# PATIENT CONSENT & ACKNOWLEDGEMENT FORM

**ACCT #**_____________
**Location #**____________
**Location Name**____________________

___Home ___LTC ___ Clinic **/** ___PT ___OT ___ST

## AUTHORIZATION TO RELEASE/OBTAIN INFORMATION

I hereby authorize Millennium Rehab and Consulting Group, Inc. to obtain and release any and all information needed from/to my insurance company, physician, employer or any other appropriate party for the purposes of treatment, payment and/or health care operations relating to my safety or care.

I also grant permission to Millennium Rehab and Consulting Group, Inc. to discuss/share any and all information with the following (family members, non-referring provider's office, etc.). This includes all information (scheduling, billing, treatment, etc.) unless a restriction is indicated below. If written documentation is desired, a separate release must be completed.

________________________________________________________

________________________________________________________

☐ None ( Please note that for minors and students, information will be shared on an as needed basis with those identified as financially responsible parties even if the box for "None" is marked. )

## CONSENT TO TREATMENT

I hereby consent to the treatment as prescribed by my physician and provided by Millennium Rehab and Consulting Group, Inc., its employees, or representative. I further understand that the agency is authorized to carry out all instructions of the patient's doctors and that the agency is hereby relieved of any and all liability occurring from the performance of the doctor's instructions.

## ASSIGNMENT OF BENEFITS/FINANCIAL RESPONSIBILITY

I fully assign payment directly to Millennium Therapy Rehab and Consulting Group, Inc. for services rendered and I understand that I am liable for charges not reimbursed by the insurance company. All accounts are due and payable upon receipt of the bill.

## NOTICE OF INFORMATION PRACTICES

I acknowledge that I have been given the opportunity to review Millennium Therapy's Notice of Privacy Practices. I also understand that a copy of this policy will be provided to me in writing at my request. If I have any questions or complaints I can contact the Privacy Officer.

________________________________________ ____________________
**Signature of Patient** **Date**

If patient is a minor or is unable to make the above determinations independently:

________________________________________ ____________________
**Signature of Patient Representative** **Date**

________________________________________
**Relationship to Patient**

If you would like to be added to our email list to receive different updates and tips on various subjects, please list your email address below.

________________________________________

Millennium Therapy complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.
Millennium Therapy cumple con las leyes federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo.
Millennium Therapy 遵守適用的聯邦民權法律規定，不因種族、膚色、民族血統、年齡、殘障或性別而歧視任何人。
Millennium Therapy tuân thủ luật dân quyền hiện hành của Liên bang và không phân biệt đối xử dựa trên chủng tộc, màu da, nguồn gốc quốc gia, độ tuổi, khuyết tật, hoặc giới tính.

# MILLENNIUM PATIENT INFORMATION SHEET

**ACCT #**______________
**Location #**______________
___Home ___LTC ___ Clinic / ___PT ___OT ___ST **Location Name**____________________

**PATIENT**

**Legal Name** ________________________________________________
First Middle Last

**Date of Birth**________/_________/________ **Social Security #:**______________________________

**Address**______________________________**City**____________________**State**______ **Zip**__________

**Home Phone (____)**______________________ **Cell Phone (______)**__________________________

**Marital Status: M S D W** **Sex: M F** **Student: Yes, FT PT or No**

**Employer:**______________________________ **Work Phone: (____)**__________________

**Address**______________________________ **City**____________________ **State**_____ **Zip**____________

**Is the Injury the Result of a Work Comp Claim? Y N**
**Is the Injury the Result of an Auto/Liability Claim? Y N**
(If yes, please enter contact information under the Insurance Section)

**Are You Working with an Attorney? Y N**
**Name:**____________________________________**Phone:**____________________

**Has the Patient Been Seen for PT, OT, ST and/or Chiropractic Services this year? Y N**
**If so, where were services received and approx. how many visits:**______________________________

**Are you receiving any HomeCare Services at this time? Y N**

**Emergency Contact :**____________________ **Phone #**__________________ **Relationship**______________

★ **How Did You Hear About Millennium Therapy?**______________________________________________

**APPT. REMINDERS**

**Would you like to receive automatic appointment reminders? Y N**
**If yes, please choose an option:**
____ Text (cell number must be given above) Cell Provider (Verizon, etc.): __________________
____ Email: ______________________________________________

**IF MARRIED**

**Spouses Name**____________________________________________________________
**Date of Birth:**________/________/________ **Social Security Number:**____________________________
**Employer:**________________________________________ **Work Phone:(____)**____________________
**Address:**__________________________________ **City**____________________ **State**______ **Zip**__________

**IF PATIENT IS A MINOR OR FULL TIME STUDENT**

**Financially Responsible Party #1:** Name: ______________________________________
Date of Birth:____________ SSN:__________________ Relationship To Patient: _____________
Employer:________________________________________ Work Phone:(_____)______________________
Address:__________________________________ City____________________ State______ Zip____________

**Financially Responsible Party #2:** Name: ______________________________________
Date of Birth:____________ SSN:__________________ Relationship To Patient: _____________
Employer:________________________________________ Work Phone:(_____)______________________
Address:__________________________________ City____________________ State______ Zip____________

## Insurance Information

**Primary Insurance/Liability/WC**

**Insurance Co:**________________________________
**Insured's Name:**______________________________
**Insured's Date of Birth:** _______/_______/_________
**Relationship to Patient:**_________________________
**Policy/ID#:**__________________________________
**Group #:**____________________________________
**Insurance Co Phone #:**_________________________
**Insurance Co Address:**_________________________
____________________________________________

**Secondary Insurance**

**Insurance Co:**________________________________
**Insured's Name:**______________________________
**Insured's Date of Birth:** ________/_________/__________
**Relationship to Patient:**_________________________
**Policy/ID#:**__________________________________
**Group #:**____________________________________
**Insurance Co Phone #:**_________________________
**Insurance Co Address:**_________________________
____________________________________________

## MEDICAL HISTORY QUESTIONNAIRE FOR THERAPY PATIENTS

**Name:** ______________________________________ **Date:** ________________

| **GENERAL** | **YES** | **NO** |
|---|---|---|
| Illness or injury in the last 5 years? | ☐ | ☐ |
| If yes, what body part(s) ___________________________ when __________________ | | |
| Permanent medical restrictions for any reason? | ☐ | ☐ |
| If yes, explain_____________________________________________________________ | | |
| Any condition or medical restriction that you feel may prevent you from safely participating in therapy | ☐ | ☐ |
| If yes, explain _____________________________________________________________ | | |

| **NEUROLOGICAL DISORDERS & CONDITIONS** | | |
|---|---|---|
| Head/Brain injuries, disorders or illnesses | ☐ | ☐ |
| Seizures, epilepsy | ☐ | ☐ |
| Eye disorders or impaired vision (except corrective lenses) | ☐ | ☐ |
| Ear disorders, loss of hearing or balance | ☐ | ☐ |
| Loss of, or altered consciousness | ☐ | ☐ |
| Fainting spells, dizziness or vertigo, loss of consciousness | ☐ | ☐ |
| Stroke or paralysis | ☐ | ☐ |

| **CARDIOVASCULAR/PULMONARY DISORDERS & CONDITIONS** | | |
|---|---|---|
| Heart palpitations, irregular heartbeat, chest pain | ☐ | ☐ |
| Heart disease or heart attack; other cardiovascular condition | ☐ | ☐ |
| Heart surgery (valve replacement/bypass, angioplasty, pacemaker) | ☐ | ☐ |
| Shortness of breath, lung problems | ☐ | ☐ |
| High blood pressure | ☐ | ☐ |

| **MUSCULOSKELETAL DISORDERS & CONDITIONS** | | |
|---|---|---|
| Muscular disease | ☐ | ☐ |
| Missing or impaired hand, arm, foot, leg, finger, toe | ☐ | ☐ |
| Spinal injury or disease | ☐ | ☐ |
| Chronic low back pain, back surgery, disc disease, back injury or strain | ☐ | ☐ |
| Leg ulcers, swelling of ankles, leg pain on walking | ☐ | ☐ |
| Knee problems | ☐ | ☐ |
| Shoulder problems | ☐ | ☐ |
| Carpal Tunnel Syndrome | ☐ | ☐ |
| Repetitive Strain in arms/legs | ☐ | ☐ |

**OTHER CONDITIONS**

Diabetes or elevated blood sugar controlled by: ☐ Diet ☐ Pills ☐ Insulin

| | | |
|---|---|---|
| Falls in the last 6 months? | ☐ | ☐ |
| Sleep disorders (pauses in breathing, daytime sleepiness, snoring, etc.) | ☐ | ☐ |
| Currently pregnant (If yes, due date: ________________) | ☐ | ☐ |

Any other known medical conditions? If yes, please list: ________________________

____________________________________________________________________________

Current Medications:_________________________________________________________

____________________________________________________________________________

| | | |
|---|---|---|
| Allergies (medications, latex, adhesive, lotions, other?) | ☐ | ☐ |

If yes, please list:__________________________________________________________

____________________________________________________________________________

Signature of Completing Party: _____________________________________________

Revised 5/22/17