ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with Good Shepherd and GS Integrated Healthcare Systems, LLC's Notice of Privacy Practices ("Notice"):

- It informs me of how Good Shepherd will use my health information for the purposes of my treatment, payment for my treatment, and Good Shepherd's healthcare operations.
- The Notice explains in more detail how Good Shepherd may use and share my health information for purposes other than treatment, payment, and health care operations.
- Good Shepherd will use and share my health information as required/ permitted by law.

Patient's Complete Legal Name: _____
(please print)

Patient's DOB: _____ Date: _____

Signature: X_____
(Patient of Legal Representatives)

File in Patient Chart

GOOD SHEPHERD REHABILITATION
PATIENT CONTRACT/ RELEASE & INSURANCE AUTHORIZARION
EFFECTIVE APRIL 10, 2011

PATIENT CONTRACT

I, _____ , agree to comply with my Physician's recommendation to attend Good Shepherd Rehabilitation Program and the recommendations of the Therapist(s).

I will attend my therapy sessions regularly unless an emergency or crisis occurs. If I am ill or unable to attend, I will call the clinic to reschedule or cancel my therapy session.

If I fail to do so, I will be responsible to pay a NO CALL/ NO SHOW fee of $25.00

_____ X_____ _____
Patient Name | Patient Signature | Date

_____ _____ _____
Patient's Representative Name (If necessary) | Patient's Representative Signature (if necessary) | Date

PATIENT RELEASE & INSURANCE AUTHORIZATION

INSTRUCTIONS: PLEASE READ THE FOLLOWING INFORMATION CAREFULLY, INITIAL THE SPACES THAT APPLY.
PLEASE SIGN & DATE AT THE BOTTOM.

_____ I hereby give Good Shepherd Rehabilitation authorization for payment of insurance benefits made directly to Good Shepherd Rehabilitation and any assisting physicians, for services rendered.
_____ I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection and reasonable attorney fees. I further agree that a photocopy of this agreement shall be as valid as the original.
_____ I further authorize the release of any medical information required by my insurance carrier(s).
_____ I understand that I am financially responsible for charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

MEDICARE PATIENT RELEASE, AUTHORIZATION, & ACKNOWLEDGMENT

_____ I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct.
_____ I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers, any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.
_____ I am aware that Medicare and/ or insurance will not reimburse some cost/s (deductible) of my rehabilitation.
_____ I am aware the Medicare Law requires Good Shepherd Rehabilitation to make me aware that I will be billed for these non-reimbursable services.
_____ I HAVE READ THE ABOVE AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR PAYING ANY AND ALL CHARGES INCURRED IN THE REHABILITATION PROGRAM NOT REIMBURSED.

_____ X_____ _____
Patient Name | Patient Signature | Date

_____ _____ _____
Patient's Representative Name (If necessary) | Patient's Representative Signature (if necessary) | Date

Good Shepherd
Comprehensive Outpatient
Rehabilitation Facility
P.O BOX 777851
HENDERSON, NV 89077 – 7851
Tel. (702) 893 3333
Fax (702) 893 0095

General Consent for Care and Treatment Consent

TO THE PATIENT: *You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/ or procedure for any identified condition(s).*

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a physician, and / or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care provider or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____	_____
Signature of Patient or Personal Representative	Date
_____	_____
Printed Name of Patient or Personal Representative	Relationship to Patient
_____	_____
Printed Name of Witness and Signature	Employee Job Title

Good Shepherd
Comprehensive Outpatient Rehabilitation Facility

GOOD SHEPHERD REHABILITATION
COMPREHENSIVE REHABILITATION EVALUATION QUESTIONNAIRE
COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE

FIRST NAME	LAST NAME		DATE OF BIRTH
HEIGHT	WEIGHT	AGE	CHECK ONE: ☐ MALE ☐ FEMALE

MAIN DIAGNOSIS

IF DIFFERENT THAN DIAGNOSIS, WHAT CONDITION(S) BRINGS YOU TO GOOD SHEPHERD?

DO YOU HAVE A COPY OF YOUR CURRENT MEDICATIONS ON HAND? CHECK ONE: ☐ YES ☐ NO

HAVE YOU EVER RECEIVED ANY OF THE FOLLOWING THERAPIES PREVIOUSLY: (CHECK ALL THAT APPLY)
☐ PHYSICAL THERAPY ☐ OCCUPATIONAL THERAPY ☐ SPEECH THERAPY ☐ CARDIAC ☐ PULMONARY
EXPLAIN (WHEN & WHY): _____

ARE YOU SCHEDULED FOR ANY UPCOMING SURGERIES (BACK, KNEE, SHOULDER, HIP, LUNGS, STENTS, AND/OR PACEMAKERS)? CHECK ONE: ☐ YES ☐ NO IF SO, WHAT& WHEN? _____

ARE YOU CURRENTLY ON AN EXERCISE ROUTINE? CHECK ONE: ☐ YES ☐ NO
IF SO, PLEASE DESCRIBE (WHAT & TIMES PER WEEK): _____

ARE YOU CURRENTLY RECEIVING ANY THERAPIES? CHECK ONE: ☐ YES ☐ NO

ARE YOU CURRENTLY RECEIVING DIALYSIS? CHECK ONE: ☐ YES ☐ NO

ARE YOU CURRENTLY RECEIVING HOME HEALTH SERVICES? CHECK ONE: ☐ YES ☐ NO

MEDICAL HISTORY (CHECK ANY THAT APPLY):

☐ GASTRIC REFLUX ☐ ORTHOPEDIC COMPLICATIONS ☐ FAINTING SPELLS ARTHRITIS: ☐ GOUT ☐ OSTEOARTHRITIS ☐ RHEUMATOID
☐ SEIZURES ☐ MAJOR CHILDHOOD ILLNESS ☐ HISTORY OF FALLS
☐ VISION OR HEARING LOSS EAR: ☐ LEFT ☐ RIGHT EYE: ☐ LEFT ☐ RIGHT
☐ LOSS OF SENSATION WHERE & HOW LONG? _____
☐ NEUROPATHY
☐ CANCER WHERE? _____ WHEN? _____ ☐ CHEMOTHERAPY
☐ PROSTHETICS? EXPLAIN (WHERE & HOW LONG): _____
☐ SURGICAL ELECTRIC STIMULATION IMPLANTS ☐ STROKE (MONTH / YEAR): _____
☐ ANEURYSM (MONTH / YEAR): _____ ☐ HEART ATTACK (MONTH / YEAR): _____
☐ STENT IMPLANTED (MONTH / YEAR): _____ ☐ PACEMAKER / AICD (MONTH / YEAR): _____
☐ BYPASS (MONTH / YEAR): _____ ☐ VALVE REPLACEMENT (MONTH / YEAR): _____
☐ PAST SURGERIES (I.E. HIP, KNEE, LUNG, SHOULDER): _____
UNDER WENT A STRESS TEST: ☐ YES ☐ NO IF SO, WHEN? _____
PRIMARY DOCTOR NAME: _____ PHONE NUMBER: _____
CARDIOLOGIST NAME: _____ PHONE NUMBER: _____
DO YOU CHECK YOUR BLOOD PRESSURE AT HOME? ☐ YES ☐ NO RESTING RATE: _____

BACK →

Good Shepherd
Comprehensive Outpatient Rehabilitation Facility

GOOD SHEPHERD REHABILITATION
COMPREHENSIVE REHABILITATION EVALUATION QUESTIONNAIRE
COMPLETED BY PATIENT OR PATIENT REPRESENTATIVE
CONTINUED

RESPIRATORY HISTORY (CHECK ANY THAT APPLY):

☐ COPD ☐ RESPIRATORY INFECTIONS ☐ BRONCHITIS
☐ SINUS DIFFICULTIES ☐ EMPHYSEMA ☐ ALLERGIES
☐ ASTHMA ☐ WHEEZE ☐ SHORTNESS OF BREATH
☐ DAILY COUGH WHEN YOU COUGH DO YOU BRING UP MUCUS? ☐ YES ☐ NO IF YES, WHAT COLOR? _____

ARE YOU CURRENTLY ON O_2? ☐ YES ☐ NO IF YES, PLEASE LIST THE AMOUNT IN LITERS: _____

DO YOU SMOKE? ☐ YES ☐ NO IF YES, FOR HOW LONG? _____

DO YOU LIVE WITH A SMOKER? ☐ YES ☐ NO

DO YOU NORMALLY EAT? ☐ BREAKFAST ☐ LUNCH ☐ DINNER

DO YOU EAT SNACKS IN-BETWEEN MEALS? ☐ YES ☐ NO

DIABETES HISTORY (CHECK ANY THAT APPLY):

☐ DIABETIC ☐ BORDERLINE DIABETIC

DO YOU CHECK YOUR BLOOD SUGARS ROUTINELY? ☐ YES ☐ NO
DO YOU DOCUMENT YOUR CURRENT BLOOD SUGARS? ☐ YES ☐ NO
ARE YOU CURRENTLY ON INJECTABLE INSULIN? ☐ YES ☐ NO
ARE YOU ON AN INSULIN PUMP? ☐ YES ☐ NO
ARE YOU ABLE TO BRING YOUR OWN GLUCOMETER FOR EACH THERAPY SESSION? ☐ YES ☐ NO
ARE YOU ABLE TO ATTEND A THERAPY PROGRAM UP TO THREE(3) TIMES PER WEEK IF NECESSARY? ☐ YES ☐ NO

SLEEP HISTORY (CHECK ANY THAT APPLY):

PLEASE DESCRIBE HOW WELL YOU TYPICALLY SLEEP: _____

DO YOU TAKE PILLS TO HELP YOU SLEEP? ☐ YES ☐ NO
DO YOU SLEEP AT LEAST 6-7 HOURS IN A TYPICAL NIGHT? ☐ YES ☐ NO
DO YOU HAVE DIFFICULTY SLEEPING 3 TO 4 TIMES A WEEK? ☐ YES ☐ NO
DO YOU SNORE OR HAVE UNREFRESHING SLEEP? ☐ YES ☐ NO
DO YOU HAVE GASPING EPISODES DURING SLEEP? ☐ YES ☐ NO
ARE YOU CURRENTLY USING ANY SLEEPING DEVICES (I.E. BYPAP, CPAP, ECT.)? _____

SUMMARY OF PAIN (CHECK ANY THAT APPLY):

LOCATION: MARK AN X ON THE DIAGRAM IN THE AREA(S) THAT YOU EXPERIENCE PAIN

DESCRIPTION: ☐ ACHING ☐ DULL ☐ GRINDING ☐ SHARP
☐ SHOOTING ☐ THROBBING ☐ TINGLING

PAIN IS AGGRAVATED BY: _____
PAIN IS RELIEVED BY: _____

CIRCLE THE NUMBER WHICH BEST REPRESENTS YOUR PAIN TODAY:
NONE 1 2 3 4 5 6 7 8 9 10 WORST

AT THE ONSET OF PAIN IT
☐ ACUTE ☐ GRADUAL
☐ CHRONIC ☐ SUDDEN