1-877-REHAB13

(1-877-734-2213)

http://www.wellspan.org/offices-locations/ambulatory-services/rehabilitation/

ADAMS COUNTY LOCATIONS

Adams Health Center .... (717) 339-2620
Aspers Health Center .... (717) 339-2580
Deatrick Commons ..... (717) 339-2540
Fairfield Town Center.... (717) 642-6077
Herr's Ridge..... (717) 337-4206

YORK COUNTY LOCATIONS

Apple Hill ..... (717) 741-8240
Bannister Street ..... (717) 812-5850
Queensgate Towne Center.... (717) 812-5800
Red Lion..... (717) 851-7500
Shrewsbury ..... (717) 812-5600
SPORT Center Hanover ..... (717) 632-3431
Wheatlyn ..... (717) 812-7400
York Hospital Pediatrics..... (717) 851-2601

Welcome! Thank you for choosing WellSpan Rehabilitation for your therapy needs. We have a team of dedicated therapists who make high quality, personalized care a top priority. Wellspan Rehabilitation offers a variety of services including, but not limited to:

Physical Therapy – Guides you to restore and improve mobility

Occupational Therapy - Assists you through daily activities, including getting dressed, cooking dinner, performing at work and driving a car.

Speech Therapy - Coaches you to regain your communication skills and improve your swallowing ability

Registration - There are two options available for you to register for your rehab appointment. By doing so, our insurance team can verify your benefits prior to your arrival.

- Call **1.877.734.2213** and a rehab representative will be happy to assist you. Have your insurance card(s) available when you call. Hours for registration are Monday thru Thursday: 7:00 am to 5:00 pm and Friday: 7:00 am to 4:00 pm.
- You may choose to register online at **www.wellspan.org.**

Please **arrive 15 minutes** early for your appointment as there will be paperwork to complete on the day of your initial appointment. In addition, this provides our administrative staff the needed time to prepare your chart. Make sure you have your insurance card, photo ID, and a prescription from your doctor (if provided) available at your first appointment. **These steps will ensure that your therapist has more time to spend with you.**

Be sure to arrive wearing **comfortable, loose fitting clothing** that you are able to move around in.

If for any reason you are unable to keep this appointment, we ask that you please call the office at least 24 hours prior to your appointment. Feel free to contact us if you have any further questions. We look forward to seeing you soon!

Revised 9/11/14

Adam County Locations

WellSpan Rehabilitation at the Adams Health Center
Physical, Occupational, and Speech Therapy
Rehabilitation suite is down the first hall and will be on your right.
40 V-Twin Drive, Suite 101
Gettysburg, PA 17325
Phone: (717) 339-2620
Fax: (717) 339-2621

WellSpan Rehabilitation at Aspers
Physical Therapy
Proceed to the main reception area on left. Our receptionists will instruct you as to where to go for the rehabilitation suite.
2060 Carlisle Road
Aspers, PA 17304
Phone: (717) 339-2580
Fax: (717) 677-4452

WellSpan Rehabilitation at Deatrick Commons
Physical, Occupational, and Speech Therapy
16C Deatrick Drive
Gettysburg, PA 17325
Phone: (717) 339-2540
Fax: (717) 337-2977

WellSpan Rehabilitation at Herr's Ridge
Physical, Occupational, and Speech Therapy
Entrance to rehabilitation suite is on the left-hand side of the main lobby.
820 Chambersburg Road
Gettysburg, PA 17325
Phone: (717) 337-4206
Fax: (717) 334-9476

WellSpan Rehabilitation at Fairfield
Physical Therapy
4910C Fairfield Road
Fairfield, PA 17320
Phone: (717) 642-6077
Fax: (717) 642-6498

York County Locations

WellSpan Rehabilitation at Apple Hill
Physical, Occupational, and Speech Therapy
Utilize Entrance 3 and enter building at Entrance F, the rehab suite is located at 175.
25 Monument Road, Suite 175
York, PA 17403
Phone: (717) 741-8240
Fax: (717) 741-8131

York County Locations Continued

WellSpan Rehabilitation at Bannister Street
Physical, Occupational, Speech Therapy
1575 Bannister Street
York, PA 17404
Phone: (717) 812-5850
Fax: (717) 812-5865

WellSpan Rehabilitation Pediatrics
Physical, Occupational, and Speech Therapy
Enter the hospital through the terrace level. Follow signs to Pediatric Rehab
1001 South George Street
York, PA 17405
Phone: (717) 851-4875
Fax: (717) 851-4618

WellSpan Rehabilitation at Queensgate
Physical, Occupational, and Speech Therapy
2051 Springwood Road
York, PA 17403
Phone: (717) 812-5800
Fax: (717) 848-4535

WellSpan Rehabilitation at Red Lion
Physical Therapy
635 Lombard Road
Red Lion, PA 17635
Phone: (717) 851-7500
Fax: (717) 224-3730

WellSpan Rehabilitation at Shrewsbury
Physical, Occupational, and Speech Therapy
Upon entering building, first door on left.
73 East Forrest Avenue, Suite 210
Shrewsbury, PA 17361
Phone: (717) 812-5600
Fax: (717) 235-5705

SPORT Center Rehabilitation
Physical Therapy
207 Blooming Grove Road
Hanover, PA 17331
Phone: (717) 632-3431
Fax: (717) 633-5143

WellSpan Rehabilitation at Wheatlyn
Physical and Occupational Therapy
235 Rosedale Drive
Manchester, PA 17345
Phone: (717) 812-7400
Fax: (717) 268-0193

WELLSPAN HEALTH

☐ Gettysburg Hospital ☐ York Hospital
☐ Surgery and Rehabilitation Hospital

If label not available, please fill in below.

NAME: _____

DOB: _____

MRN: _____

MEDICAL HISTORY

List your telephone number or your preferred contact number _____.

List the date of your next appointment with the referring doctor _____.

•Do we have your permission to leave a message on your answering machine/voicemail? ☐No or ☐Yes

•Other than physicians involved in your care, is there anyone else we can speak with regarding your treatment?

☐No or ☐Yes If Yes, please list names: _____

What is your occupation? _____ Are you currently working? ☐No or ☐Yes

If you are working, do you have any work restrictions? _____

Are you on disability in relation to this problem? ☐No or ☐Yes

Are you currently taking any medications? ☐No or ☐Yes If Yes, please list your medications below:

_____

Check here ☐if you have provided a list to copy.

Do you have any allergies? ☐No or ☐Yes If Yes, please check or list your allergies below:

☐Tape ☐Latex ☐Medications _____

☐Other _____

Is your visit today from an injury? ☐No or ☐Yes If Yes, what is the date of injury _____

How did your injury occur? (please check)

☐Accident at work ☐Accident at home ☐Sports Injury ☐Car Accident

☐Unknown ☐Other _____

What medical tests have you had related to this condition? (please check)

☐None ☐X-ray ☐Bone scan ☐MRI ☐CAT scan ☐Spinal Stimulation ☐EMG/NCV

Do you have a pacemaker, defibrillator, or any other similar implant? ☐No or ☐Yes

Please list any previous injuries and/or surgeries _____

Is there any change in your bowel/bladder function? ☐No or ☐Yes

Medical Illness History (please check all boxes that apply):

☐Anemia	☐Circulatory problems	☐Hearing loss	☐Migraines/headaches
☐Arthritis	☐Depression	☐Heart problems	☐Osteoporosis
☐Asthma	☐Diabetes	☐Hepatitis	☐Pancreatitis
☐Back/neck injuries	☐Emphysema/COPD	☐Hiatal hernia	☐Prostate problems
☐Blood clot(s)	☐Epilepsy/seizures/convulsions	☐HIV	☐Smoker
☐Blood pressure	☐Fibromyalgia	☐Joint dislocation	☐Stroke
☐Cancer Type _____	☐Fracture/broken bones	☐Kidney stones	☐Thyroid disease
☐Chest pain	☐Head trauma/concussion	☐Ulcers	☐Tuberculosis

☐Other _____

Patient Signature: _____ Date: _____ Time: _____

Reviewed by: _____ Date: _____ Time: _____

WELLSPAN REHABILITATION – OUTPATIENT SERVICES

CONSENT & AUTHORIZATION FORM
TREATMENT, PAYMENT & BUSINESS OPERATIONS

Consent for Medical Treatment: I hereby consent and authorize Wellspan Rehabilitation – Outpatient Services, its agents, and employees, to the administration of medical care, including, but not limited to, routine diagnostic tests/procedures and such medical treatment as considered to be necessary by the ordering/attending physician, and/or his/her designee. I further understand that the physicians furnishing the services may be independent contractors who have been granted privileges or may be employees or agents of Wellspan Rehabilitation – Outpatient Services. Wellspan Rehabilitation – Outpatient Services cannot be held responsible for the acts of physicians who are independent contractors of the Wellspan Rehabilitation – Outpatient Services. I understand and have no objection to physicians in training or other hospital approved persons assisting in or observing my treatment when the purpose is to advance medical education.

Medicare Authorization: "Patients Certification Authorization to Release Information and Payment Request": I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Medical Assistance Recipient Statement: I certify that the information is true, correct and accurate. I understand that payment and satisfaction of this claim will be from Federal and State funds that any false claims, statements or documents or concealment of material facts may be prosecuted under applicable Federal and State laws.

Financial Agreement: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay Wellspan Rehabilitation – Outpatient Services in accordance with it's regular rates and terms and, if the account is referred to an attorney or agency for collection, to pay reasonable attorney's fees, collection expenses, court costs and other necessary and appropriate expenses incurred in collecting for services. The undersigned agrees to be responsible for charges not covered by insurance. It is understood that the obligation to pay Wellspan Rehabilitation – Outpatient Services may not be deferred for any reason, including legal actions against other parties to recover medical costs, and I consent to the release of information required for billing and collecting from third party payers".

Assignment of Benefits: I hereby assign to Wellspan Rehabilitation – Outpatient Services all medical and insurance benefits payable to me under the health insurance carrier(s). I understand that I am financially responsible for the charges not covered by this assignment.

My signature represents my acknowledgement of reading and understanding the statements. I have carefully read and understand this consent, authorization, and financial agreement, and accept the terms as initialed.

Signature of Person Authorized to Consent

Relationship to Patient

Date

Witness

Revised 3/2013