



## Houston Healthcare Therapy Agreement

### We will do our best to:

- Begin all sessions on time
- Explain your treatment program and progress to you
- Accommodate your schedule
- Be consistent with your therapist and assistant
- Reschedule if you must miss an appointment

### We ask you to:

- Arrive on time for all sessions
- Participate in setting your therapy goals
- Call at least 24 hours ahead of time if you need to cancel an appointment (pain is not a reason to cancel a session)
- Follow recommended home activities and exercise programs
- Dress appropriately for your therapy (wind suits, walking shorts and sweat pants are recommended)

### Our department guidelines are as follows:

- Three cancellations without notice will be automatic grounds for discontinuation of services
- Every effort will be made to keep you with the same therapist/assistant; however, there may be circumstances when another therapist will need to provide your treatment
- Every effort will be made to give you your preferred appointment time as the schedule allows
- All co-pays are due at time of service

The goal of our staff is to provide excellent service and care for each patient on an individual basis. We will assist you in every way to achieve a positive outcome. If you have any questions please feel free to speak with your therapist.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_

Staff signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Pavilion Rehab**  
233 North Houston Road, Suite B  
Warner Robins, Georgia 31093  
478.923.2937

**Houston Lake Rehab**  
2510 Highway 127  
Kathleen, Georgia 31047  
478.988.1882



**HOUSTON HEALTHCARE**  
*Rehabilitation Services*

**Registration Form**

NAME \_\_\_\_\_ DOB \_\_\_\_\_  
AGE \_\_\_\_\_ SEX \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_ TELEPHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
PATIENTS SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ CELL PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_ COUNTY \_\_\_\_\_  
REFERRING PHYSICIAN \_\_\_\_\_ PRIMARY PHYSICIAN \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ EMPLOYER PHONE \_\_\_\_\_  
EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_  
IF RETIRED, GIVE DATE \_\_\_\_\_ SPOUSE RETIRE DATE \_\_\_\_\_

**GUARANTOR INFORMATION IF PATIENT IS A MINOR**

NAME OF PARENT OR GUARDIAN \_\_\_\_\_  
RELATIONSHIP \_\_\_\_\_  
ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CELL PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
RELATIONSHIP TO PATIENT \_\_\_\_\_  
NEAREST RELATIVE \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
ADDRESS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_



**HOUSTON HEALTHCARE**  
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**INSURANCE INFORMATION**

**PRIMARY INSURANCE** \_\_\_\_\_ POLICY # \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ GROUP # \_\_\_\_\_

(If different from patient)  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

IF RETIRED, GIVE DATE \_\_\_\_\_ SPOUSE RETIRE DATE \_\_\_\_\_

**SECONDARY INSURANCE** \_\_\_\_\_ POLICY# \_\_\_\_\_

INSURANCE PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ ADDRESS \_\_\_\_\_

SUBSCRIBER NAME \_\_\_\_\_ GROUP # \_\_\_\_\_

(If different from patient)  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ SS# \_\_\_\_\_ RACE \_\_\_\_\_ SEX \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_

**ADDITIONAL INSURANCE INFORMATION**

\*WORKER'S COMPENSATION \_\_\_\_\_

EMPLOYER \_\_\_\_\_ CLAIM # \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_

CONTACT NAME \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

\*AUTOMOBILE LIABILITY \_\_\_\_\_ DATE OF INJURY \_\_\_\_\_

NAME OF INSURED \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

INSURED'S ADDRESS \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

INSURANCE COMPANY \_\_\_\_\_ PHONE \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

CLAIM # \_\_\_\_\_ CONTACT \_\_\_\_\_



**HOUSTON HEALTHCARE**  
*Rehabilitation Services*

**GENERAL MEDICAL HISTORY**

NAME \_\_\_\_\_ INJURY DATE \_\_\_\_\_

PROBLEM AREA \_\_\_\_\_

ARE YOU CURRENTLY WORKING? Y N TYPE OF WORK \_\_\_\_\_

REGULAR DUTY \_\_\_\_\_ LIGHT DUTY \_\_\_\_\_ MEDICAL LEAVE \_\_\_\_\_

HAND DOMINANCE RIGHT \_\_\_\_\_ LEFT \_\_\_\_\_

PLEASE CHECK IF YOU HAVE BEEN TREATED FOR:

- |   |  |
|---|--|
| <input type="checkbox"/> HEART ATTACK               | <input type="checkbox"/> KIDNEY DISEASE                                |
| <input type="checkbox"/> PACEMAKER                  | <input type="checkbox"/> ANY INFECTIOUS DISEASE: (TB, AIDS, HEPATITIS) |
| <input type="checkbox"/> HERNIAS                    | <input type="checkbox"/> DIABETES                                      |
| <input type="checkbox"/> HIGH BLOOD PRESSURE        | <input type="checkbox"/> METAL IMPLANT/JOINT REPLACEMENT               |
| <input type="checkbox"/> LUNG DISEASE/PROBLEMS      | <input type="checkbox"/> PSYCHIATRIC/EMOTIONAL PROBLEMS                |
| <input type="checkbox"/> HEAD TRAUMA/CONCUSSION     | <input type="checkbox"/> ARE YOU PREGNANT?                             |
| <input type="checkbox"/> STROKE                     | <input type="checkbox"/> ALLERGIES: (LATEX, MEDICATION, FOOD)          |
| <input type="checkbox"/> DIZZINESS/BALANCE PROBLEMS | <input type="checkbox"/> BACK/NECK INJURIES                            |
| <input type="checkbox"/> TOBACCO USAGE              | <input type="checkbox"/> ARTHRITIS                                     |
| <input type="checkbox"/> CANCER                     | <input type="checkbox"/> FRACTURES                                     |
| <input type="checkbox"/> GASTROINTESTINAL PROBLEMS  |  |
| <input type="checkbox"/> JOINT DISLOCATION          |  |

LIST CURRENT MEDICATIONS \_\_\_\_\_

HAVE YOU RECENTLY HAD AN X-RAY, MRI, AND/OR CT SCAN FOR YOUR CONDITION?

\_\_\_\_\_

FINDINGS \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE LIST ANY MAJOR SURGERY/HOSPITALIZATIONS WITHIN THE PAST FIVE YEARS:

REASON \_\_\_\_\_ DATE \_\_\_\_\_

REASON \_\_\_\_\_ DATE \_\_\_\_\_

HAVE YOU EVER BEEN EVALUATED AND/OR TREATED BY ANY OTHER PHYSICAL THERAPIST, OCCUPATIONAL THERAPIST, CHIROPRACTOR, OR HEALTH CARE PRACTITIONER FOR THIS CONDITION? \_\_\_\_\_



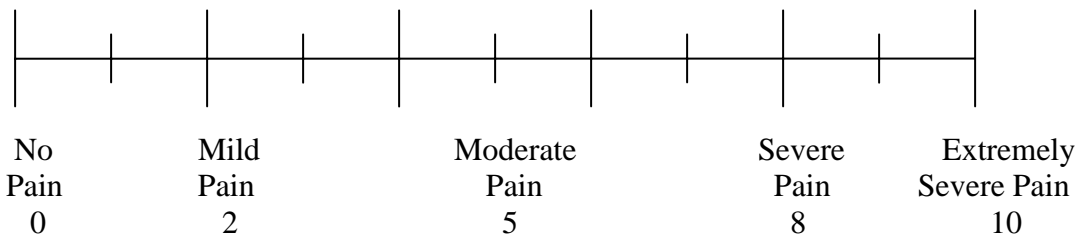
HOUSTON HEALTHCARE  
Rehabilitation Services

**Rehab Outcomes  
Intake**

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

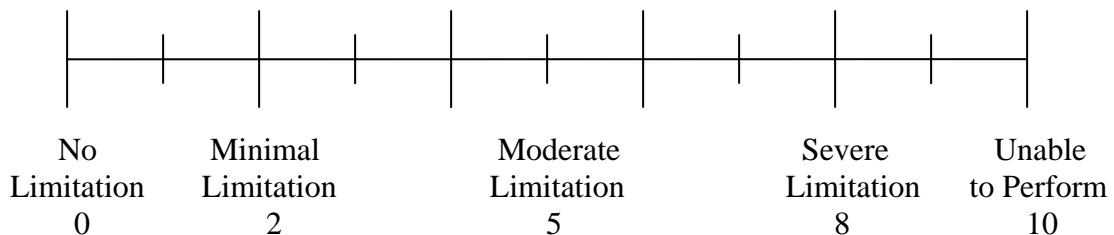
**Pain**

On a scale of 0 to 10, with 0 being no pain and 10 being the most severe pain, place an 'X' on the scale below to rate your current level of pain.



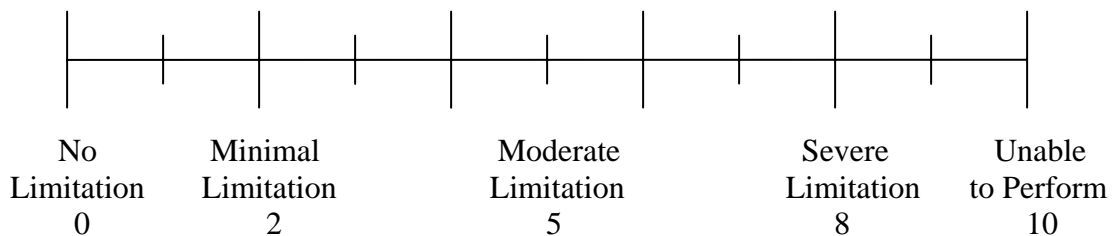
**Motion**

On a scale of 0 to 10, with 0 showing no limitations in your ability to move and 10 being unable to, place an 'X' on the scale below for your current level of motion (bending over, reaching overhead, twisting your trunk, etc.)



**Function**

On a scale of 0 to 10, with 0 being able to perform your entire normal daily activities, and 10 being that you are unable to perform any of your normal daily activities, place an 'X' on the scale below for your current ability to perform your normal daily activities.



Insurance: \_\_\_\_\_

Zip Code: \_\_\_\_\_

MD: \_\_\_\_\_



**HOUSTON HEALTHCARE**  
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**PAVILION REHAB**

*233 North Houston Road, Suite B  
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**HOUSTON LAKE REHAB**

*2510 Highway 127  
Kathleen, Georgia 31047  
478.988.1882*

As a courtesy, we try to verify your therapy benefits prior to your first visit. However, it is **your responsibility** to inform us if referrals or limitations are required by your policy.

If you wish your claims to be filed to another insurance company other than your group health insurance, **you must provide the necessary information.**

Signature: \_\_\_\_\_

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