SLRC
St. Lawrence Rehabilitation Center

Outpatient Services
2381 Lawrenceville Road
Lawrenceville, NJ 08648-2024
609-896-9500 voice
609-896-0698 fax
www.slrc.org web

Patient Name: _____

Account #: _____

ST. LAWRENCE REHABILITATION CENTER OUTPATIENT POLICIES AND REGISTRATION INFORMATION

Your first day of outpatient therapy has been scheduled. Please arrive 15 to 30 minutes early to complete the registration process prior to your evaluation. Please wear loose-fitting clothing and appropriate footwear.

The following is required at registration:

- Complete the enclosed forms, including this form, prior to your first visit. You may attach your own medication list to the pink sheet.
- Bring your insurance cards and a photo ID.
- Be sure that your primary physician has completed a referral for all requested services (If required by your insurance plan).
- You must bring a current prescription (dated within 30 days) for all prescribed therapies. Please note that during your course of treatment this prescription may need to be renewed. Your therapist will keep you informed and advise you to obtain a new one if needed.
- Co-pays will be collected at the time of service. Credit cards, cash, and personal checks will be accepted.

Outpatient Policies

- Your therapy appointment will take between 30 and 60 minutes, depending upon the goals set for that particular appointment.
- Please arrive on time. If you arrive late your therapist may shorten your treatment session.
- Family members, friends, or aides are to wait in the waiting room unless participation is requested by the therapist.
- If you have any concerns regarding your care, the environment, or the equipment contact the Clinical Outpatient Director at (609) 896-9500 ext. 2383.
- Please avoid use of cell phones during your treatment session.
- Please note that if either of the following occurs three times within one month you may be removed from the schedule at the discretion of Outpatient Office Manager:
    - You do not show for your scheduled appointment without calling.
    - You cancel a scheduled appointment without providing at least 24 hours notice.
- If during the course of your therapy you become hospitalized, we will need a note from your doctor clearing you to return to therapy.

Thank you for choosing the St. Lawrence Outpatient Therapy Department as your rehabilitation facility. We look forward to meeting you and helping you to achieve the highest level of function possible.

Sincerely,
Debbie Miktus
Outpatient Office Director

I have read the above information: _____

St. Lawrence Rehabilitation Center
Outpatient Services Department
Medication List and Communication Needs Assessment

Patient Name: _____ Account #: _____

Please complete this list with all prescription drugs as written on your drug bottle(s):

Medication	Dose	Times	How long have you been taking?

What over-the-counter drugs or herbal remedies do you take? ☐ None

Drug/Herbal Product	Amount	Frequency

Patient requires the following when discussing healthcare information:
☐ Communication board ☐ Glasses ☐ Hearing aide ☐ Translator ☐ None

Patient has other cultural concerns: ☐ yes (see below) ☐ no

_____

Patient prefers to discuss healthcare in a language other than English. □ yes □ no
If yes, patient was informed that interpreter services are available free of charge.

☐ Patient prefers to use hospital interpreter service
☐ Patient wishes to use own interpreter, _____

Medication list and communication needs reviewed with patient.

_____
Therapist Signature **Date/Time**

_____
Therapist Signature **Date/Time**

_____
Therapist Signature **Date/Time**

St. Lawrence Rehabilitation Center

PATIENT NAME _____ OUTPATIENT#_____

CONSENT FOR EXAMINATION AND TREATMENT:
I hereby give permission for treatment and/or any laboratory, x-ray, inhalation and/or rehabilitation therapy, etc. that the attending physician has ordered. Residents, students or other medical personnel may participate in my treatment as deemed appropriate by the attending physician.

AUTHORIZATION TO PAY INSURANCE BENEFITS:
I hereby authorize payment directly to the above named hospital upon receipt of the itemized statement for services rendered to the patient, benefits herein specified and otherwise payable to the undersigned, but not to exceed hospital's regular charge for this service.

GUARANTY OF ACCOUNT:
In consideration of services rendered or to be rendered by *St. Lawrence Rehabilitation Center* to the named patient, we (I) jointly and separately guaranty payment of any and all services rendered which are not covered or allowed by any insurance coverage. We (I) understand all bills are payable and become due upon receipt. We (I) understand that all accounts not settled will be forwarded to a collection agency.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the above named hospital to release any necessary information related to my financial records and medical records, within 90 days.

RECEIPT OF OUTPATIENT HANDBOOK:
I acknowledge that I have received and will be responsible for reviewing the outpatient handbook, which contains information about outpatient services, programs, policies, and patient rights and responsibilities.

BENEFIT INFORMATION:
I acknowledge that my insurance coverage has been adequately explained to me. I agree to **immediately** notify the Outpatient Coordinator of any change in my health insurance coverage or identification number.

Patient/Guarantor: _____ Date _____

OP Staff/Title: _____ Date _____

St. Lawrence Outpatient Rehabilitation Intake Form

Patient Data

Name: _____ _____ **Gender**: M F TG
(Last) (First) (Middle) (Suffix or title)

Date of Birth: _____/_____/_____ **Age**: _____ **Marital Status**: S M D W Separated

Street & Apt #: _____

City: _____ **State**: _____ **Zip**: _____

Contact Information: ☐ **Home #**: ( ) _____-_____ ☐ **Work #**: ( ) _____-_____

(Please check preferred number) ☐ **Cell #**: ( ) _____-_____ **E-mail**: _____

I'd like to receive E-mails from St. Lawrence Rehab Center about services, events, and programs: ☐ Yes ☐ No

How did you hear about us? _____

Emergency Contact

Name: _____ **Relationship**: _____

Phone: ( ) _____-_____ **Is this person your Care Giver?** ☐ Yes ☐ No

Insurance and Subscriber Information

The Insurance Subscriber is the person who is the "holder" of the insurance policy covering the patient

Name: _____ _____
(Last) (First) (Middle) (Suffix or title)

Date of Birth: _____/_____/_____ **SSN**: _____-_____-_____ **Phone Number:** ( ) _____-_____

Street & Apt #: _____

City: _____ **State**: _____ **Zip**: _____

Relationship to Patient: ☐ *Self* ☐ *Spouse* ☐ *Parent* ☐ *Other*

Primary Insurance: _____
(Insurance Carrier) (Policy Number) (Group Number)

Secondary Insurance: _____
(Insurance Carrier) (Policy Number) (Group Number)

The injury is related to: ☐ Work ☐ Car Accident **Claim #**: _____

Clinical Information

Reason for the therapy visit/ type of problem: _____

Date of injury or accident/ start of problem: _____/_____/_____

Are you receiving home health care? ☐ Yes ☐ No

Have you had therapy earlier this year? ☐ Yes ☐ No **If yes, when?** _____/_____/_____

Primary Care Physician Name: _____ **Phone #**: _____

Although your insurance has been verified, knowledge of your specific insurance benefits and out of pocket expenses is your responsibility. If you have any questions, or we can be of assistance, please feel free to ask.

Patient Signature: _____ **Date**: _____/_____/_____

St. Lawrence Rehabilitation Center
Outpatient Therapy Department

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date** : _____/_____/_____
(Last) (First) (Middle)

Date of Birth: _____/_____/_____ **Account Number**: _____

Allergies: (including medications)

_____ _____

_____ _____

Latex Allergy? ☐Yes ☐ No

Height: _____

Weight: _____

***See Medication List, Communication, and Cultural Needs Assessment Form**

Number of falls over Past Year: ☐None ☐ (#) _____

Occupation: _____

Past Medical History: (Please check all that are part of your past medical history.)

- ☐ High Blood Pressure
- ☐ Diabetes NIDDM
- ☐ Diabetes IDDM
- ☐ Swollen Ankles
- ☐ Anemia
- ☐ Asthma
- ☐ Seizures
- ☐ Pneumonia
- ☐ Persistent cough
- ☐ Pacemaker
- ☐ Heart Attack: (year) _____
- ☐ Tuberculosis
- ☐ COVID-19
- ☐ Indigestion
- ☐ Nausea/ Vomiting
- ☐ Ulcers
- ☐ Hepatitis
- ☐ Currently Pregnant
- ☐ H/o pregnancy
- ☐ Hemorrhoids
- ☐ Gall bladder disease
- ☐ Colitis
- ☐ Thyroid Disease
- ☐ Head or Neck radiation
- ☐ Headaches/ Migraines
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Neuropathy
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Low back problems
- ☐ Hearing Deficit
- ☐ Bronchitis
- ☐ Numbness of arms and legs
- ☐ Skin diseases
- ☐ Blood disorders
- ☐ Sexually Transmitted Disease
- ☐ Anxiety
- ☐ Depression
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Gout
- ☐ Sleep problems

☐ Heart Disease/ Condition(s): _____

☐ Neurological Disorder(s): _____

☐ Cancer (type, year): _____

☐ Learning disability i.e. ADD, ADHD, Dyslexia: _____

☐ Other: _____

Special Equipment/ DME that I currently own/ rent:

_____ _____ _____ _____

_____ _____ _____ _____

Patient Signature: _____ **Date** : _____/_____/_____

St. Lawrence Rehabilitation Center
Outpatient Therapy Department

PATIENT MEDICAL HISTORY FORM

Name: _____ **Date** : _____/_____/_____
(Last) (First) (Middle)

Account Number: _____

Surgery & Hospitalization: (List year and type of operation or diagnosis after hospitalization)

_____ _____ _____ _____

_____ _____ _____ _____

Family History: (write family member and their age when diagnosed)

Cancer: _____ **Mental Disease** (Anxiety, depression): _____

Hypertension: _____ **Autoimmune Disease** (Lupus, RA): _____

Diabetes: _____ **Dementia/ Alzheimer's**: _____

Strokes: _____

Prevention:

Do you wear a bike helmet? ☐ Yes ☐ No **Do you use drugs?** ☐ Yes ☐ No If yes, type? _____

Do you smoke? ☐ Yes ☐ No _____/ day **Do you exercise regularly?** ☐ Yes ☐ No

Do you drink alcohol? ☐ Yes ☐ No _____/week **Type of exercise/ leisure activity:** _____

Have you ever worked with chemicals, paints, asbestos, or other hazardous material? ☐ Yes ☐ No **Do you drink coffee?** ☐ Yes ☐ No _____ cups/ day

Please check any of the following that are NEW, UNUSUAL, or ATYPICAL for you:

- ☐ Difficulty breathing
- ☐ Regular cough
- ☐ Arm/ leg swelling
- ☐ Heart racing in your chest
- ☐ Difficulty swallowing
- ☐ Heartburn/ indigestion
- ☐ Constipation/ diarrhea
- ☐ Blood in stools
- ☐ Postmenopause
- ☐ Problems urinating
- ☐ Urinary incontinence
- ☐ Blood in the urine
- ☐ Stress at home or work
- ☐ Problems with balance
- ☐ Headaches/ migraines
- ☐ Shortness of breath
- ☐ Confusion
- ☐ Anxiety
- ☐ Pain insomnia
- ☐ Weight loss/ gain
- ☐ Nausea/ vomiting
- ☐ Dizziness/ lightheadedness
- ☐ Fatigue
- ☐ Weakness
- ☐ Fever/ chills/ sweats
- ☐ Numbness or tingling
- ☐ Tremors
- ☐ Seizures
- ☐ Double vision
- ☐ Change in vision
- ☐ Eye redness
- ☐ Skin rash
- ☐ Problems sleeping
- ☐ Sexual difficulties
- ☐ Night sweats
- ☐ Hearing problems
- ☐ Recently fallen down
- ☐ Joint/ muscle swelling
- ☐ Easy bruising
- ☐ Excessive bleeding

Patient Signature: _____ **Date** : _____/_____/_____

St. Lawrence Rehabilitation Center
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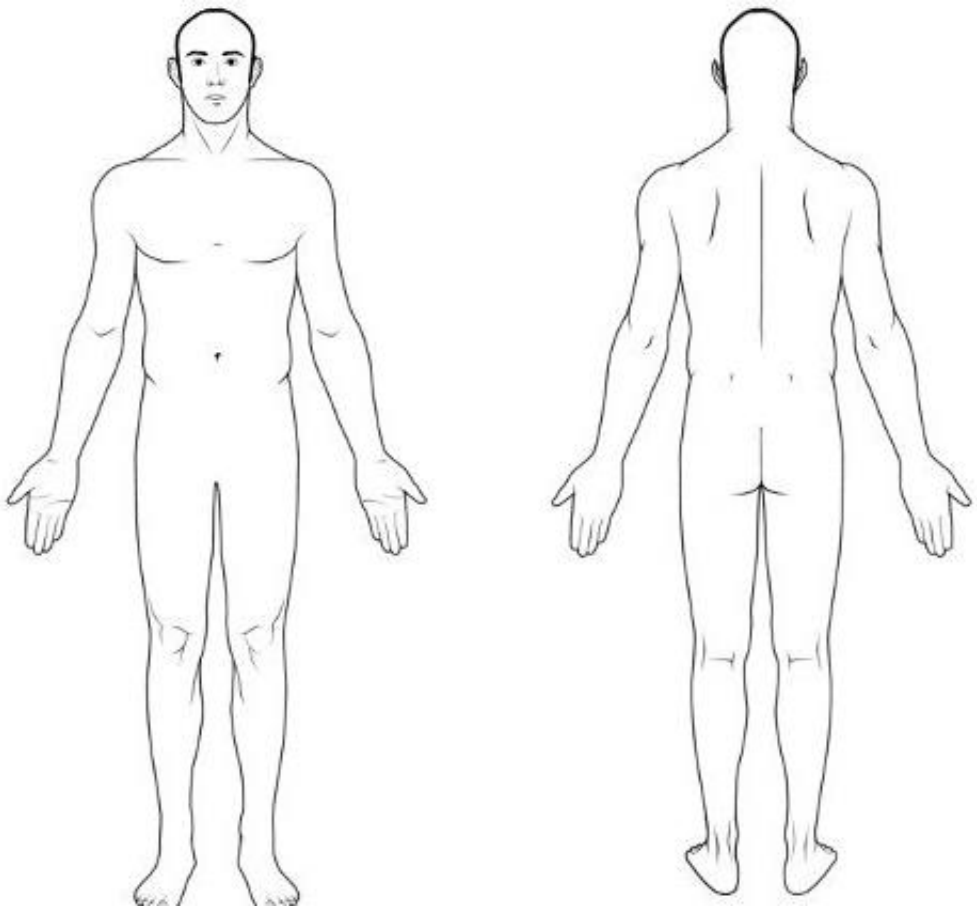
PAIN SURVEY

Indicate where your pain is located and what type you feel at the present time. Use the symbols below to describe your pain or simply shade in painful areas. Do not indicate areas of pain which are not related to your present injury or condition.

Symbol Key: /// Stabbing XXX Burning OOO Pins and Needles === Ache



☐ **I have no pain**

Rate your Pain: (0 = no pain, 10 = extremely intense/ worst pain)

Current Pain: 0 1 2 3 4 5 6 7 8 9 10

Best Over Past Week: 0 1 2 3 4 5 6 7 8 9 10

Worst Over Past Week: 0 1 2 3 4 5 6 7 8 9 10

Patient Signature: _____ **Date** : _____/_____/_____

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St. Lawrence Notice of Privacy Practices

I. THE NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

II. **St. Lawrence / Morris Hall will Safeguard Your Protected Health Information.**
We are required to extend certain protections to your PHI, and give you this Notice about our privacy practices that explains how, when and why we may use or disclose your PHI. Except in specified circumstances, we must use or disclose only the minimum necessary PHI to accomplish the intended purpose of the use of disclosure.

III. **Use and Disclosure of Your Protected Health Information.**
We have a limited right to use and/or disclosure your PHI for purposes of treatment, payment or our health care operations. For uses beyond that, we must have your written authorization unless the law permits or requires us to make the use or disclosure without your authorization.

IV. **Your Rights Regarding Your Protected Health Information.**
Your rights include, but are not limited to, the right to request access to, copy, and to request amendment to your PHI. You have the right to request restrictions to the use of your PHI.
Uses and Disclosures Requiring You to have an Opportunity to Object.
In the following situations, we may disclose limited PHI if we inform you in advance and you do not object, as long as it is not prohibited by law. If there is an emergency and you cannot be given opportunity to object, disclosure may be made if it is determined to be in your best interests. You must be given an opportunity to object to further disclosure as soon as your are able to do so.

Patient Directories: Your name, location, and general condition may be put into our patient directory for disclosure to callers or visitors who ask for you by name. Additionally, your religious affiliation may be shared with clergy.

To families, friends or others involved in your care: We may share with these people information directly related to their involvement in your care or related to payment. We may also notify them about your location, general condition, or death.

V. **Complaints related to our Privacy Practices.**
If you think we may have violated your privacy rights, or you disagree with a decision we made about access to your PHI, you may file a complaint.

VI. The Contact Person for Information, or to Submit a Complaint.
You may submit a complaint to the Privacy Officer, Frank MacLeod. You may also file a written complaint with the Secretary of the U.S. Department of Health and Human Services. We will take no retaliatory action against you if you make such complaints.

VII. **This notice was effective on April 14, 2003**

VIII. **Acknowledgment: I have received a copy of tis Notice.**

_____ _____

Printed Name Signature, Date