dressing/Undressing (Skip this section if child is under 1 year)

If over 1 year, can your child independently:					
Remove socks	❑ Y	❑ N	Put on pants, shorts, skirts	❑ Y	❑ N
Untie shoe bow	❑ Y	❑ N	Put on shoes	❑ Y	❑ N
Remove shoes	❑ Y	❑ N	Lace Shoes	❑ Y	❑ N
Remove pants, shorts, skirts	❑ Y	❑ N	Put on pull-over shirt	❑ Y	❑ N
Remove pull-over shirt	❑ Y	❑ N	Tie shoe bow	❑ Y	❑ N
Put on socks	❑ Y	❑ N			
Fasteners:					
Unbutton	❑ Y	❑ N	Buckle	❑ Y	❑ N
Unzip separating zipper	❑ Y	❑ N	Insert belt into loops	❑ Y	❑ N

Children's
REHAB CENTER

Unbuckle	❑ Y	❑ N	Snap front	❑ Y	❑ N
Fasten front button	❑ Y	❑ N	Zip separating zipper	❑ Y	❑ N

Children's REHAB CENTER

Communication History					
Does your child show any of the following:					
Communication difficulty or trouble expressing wants/needs	❑ Y	❑ N	Frustration with communication	❑ Y	❑ N
Describe:			Describe:		
Understands when you talk to him/her	❑ Y	❑ N	Have tantrums due to speech frustration	❑ Y	❑ N
Family members understand language spoken	❑ Y	❑ N	Communication interferes with peer interaction	❑ Y	❑ N
Imitates sounds	❑ Y	❑ N	Follows simple directions	❑ Y	❑ N
Imitates words	❑ Y	❑ N	Answers yes/no questions	❑ Y	❑ N
Imitates phrases	❑ Y	❑ N	Uses sign language	❑ Y	❑ N

At what level does he/she communicate most effectively? (choose one)				
❑ Gestures only	❑ Gestures and babbling/nonsense words	❑ Gestures with a few words	❑ Single words	❑ Short phrases (2-4 words)

How much of his/her speech can you understand?			
❑ <25%	❑ 25-50%	❑ 50-75%	❑ 100%

List words used consistently:
How many total words does he/she has:
List signs used consistently:
How many total signs does he/she use:

Which does he/she identify by pointing to? (check all that apply)			
❑ Objects	❑ Pictures	❑ Body parts	❑ Family members

How does he/she protest?
How does he/she request something from you?

Oral Motor/Sensory Issues				
Describe current diet:				
My child currently eats: (check all that apply)				
❑ Formula Type/Brand:	❑ Baby food Stage:	❑ Pureed food	❑ Soft foods	❑ Regular diet

Does your child currently or has your child ever required thickened liquids?	❑ Y	❑ N

Children's REHAB CENTER

Does your child show any of the following:			Comments:	
Difficulty sucking or swallowing as an infant	❑ Y	❑ N		
Allow tooth brushing without a struggle	❑ Y	❑ N		
Use a pacifier	❑ Y	❑ N		
Suck thumb or finger	❑ Y	❑ N		
Mouth toys for exploration	❑ Y	❑ N		
Drooling	❑ Y	❑ N		
Picky eater	❑ Y	❑ N	Preferred foods:	Foods avoided:
Gag, choke, vomit with meals	❑ Y	❑ N	Specific trigger if known (sight, smell, consistency/texture, specific foods, etc.):	
Ever been on reflux medication	❑ Y	❑ N		
Unusual fears for his/her age	❑ Y	❑ N		
Normal sleep/wake patterns	❑ Y	❑ N		
Excessively bothered by noise, light, or sensation	❑ Y	❑ N		
Get so upset you are unable to comfort	❑ Y	❑ N		
Able to calm self	❑ Y	❑ N		
Engages in constructive play (puzzles, blocks, etc.)	❑ Y	❑ N		
Pretend plays	❑ Y	❑ N		
Describe any unusual reactions to dressing, bathing, etc.:				
Easiest way to comfort child:				
Favorite toy/character:				
Activity he/she would enjoy when you have 30 minutes to spend together:				