COMMERCIAL INSURANCE
Patient & Payer Information Form

***All** Patients or Patients' Legal Representative, please complete all Sections*

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) ______-________ Home (_____) ______-________ Mobile (_____) ______-________ Work (_____) ______-________ Emergency

Email: ____

We use an automated reminder system to help reduce missed appointments. (If you choose the phone call, it can take awhile to kick in). What method would you prefer? ☐ phone call ☐ email ☐ text message

(2) Patient

Sex: M F

Birthdate: _____/_____/______

S.S # XXX/XX/_______

Legal Photo ID # ______________________
(Driver's License, Passport, Other State/Federal Photo ID)

Please tell us how you heard about us:____

(3) Condition to be treated in Physical Therapy: ______________________________

Date condition began? Date:____/____/____

Is it related to an auto accident? No Yes Date of accident ____/____/____

Is it a non-work related accident? No Yes Date of accident ____/____/____

Did this condition result in surgery? No Yes If Yes, date of surgery ____/____/____

Have You Had PT for this Condition? No Yes If Yes, Where?______________________________

Have you had chiropractic services for this condition? No Yes If Yes, where?______________________________
If Yes, when? ______________________________

(4) Patient's Doctor: Please list the Doctor who referred you to therapy or your Primary Care doctor

Office Phone: (____) _____-_______

Dr's Name: Last First Initial MD, DO, DDS, Other

Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

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(5) If Filing Insurance : Check A or B

A. ____ **Patient is the insured** (Do not need to complete the rest of #5 or any of #6)

B. ____ **Insured is ___Spouse ____Parent** (Complete all of #5 and all of #6)

____

Name: Last First Initial Sr./Jr.

____

Address: Street Apt.# City State Zip Code

Phone: (___) ____-______ (___) ____-______ (___) ____-______ (___) ____-____
Home Mobile Work Emergency

(6) Insured Person:

Complete if not the patient

Date of Birth: ____/____/____ **S.S. #** XXX/XX_______

Legal ID # ____________ **Insured's Sex: M F**

___ **Employed** ___ **Unemployed** ___ **Retired**

(7) Employer Information (Please complete if the insured person's employer is the source of benefits)

Employer Name: ______________________________ **Employer Phone # (   )** _____- ______

Address: ____ ________________
Street City State Zip Code

Name of Employer Contact: ___________________________ **Contact's Phone # (   )** _____- ______

(8) Payer Information:

Primary Insurance Company:

Ins. Co. Name: ________________ **Insured's Name:** _______________ **Ins. Ph #**_____________

Patient ID #: ___________**Group. #** ___________ **Policy/Plan #:** _____________________

Secondary Insurance Company: (If YES, please complete) **Insured is:** _____**Patient** _____**Spouse** _____**Parent**

Ins. Co. Name: ________________ **Insured's Name:** _______________ **Ins. Ph#**_____________

Patient ID #: ___________**Group. #** ___________ **Policy/Plan #:** _____________________

Claims Mailing Address:____
Street City State Zip Code

Employer Name: ______________________________ **Employer Phone # (   )** _____- ______

Address: ____ ________________
Street City State Zip Code

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(9) Medications : (This includes prescriptions, over the counter drugs, herbal and nutritional supplements)

Medication/Drug or Supplement Name	Prescription		Dosage	Frequency Per Day				Route of Administration				
	Yes	No		1	2	3	4	Oral	IV	Injection	Patch	Other

(10) Payment Authorization: *(Initials required for all 3 statements)*

_________ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Rx Rehab for all services delivered; if I am paid directly I will promptly pay Rx Rehab all monies paid to me**

_________ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date**

_________ **Certification of Information**

Initials **I certify that the information I have provided Rx Rehab for payment including, but not limited to, Related accidents, illnesses or other insurers is accurate and truthful**

(11) Signature/ Date:

____ ______________

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 11 on Page 3

Informed Consent for Therapy Services

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information and I consent to the evaluation(s) and treatment provide by Rx Rehab Physical Therapy.

____

Signature

____

Print name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Rx Rehab Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Rx Rehab Physical Therapy to release any of my protected healthcare information.

____
Patient's or Authorized Representative's Printed Name & Date

____
Patient's or Authorized Representative's Signature

Copyrights Protected By BCMS, Inc.
Written Authorization For Use Required

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

(1) **Patient's Printed Name**:

____
Last First Initial or Other

Date of Birth: ____/_____/___ Insurance # exactly as on card (including letters)___________________

(2) Rx Rehab will only disclose the protected health information you want disclosed.
Check only one box to tell Rx Rehab the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at Rx Rehab to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination ______ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History ______ Treatments _____Other- ________________________________

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: ______________________________ Attorney: ______________________________
Parent: ______________________________ Employer: ______________________________
Friend: ______________________________ School: ______________________________
Other: ____General Public______________________ Other: ______________________________

(5) Check only one box indicating how long Rx Rehab can use this authorization:

☐ Disclose my information indefinitely (as long as Rx Rehab has custody of my files)

☐ Disclose my PHI for the following period beginning ___/___/_______ and ending ___/___/________

(6) Please initial all items below indicating that you have read and understand the rights or information below:

_______ I understand that this authorization does not expire unless I have indicated an expiration date above
_______ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
_______ I understand that if I give authorization I may revoke it at any time by notifying this Rx Rehab in writing
_______ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
_______ I understand that if Rx Rehab requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
_______ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
_______ Rx Rehab will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

______________________________ **or** ______________________________
Signature of Patient **Date** **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**

You May Refuse to Sign this Authorization