MAJOR HAÜS
#58 North Montrose Avenue
P.O. Box N-4119
Nassau, Bahamas
Phone: (242) 601-5145

Email: info@majorchangesrehab.com
Website: www.majorchangesrehab.com
Facebook: www.facebook.com/majorchangesrehab
Instagram: www.instagram.com/majorchanges.rehab

MAJOR CHANGES Rehab Centre
www.majorchangesrehab.com

NEW PATIENT FORM - PERSONAL INFORMATION

Today's Date:

Patient Information

Last Name: _____
First Name: _____ MI: ____
Street Address: _____
P.O. Box: _____ City: _____ Island: _____
Email: _____
Home #: _____ Office #: _____
Mobile #: _____ Other #: _____
Marital Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed
Date of Birth: _____ Age: _____ Sex (M/F): _____
Occupation: _____
Employer's Address: _____
P.O. Box: _____ City: _____ Island: _____
Emergency Contact: _____ Relation: _____
Phone #: _____ Phone 2#: _____
Physician Name: _____
Phone #: _____

Responsible Party

Last Name: _____
First Name: _____ MI: ____
Street Address: _____
P.O. Box: _____ City: _____ Island: _____
Email: _____
Home #: _____ Office #: _____
Mobile #: _____ Other #: _____
Date of Birth: _____ Age: _____ Sex (M/F): _____
Occupation: _____
Employer's Address: _____
P.O. Box: _____ City: _____ Island: _____

Insurance Information

Primary Insurance: _____
Policy #: _____ Group #: _____
Claims Address: _____
P.O. Box: _____ City: _____ Island: _____
Insurance Phone #: _____
Policyholder Name: _____

Secondary Insurance: _____
Policy #: _____ Group #: _____
Claims Address: _____
P.O. Box: _____ City: _____ Island: _____
Insurance Phone #: _____
Policyholder Name: _____

How did you hear of us?

[ ] Friend/Relative [ ] Internet[ ] Yellow Pages [ ] Newspaper [ ] Insurance Directory
Referral – Name _____

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MEDICAL HISTORY FORM - PERSONAL INFORMATION

Patient Information – CHART: _____

TODAY'S DATE: _____

Referring Physician: _____

Last Name: _____ First Name: _____ MI: ____

Date of Birth: _____ Age: _____ Sex (M/F): _____

Marital Status: Single [ ] Married [ ] Divorced [ ] Widowed [ ]

Current Status

Which of the following describes you currently:

[ ] Working; If Yes, then Full Duties [ ] or Limited Duties [ ]

[ ] Not Working as a result of injury or pain

[ ] Not working as a result of other health problem

[ ] Homemaker, Retired or Unemployed

How long have you worked at your current job? _____

Does your job require lifting, standing, sitting? Yes [ ] No [ ]

Employer at time of injury: _____

YOUR Symptoms

Are your symptoms mostly in your back, neck, hand, legs or elsewhere? _____

How long have you endured these symptoms?

[ ] < 6 Weeks [ ] > 7-12 Weeks [ ] 4 Months or More

Is pain radiating past your knee or elbow? [ ] Yes [ ] No

Does your leg or arm ever go numb? [ ] Yes [ ] No

Have you lost bowel or bladder control? [ ] Yes [ ] No

Your pain is: [ ] Constant [ ] It Comes & Goes

Does pain wake you at night? [ ] Yes [ ] No

What makes the pain better? (Rest, Ice, Heat, Pills) _____

_____

What makes the pain worse? (Sitting, Standing, Lifting) _____

_____

Is pain radiating into the arm or leg? [ ] Yes [ ] No

If Yes, describe _____

Lost control over bowel or bladder functions? [ ] Yes [ ] No

If Yes, describe _____

Any weakness or numbness in arms or legs? [ ] Yes [ ] No

If Yes, describe _____

How long can you: Sit _____ Stand _____ Walk _____

Is your pain the result of a: [ ] Fall [ ] Auto Accident [ ] Other

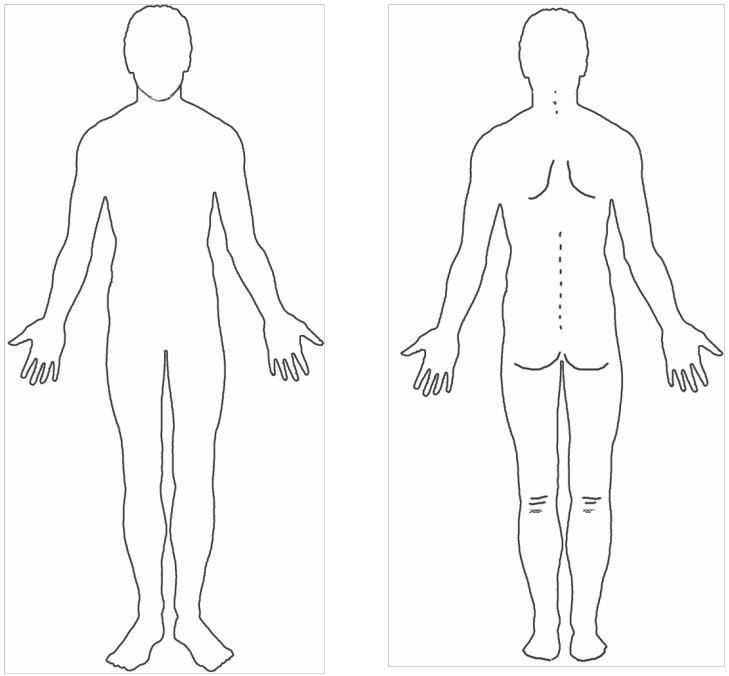
_____

YOUR Pain

Draw your pain on the diagrams shown. Use the corresponding symbols to show the type of pain you feel.

STABBING PAIN ////	**BURNING PAIN OOOO**
ACHING PAIN XXXX	**PINS & NEEDLES VVVV**
NUMBNESS ====	

FRONT **BACK**



Circle the pain level on a scale of 1 to 10, 10 being unbearable.

|----------|

1 2 3 4 5 6 7 8 9 10

Reviewed By: _____ Date: _____

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MEDICAL HISTORY FORM – PAGE 2

Previous Treatments & Tests

Name the doctor that first treated you for this problem

_____

Have you seen a spine surgeon in the past? [ ] Yes [ ] No
If Yes, Surgeon's name _____
What treatments did you have? _____

_____

Test you have had? [ ] CT Scan [ ] MRI [ ] X-Ray [ ] EMG [ ] Other

_____

Did you have any injections for your problem? [ ] Yes [ ] No
List: _____
Did these injections help? [ ] Yes [ ] No
If yes, please describe: _____
Did you have any previous back or neck surgery? [ ] Yes [ ] No
If yes, please describe: _____
Please list PREVIOUS SURGERIES and dates: _____

_____

_____

Have you ever had a blood transfusion? [ ] Yes [ ] No
If yes, please describe: _____
Have you had physical therapy for your problem? [ ] Yes [ ] No
If yes, please describe: _____
Did this therapy help? [ ] Yes [ ] No
If yes, please describe: _____
Do you do special exercises for your injury? [ ] Yes [ ] No
If yes, please describe: _____
List any medications you are taking? _____

_____

List other medications you have tried? _____

_____

What do you hope we can accomplish today? _____

_____

What other concerns do you have? _____

_____

Your Health

List any allergies that you have _____

_____

Do you have any adverse reactions to anesthesia? [ ] Yes [ ] No
If yes, please describe: _____
Do you smoke? [ ] Yes [ ] No If Yes, How many packs? _____
Do you drink alcohol? [ ] Yes [ ] No If Yes, How often? _____
Do you have any of the following medical problems?

AIDS / HIV	[ ] Yes [ ] No	Cancer	[ ] Yes [ ] No
Nerve Problems	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No
Arthritis / Joint Pain	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Stomach Problems	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No
Thyroid Problems	[ ] Yes [ ] No	Anxiety	[ ] Yes [ ] No
Psychiatric Prob.	[ ] Yes [ ] No	High BP	[ ] Yes [ ] No
Depression	[ ] Yes [ ] No	Migraines	[ ] Yes [ ] No
Heart Problems	[ ] Yes [ ] No	Swollen Ankles	[ ] Yes [ ] No
Bleeding Disorders	[ ] Yes [ ] No	Headaches	[ ] Yes [ ] No
Muscle Diseases	[ ] Yes [ ] No		

Recently have you had:

Fever / Chills	[ ] Yes [ ] No	Weight Loss	[ ] Yes [ ] No
Worse Pain at Night	[ ] Yes [ ] No	Chest Pain	[ ] Yes [ ] No
Shortness of Breath	[ ] Yes [ ] No	Night Sweats	[ ] Yes [ ] No

Other Problems _____

Your FAMILY Health History

Back / Neck Prob.	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No
AIDS / HIV	[ ] Yes [ ] No	High BP	[ ] Yes [ ] No
Arthritis / Joint Pain	[ ] Yes [ ] No	Cancer	[ ] Yes [ ] No
Migraines	[ ] Yes [ ] No	Headaches	[ ] Yes [ ] No
Arthritis / Joint Pain	[ ] Yes [ ] No	Diabetes	[ ] Yes [ ] No
Bleeding Disorders	[ ] Yes [ ] No	Epilepsy	[ ] Yes [ ] No
Muscle Diseases	[ ] Yes [ ] No	Heart Prob.	[ ] Yes [ ] No
Psychiatric Prob.	[ ] Yes [ ] No	Nerve Prob.	[ ] Yes [ ] No
Thyroid Problems	[ ] Yes [ ] No	Stomach Prob.	[ ] Yes [ ] No

Other Problems _____

_____

Reviewed By: _____ Date: _____

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CONSENT FORM

Financial Agreement

I hereby give authorization for payment of insurance benefits to be made directly to the provider and any assisting providers 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's fees, if required. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

Insurance authorization must be obtained before a patient is seen. If I do not inform the providers in this facility of my current insurance and the insurance is denied because of no authorization, I will be responsible for payment. If authorization is not obtained from the insurance company before my scheduled appointment and I still choose to be seen by the provider, I will be responsible for the bill at the time of service.

Privacy Notice

I hereby acknowledge that I have received a copy this facility's Privacy Notice. I further acknowledge that a copy of the current Privacy Notice is displayed in the reception area. Upon request, I will be offered a copy of any amended Privacy Notices.

PATIENT NAME:	
SIGNATURE:	
DATE:	
RELATIONSHIP:	

If unsigned by the patient, please indicate the relationship between the signee and the patient.

Consent for a Minor

I grant the providers associated with this facility the authority to administer treatments and perform such procedures as are deemed necessary for this patient.

PATIENT NAME:	
SIGNATURE:	
DATE:	
RELATIONSHIP:	

For Office Use Only

Date Received:
Copayment:
Authorization – Yes [ ] No [ ]
Processed By: Auth#:
Practice Follow-up – Yes [ ] No [ ]
Date of Follow-Up:

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CODE OF CONDUCT FORM
FOR PATIENTS, PARENTS & VISITORS

In an effort to provide a safe and healthy environment for our team and patients, Major Changes Rehab Centre expects patients, parents and accompanying family and visitors to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of patients and our team. To assist in providing this, all persons accessing the service of the practice are expected to observe the Practice Code of Conduct.

The Code of Conduct states:
Persons attending the practice whether in person, via telephone or video conferencing should behave in a manner that respects the rights of others and the practice environment.

The following behavior falls outside the code of contact and is therefore considered to be unacceptable:

- Physical assault or any form of threatening / aggressive gestures and / or actions
- Excessive noise obtrusive to others (staff, other patients and visitors)
- Use of threatening / abusive / intimidating / harassing or obscene behavior in any form
- Offensive language of a racial, cultural, sexual or personally derogatory nature
- Demands for appointments for services despite being advised they are full
- Theft or damage to property
- Inappropriate behavior involving alcohol / substance misuse
- Requests that would constitute illegal or unethical behavior

Any person acting in an unacceptable manner will be asked by a member of team to cease behavior and requested to observe the Code of Conduct. Failure to do so, could result in removal from the practice list.

Violent behavior (verbal or physical) is never tolerated and will result in police prosecution of the aggressor and the direct and immediate removal of the patient concerned from the practice list.

As a patient registered at Major Changes Rehab Centre, I confirm and have read, received and understood the Code of Contact and agree to abide by it.

PATIENT NAME:	
SIGNATURE:	
DATE:	

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PRIVACY NOTICE | YOUR PERSONAL HEALTH INFORMATION

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully. We understand that the privacy of your personal information is important to you. As your provider, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to ask us. We need to collect personal information about you and your family as part of our registration process, during the course of your care, and from other health care entities you utilize such as hospitals, laboratories, other physicians, imaging facilities and your insurance company. This personal information includes items such as your name, address, phone number, birth date, national insurance number, employer, health history, insurance policy and coverage information and any information you provide via our website. During the course of your treatment we will collect health information regarding diagnosis, treatment plans, progress and any test results or films.

HOW YOUR INFORMATION IS USED

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other physicians or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. We do not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies. We may contact you to provide appointment reminders or information about treatment alternatives or other health related-benefits and services that may be of interest to you.

SAFEGUARDING YOUR PERSONAL AND HEALTH INFORMATION

We are required to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you. We maintain physical, electronic and procedural safeguards to comply with regulations that guard your personal and health information. You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

I have read and received a copy of this Privacy Policy.

PATIENT NAME:	
SIGNATURE:	
DATE:	