Advanced Rehabilitation and Health Specialists - Health Update Form

Date_______________ Name____ Date of Birth ____/____/_____
Phone___________________________________ Referring physician_________________________________

NEW Drug name and Dosage amount

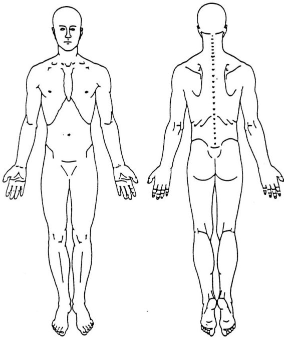
If no change since previous Visit, no need to complete.

1. ____ 5. ____
2. ____ 6. ____
3. ____ 7. ____
4. ____ 8. ____

ONLY NEW SURGERIES and/or HOSPITALIZATIONS SINCE YOUR LAST VISIT: INCLUDE DATE AND REASON.

1. ____ ____________________________________
2. ____ ____________________________________
3. ____ ____________________________________

Use the diagram below to indicate where you have pain or other symptoms.



Pain scale (0-10, 10 being the worst pain)

0-------------------5--------------------10

Please describe the problem that brings you here: ____

____

CONSENT TO TREATMENT: I have read, understood, and verified that the above information is true and correct. I realize I am a partner in my treatment and will be informed of my plan of care, goals and expected outcomes. I realize that I can openly discuss questions or concerns with ARHS staff in a confidential manner.

***CANCELLATION POLICY.** Should you need to cancel/reschedule an appointment please do so 24-Hours before your appointment time. Failure to do so will result in a $25 charge to your account. We realize emergencies arise and are sometimes unavoidable; however, advanced notification allows us to keep the office operating efficiently.

*__YOUR CO-PAY IS DUE AT EACH VISIT__. Should your insurance deny payment, you will be responsible for outstanding charges. If your Insurance pays you, you will remit payments to ARHS.

*__PATIENT ACCOUNT POLICY__. A patient's account is not allowed to exceed more than $250 and/or 30 days past due. If this should occur the patient WILL BE REQUIRED to make payment in full before care will be continued.

***__I acknowledge__ Advanced Rehabilitation and Health Specialists are in compliance with all HIPAA and Privacy Policies.

***__I Authorize__ Advanced Rehabilitation and Health Specialists to discuss my health information with:

1. ___________________________________ 2. ___________________________________

PRINT PATIENT NAME:____

PATIENT SIGNATURE: ____ DATE: ____________

PARENT'S SIGNATURE IF MINOR: _____________________________________ DATE: ____________