Rehab 1 Network
Where Great Comebacks Begin…

1 PATIENT INFORMATION

Today's Date ______________________

Patient's Last/First ______________________
Address ______________________
City __________ State ______ Zip ______
Home Phone ______________________
Work Phone ______________________
Cell Phone ______________________
Email ______________________
Would you like to receive our Newsletter? □ Yes □ No
SSN ______________________
Sex ______ Date of Birth ______________
Employment Status: FT PT Retired Student Umpl
Marital Status______________________
Employer ______________________
Employer Address ______________________
City __________ State ______ Zip ______

Referring Physician ______________________
Primary Physician ______________________
Next MD Appt ______________________
Dx/Chief Complaint ______________________
____
Date of 1st. Symptom or Injury ______________

Was this an accident? [ ] Yes [ ] No
Accident Type [ ] Work [ ] Auto [ ] Other
Date of Accident ______________
State in which accident occurred ________
Have you received ANY previous therapy this year?
[ ] Yes [ ] No
Are you receiving Home Health services at this time?
[ ] Yes [ ] No

In Case of Emergency, please contact:

Name ______________________ Relationship ______________________
Home Phone ______________________ Work Phone ______________________

2 INSURANCE

Copay/Coins: ________ Ded ________ Auth: ________

Primary Insurance

Insurance Co.______________________
Member ID No. ______________________
Group No. ______________________
Insured's Last/First ______________________
Address ______________________
City __________ State ______ Zip______
DOB__________ Relationship: __________
Employer ______________________
Employer Phone______________________

Secondary Insurance

Insurance Co.______________________
Member ID No. ______________________
Group No. ______________________
Insured's Last/First ______________________
Address ______________________
City __________ State ______ Zip______
DOB__________ Relationship: __________
Employer ______________________
Employer Phone______________________

Appt Date __________ Therapist __________ Additional Appts ______________
Notes:

Confirmed Initial Appt: Yes No

3 Admission/Treatment Agreement

Consent to Medical and Related Health Care: I request and consent to the medical care and treatment procedures as determined necessary by my physician(s). I acknowledge the care I receive while in this facility is under the direction of my physician(s).

Medical and Allied Health Care Providers: I have been informed and understand that the Physical/Occupational Therapist providing services to me in this facility are not independent contractors and are employees of this facility unless otherwise specifically identified.

Teaching Programs: I understand this facility may, from time to time, enter into agreements with academic medical, and allied health program. Because of these agreements, physical/occupational therapy students may participate in my care. I agree to participate in these programs, but have the right to limit my participation at any time.

Patient Rights: I acknowledge access to the Patient Rights information explaining my rights as a patient of this facility.

Personal Property: I have been informed and understand this facility will not be liable for any loss of my personal property unless it is inventoried and placed in a secured area maintained by this facility.

Payment for Medical and Related Care, splints and durable medical equipment (DME): I agree to pay the charges incurred for the care I received as ordered by my physician(s) at this facility. I guarantee full payment of all charges unless restricted by Medicare. These charges include, but are not limited to if necessary, to stabilize an emergency medical condition. I also understand payment of Durable Medical Equipment is due the date of issue. I also agree to pay any copays and/or co-insurance charges at the time of service. There is a $10.00 fee for any and all returned checks.

In the event that I fail to pay these charges, I understand that I will be responsible for reasonable collection costs and attorney fees associated with the cost of resolving my account.

Assignment of Benefits: I hereby irrevocably assign and transfer to **THIS FACILITY** any and all benefits, either contractual, common law, or statutory, to which I am entitled or which are available to me under any medical, health, and accident, or workers' compensation policy, plan, or program. I hereby authorize and direct that any such payments be paid directly to **THIS FACILITY**. Should my insurance policy, or plan description, prohibit direct payment to providers, I direct the Payor to issue the provider a check payable to **THIS FACILITY** and myself. I further authorize and agree that a copy of this authorization shall be deemed valid as the original.

Cancellations or Late Arrivals: I understand, if possible, I will contact, **THIS FACILITY** for cancellations or late arrival. I understand two (2) consecutive missed appointments without notification may result in cancellation of all future appointments. I further understand if circumstances require my late arrival for the scheduled appointment, I may be asked to re-schedule.

I have read, understand and consent to the above agreement.

____

Patient Relationship Date

If patient is a minor:

I have read, understand and consent to the above agreement. Further, I give consent for treatment of the above named minor child by *Rehab1Network* and or its affiliated offices.

______________________ ____________

Parent/Legal Guardian Signature Date

Witness:

______________________ ____________

Facility Employee Signature Date

For Office Use Only

Revised 11/18/2009