Rehab4LIFE
PHYSICAL & OCCUPATIONAL THERAPY

Patient Registration Information

Please complete the following information. Print clearly using a dark colored pen. Thank you!

Today's Date: _____

Last Name: _____ Frist Name: _____ MI: ___

Preferred Name: _____ Birth Date: ____ / ____ / _____

Gender: M F Cell Phone: _____ Home Phone: _____

Address: _____ City: _____ State: _____

Zip Code: _____ Email (optional): _____

Do you prefer appointment reminders via text or email? Text Email Neither

Please have proof of both primary and secondary insurance(s) available.

Primary Insurance

Insurance Company: _____

Policy Holder: _____

ID #: _____

Group #: _____

Address: _____

Secondary Insurance

Insurance Company: _____

Policy Holder: _____

ID #: _____

Group #: _____

Address: _____

Worker's Compensation or Personal Injury/Auto Injury Case, please complete the following:

Claim Number: _____ Date Claim was Opened: _____

Claim Contact Person: _____ Phone: _____

State of Accident: _____ Date of Accident: _____

Automobile Insurance Company: _____

Automobile Insurance Address: _____ City: _____ State: _____

Automobile Insurance ID #: _____

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Medical History and History of Present Condition

Name: _____ Referring Physician: _____

Height: _____ Weight: _____ Number of falls in the past year: _____

Reason for Visit Today: _____ When did symptoms begin? _____

Have you had surgery for this injury: ___ Yes ___No Date of Surgery: _____

Was the onset/timing of this episode: ☐ Gradual ☐ Sudden Any previous episodes? ___ Yes ___No

Have you had any imaging (X-Rays, MRI, etc.) done? ___ Yes ___No Results: _____

On a scale from 0-10, 0 being no pain and 10 being absolute worst pain, please rate your pain today:

0 1 2 3 4 5 6 7 8 9 10

Have you had any form of treatment prior to today's visit? ___ Yes ___No What kind? _____

Please list 3 specific activities that you are unable to perform or are having difficulty doing as a result of your current complaint. Rate you present ability to perform that task by circling the number below (10 being able to perform at pre-injury level).

Activity 1: _____ 0 1 2 3 4 5 6 7 8 9 10

Activity 2: _____ 0 1 2 3 4 5 6 7 8 9 10

Activity 3: _____ 0 1 2 3 4 5 6 7 8 9 10

Are you currently taking any prescription or non-prescription medications? ___ Yes ___No If yes, please list:

_____

_____

Please list any known medical conditions: _____

_____

_____

List any other information that would assist us in your care: _____

What are your rehabilitation expectations/goals while in this program? _____

_____

Patient/Guardian Signature: _____ Date: _____

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Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment can result in a cancel/no show charge.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **FINANCIAL POLICY:** A medical insurance policy is a contract between you and your insurance company. Coverage depends upon your insurance company and the specific plan you have chosen. Rehab4Life is contracted with most insurance companies and as a service to patients, we agree to submit your claims directly to them. You may need a current physician's prescription/referral for therapy services in order to submit your claim. In order for us to submit a claim to your insurance company, we will need a copy of your insurance card. Any questions you have regarding insurance coverage or benefits should be directed to your insurance plan.

   All patient cost shares (co-payments, co-insurances and deductibles) are due at the time of treatment. For patients with co-insurance and/or deductibles, we will be asking for a good-faith payment. A good-faith payment is an estimate of what you will owe. Once the insurance carrier adjudicates the claim, we may have to bill you for any remaining balance. _____ (initial)

   Medicare Patients: If you choose to schedule therapy without a physician's prescription/referral, we MUST obtain a signed therapy plan of care from your physician within 30 days of your initial visit. Also, you must be discharged from any home health care services or agency prior to initiating outpatient therapy. Medicare will not pay for both home health and outpatient care simultaneously. _____(initial)

   Motor Vehicle: We will bill your Auto Insurance as a courtesy to you. If you do not have a direct PIP Claim, you can choose to submit your personal health insurance or pay at the time of service._____(initial)

   Work Injury Claims: Medical expenses resulting from a workplace injury/disease will be submitted to the workers' compensation program on an open claim. However, if a claim is denied for any reason, the patient will be fully responsible for the total cost of the care provided._____(initial)

Cash-Pay Policy: We offer a prompt pay rate for services paid in full at the time of service. This discount is based on the administrative savings to our practice when receiving payments up front, rather than billing for services. We will not bill your insurance company for services provided under this arrangement. No forms will be produced now or in the future for you to submit claims for insurance billing._____(initial)

Rebilling Policy: It is the patient's responsibility to provide us with correct billing information. If incorrect billing information is provided and later the correct information is provided, but it is after the timely filing deadlines of your Payor, than you will be responsible for full bill._____(initial)

Unaccompanied Minors Policy: Rehab4Life is authorized to provide treatment to a minor as appropriate when they arrive to an appointment unaccompanied by a parent/guardian; this may include changes in the current therapy the minor is receiving including treatments and exercises. The above financial policy is applicable to guarantor of unaccompanied minor._____(initial)

4. **INSURANCE BENEFITS:** Rehab4Life as a courtesy, will attempt to verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. The responsible party understands that at times, insurance carriers will not provide accurate benefit information, hence it is the patients responsibility to understand their own insurance benefits. The responsible party understands that the verification of benefits and authorization is done as a courtesy and not a guarantee of payment and that they are responsible for all charges not paid by the insurance company._____(initial)
   Please note that refusal to sign this form does not change responsibility for payment in any way.

5. **ASSIGNMENT OF BENEFITS:** I hereby assign to Rehab4Life all my rights and claims for reimbursement under my health insurance policy and such other insurance policies as I may identify in my Insurance Verification Form given to Rehab4Life . I agree to provide information as needed to establish my eligibility for such benefits.

6. **CONSENT FOR EMERGENCY CONTACT INFORMATION**
   Person to contact in case of an emergency:

_____	_____	_____
Name	Telephone Number	Relationship

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____	_____
Signature of Patient or Legally Responsible Person	Date
_____	_____
Printed Name of above	Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, **Rehab4Life** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices which provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that the Notice of Privacy Practices may change at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand for **Worker's Compensation Cases**, the minimum necessary PHI/ePHI will be released to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that **Rehab4Life** is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____] Spouse/Children:_____

[_____] Other: _____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient

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PHYSICAL & OCCUPATIONAL THERAPY

At Home
Therapy Services

602 1st St S Casselton, ND 58012

701-346-0222 (office) 701-346-0223 (fax)

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to

release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Right to Revoke: I understand that I may cancel this authorization in writing at any time, but it will not affect any release of any information processed before I can cancel it.

Patient Signature: _____ Date Signed: _____

Parent/Guardian Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED.