

**Central Nebraska Rehabilitation Services****Date:****PATIENT INFORMATION**

<b>Date of birth:</b>	<b>Last Name:</b>	<b>First Name:</b>
<b>Preferred Name:</b>	<b>Middle Name:</b>	<b>SSN:</b>
<b>Gender: Male / Female / Other / Prefer Not to Say</b>		<b>Maiden Name:</b>
<b>Marital Status (Circle One): Married / Single / Divorced / Widowed</b>		
<b>Physical Address:</b>	<b>Mailing Address (If Applicable):</b>	
<b>City:</b>	<b>State:</b>	<b>ZIP Code:</b>
<b>Home Phone:</b>	<b>Work Phone:</b>	<b>Cell Phone:</b>
<b>Email:</b>	<b>Would you like appointment reminders via (Circle One):</b> Email      Text	
<b>Cell Phone Carrier (Circle One): AT&amp;T    Sprint    T-Mobile    US Cellular    Verizon    Other: _____</b>		

**EMERGENCY CONTACT**

<b>Name &amp; Relationship:</b>	<b>Phone:</b>
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**GUARANTOR INFORMATION (IF PATIENT IS UNDER 19)**

<b>Primary Guarantor:</b>	<b>Relationship to Patient:</b>
Address (If different from patient's):	
City:	State:
SSN:	Birth Date:
Phone:	
<b>Secondary Guarantor:</b>	<b>Relationship to Patient:</b>
Address (If different from patient's):	
City:	State:
SSN:	Birth Date:
Phone:	

**REASON FOR VISIT**

<b>What area are we treating today (ex. back, knee, elbow, etc.):</b>	<b>Date of Injury/ Day Symptoms Began?</b>
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**How did you hear about us? (Circle One)**

Social Media \ Billboard \ Family/Friend \ Internet Search \ Newspaper \ Radio \ TV \ Referring Doctor \ Staff: \_\_\_\_\_

<b>Referring Doctor:</b>	<b>Date of Surgery, If applicable?</b>
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**INSURANCE INFORMATION***If patient is not the policyholder please complete the information below*

<b>Primary Insurance:</b>	
Subscriber Name:	Birth Date:
Subscriber SSN:	Relationship to Patient:
<b>Secondary Insurance:</b>	
Subscriber Name:	Birth Date:
Subscriber SSN:	Relationship to Patient:
Subscriber Address (If different from patient's):	

**Have you had any Speech, Occupational, or Physical Therapy this calendar year?    Y / N****Any Chiropractic visits this year?    Y / N      At which facility? \_\_\_\_\_**

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: \_\_\_\_\_  
(Signature of Patient, Parent, or Guardian)

Date: \_\_\_\_\_

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)

Date

Relationship to Patient:  Self  Parent  Guardian  Power of Attorney

<b>General Information</b>				Date _____	
Patient Name		Nickname		Gender <input type="checkbox"/> M <input type="checkbox"/> 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?		<input type="checkbox"/> Y	<input type="checkbox"/> N		
Is child adopted?		<input type="checkbox"/> Y	<input type="checkbox"/> 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 <input type="checkbox"/> M <input type="checkbox"/> F		List ALL patient medications currently taking and reason
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
			<input type="checkbox"/> M <input type="checkbox"/> F		
Describe reason for evaluation and areas of concern:					
<b>Pregnancy and Birth History</b>					
List any complications, illnesses, injuries, hospitalizations, bleeding, or fetal drug/alcohol exposure during this pregnancy:					
Gestational age or list due date:					
Delivery		<input type="checkbox"/> Vaginal <input type="checkbox"/> suction/vacuum <input type="checkbox"/> forceps <input type="checkbox"/> none		<input type="checkbox"/> C-section <input type="checkbox"/> planned <input type="checkbox"/> unplanned <input type="checkbox"/> emergency	
Weight:		Length:		Apgar score:	
Was child born blue? Y N		Was cord around neck <input type="checkbox"/> Y		How many times: <input type="checkbox"/> N	
Oxygen or respiratory assistance <input type="checkbox"/> Y		Type and for how long:		<input type="checkbox"/> N	
Length of hospital stay:					
NICU <input type="checkbox"/> Y		Number of days spent in NICU:		<input type="checkbox"/> N	
<input type="checkbox"/> Breast-fed		<input type="checkbox"/> Bottle-fed Formula:		<input type="checkbox"/> Both	
Describe any feeding difficulties including latching, sucking, reflux/GERD, sensitivities, etc.:					
<b>School History</b>					

School Name:		Grade:			
Services child receives through school or Early Developmental Network (check all that apply)	<input type="checkbox"/> physical therapy	<input type="checkbox"/> occupational therapy	<input type="checkbox"/> speech therapy	<input type="checkbox"/> other:	

Describe child's performance in school	Strengths:	Weaknesses:

Describe any behaviors at home or school that concern you:


Medical History			
Has your child <u>ever</u> had any of the following:			Comments (specify condition, specialists following care, dates, etc):
Heart conditions	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Respiratory conditions	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Seizures	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Frequent ear infections	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tubes in ears <input type="checkbox"/> Y <input type="checkbox"/> N
Chicken pox	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Fevers over 101 degrees	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Excessive vomiting or reflux	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Latex allergy	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Food allergies	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Other allergies	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Asthma	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Hearing problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Wears hearing aids	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Vision problems	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Wears corrective lenses	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Fallen and hit head	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Knocked unconscious	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Been intubated	<input type="checkbox"/> Y	<input type="checkbox"/> N	
Feeding tube (NG tube, G-button, PEG tube, etc.)	<input type="checkbox"/> Y	<input type="checkbox"/> 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):		

Surgeries	Date(s) & type(s):				
Upcoming medical appointments, follow-ups, surgeries	Date(s) & type(s):				
Current restrictions by doctor					
Previous outpatient therapy	Speech	<input type="checkbox"/> This clinic	<input type="checkbox"/> Other	Date & reason:	
	OT	<input type="checkbox"/> This clinic	<input type="checkbox"/> Other	Date & reason:	
	PT	<input type="checkbox"/> This clinic	<input type="checkbox"/> 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?	<input type="checkbox"/> Y	<input type="checkbox"/> N	Was your child a fussy baby?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Describe any recent loss of function due to illness or injury:					
<b>Growth and Development</b>					
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):	<input type="checkbox"/> Right	<input type="checkbox"/> Left	<input type="checkbox"/> Unsure	Age began showing preference:	
<b>Developmental Milestones for Dressing/Undressing (Skip this section if child is under 1 year)</b>					
If over 1 year, can your child independently:					
Remove socks	<input type="checkbox"/> Y	<input type="checkbox"/> N	Put on pants, shorts, skirts	<input type="checkbox"/> Y	<input type="checkbox"/> N
Untie shoe bow	<input type="checkbox"/> Y	<input type="checkbox"/> N	Put on shoes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Remove shoes	<input type="checkbox"/> Y	<input type="checkbox"/> N	Lace Shoes	<input type="checkbox"/> Y	<input type="checkbox"/> N
Remove pants, shorts, skirts	<input type="checkbox"/> Y	<input type="checkbox"/> N	Put on pull-over shirt	<input type="checkbox"/> Y	<input type="checkbox"/> N
Remove pull-over shirt	<input type="checkbox"/> Y	<input type="checkbox"/> N	Tie shoe bow	<input type="checkbox"/> Y	<input type="checkbox"/> N
Put on socks	<input type="checkbox"/> Y	<input type="checkbox"/> N			
Fasteners:					
Unbutton	<input type="checkbox"/> Y	<input type="checkbox"/> N	Buckle	<input type="checkbox"/> Y	<input type="checkbox"/> N
Unzip separating zipper	<input type="checkbox"/> Y	<input type="checkbox"/> N	Insert belt into loops	<input type="checkbox"/> Y	<input type="checkbox"/> N

Unbuckle	<input type="checkbox"/> Y	<input type="checkbox"/> N	Snap front	<input type="checkbox"/> Y	<input type="checkbox"/> N
Fasten front button	<input type="checkbox"/> Y	<input type="checkbox"/> N	Zip separating zipper	<input type="checkbox"/> Y	<input type="checkbox"/> N

<b>Communication History</b>					
Does your child show any of the following:					
Communication difficulty or trouble expressing wants/needs	<input type="checkbox"/> Y	<input type="checkbox"/> N	Frustration with communication	<input type="checkbox"/> Y	<input type="checkbox"/> N
Describe:			Describe:		
Understands when you talk to him/her	<input type="checkbox"/> Y	<input type="checkbox"/> N	Have tantrums due to speech frustration	<input type="checkbox"/> Y	<input type="checkbox"/> N
Family members understand language spoken	<input type="checkbox"/> Y	<input type="checkbox"/> N	Communication interferes with peer interaction	<input type="checkbox"/> Y	<input type="checkbox"/> N
Imitates sounds	<input type="checkbox"/> Y	<input type="checkbox"/> N	Follows simple directions	<input type="checkbox"/> Y	<input type="checkbox"/> N
Imitates words	<input type="checkbox"/> Y	<input type="checkbox"/> N	Answers yes/no questions	<input type="checkbox"/> Y	<input type="checkbox"/> N
Imitates phrases	<input type="checkbox"/> Y	<input type="checkbox"/> N	Uses sign language	<input type="checkbox"/> Y	<input type="checkbox"/> N
At what level does he/she communicate most effectively? (choose one)					
<input type="checkbox"/> Gestures only	<input type="checkbox"/> Gestures and babbling/nonsense words	<input type="checkbox"/> Gestures with a few words	<input type="checkbox"/> Single words	<input type="checkbox"/> Short phrases (2-4 words)	
How much of his/her speech can you understand?					
<input type="checkbox"/> <25%	<input type="checkbox"/> 25-50%	<input type="checkbox"/> 50-75%	<input type="checkbox"/> 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)					
<input type="checkbox"/> Objects	<input type="checkbox"/> Pictures	<input type="checkbox"/> Body parts	<input type="checkbox"/> Family members		
How does he/she protest?					
How does he/she request something from you?					
<b>Oral Motor/Sensory Issues</b>					
Describe current diet:					
My child currently eats: (check all that apply)					
<input type="checkbox"/> Formula Type/Brand:	<input type="checkbox"/> Baby food Stage:	<input type="checkbox"/> Pureed food	<input type="checkbox"/> Soft foods	<input type="checkbox"/> Regular diet	
Does your child currently or has your child ever required thickened liquids?				<input type="checkbox"/> Y	<input type="checkbox"/> N

Does your child show any of the following:			Comments:	
Difficulty sucking or swallowing as an infant	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Allow tooth brushing without a struggle	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Use a pacifier	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Suck thumb or finger	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Mouth toys for exploration	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Drooling	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Picky eater	<input type="checkbox"/> Y	<input type="checkbox"/> N	Preferred foods:	Foods avoided:
Gag, choke, vomit with meals	<input type="checkbox"/> Y	<input type="checkbox"/> N	Specific trigger if known (sight, smell, consistency/texture, specific foods, etc.):	
Ever been on reflux medication	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Unusual fears for his/her age	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Normal sleep/wake patterns	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Excessively bothered by noise, light, or sensation	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Get so upset you are unable to comfort	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Able to calm self	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Engages in constructive play (puzzles, blocks, etc.)	<input type="checkbox"/> Y	<input type="checkbox"/> N		
Pretend plays	<input type="checkbox"/> Y	<input type="checkbox"/> 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:				