Self Pay Patient 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 ____/____/____
Is it a 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? _____

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

Self Pay Patient Form

(4) Insured Status:

Are you insured by:

Medicare: No Yes If yes, please note we are required by Medicare to submit claims for services we provide to you unless you do not permit us to file your claims. Do you understand and still wish to self-pay No Yes If no, we will need to provide you with a different form. If yes, do not complete page 2 and go straight to page 3.

Commercial Insurer? No Yes If yes, do you want us to file your claims if we are in network? No Yes. If yes, please complete page 2 & 3; if no, don't complete 5, 6, 7, 8 & 9 please sign # 10 on page 3: If we are out of network would you like us to provide you with information to self-file your claims No Yes. Please go directly to page 3 and sign # 10.

(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 this page)

Name: Last First Initial Sr./Jr.

Address: Street Apt.# City State Zip Code

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

(6) Insured Person:

Complete if the insured not (you) 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 is the source of benefits)

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

Address: _____ _____
Street City State Zip Code

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

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

Self Pay Patient Form

(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

(9) 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, copayment 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 insurance information is accurate and truthful.**

(10) Signature/ Date:

_____ _____

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

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

Missed Visit Policy

At Rx Rehab Physical Therapy, our goal is to help all patients reach a fully recovered state. Your physical therapist will provide you with your plan for care during the evaluation appointment and will inform you of the required number of visits to help you achieve your goals. Patients who attend all of their physical therapy visits are 93% more likely to fully recover from an injury whereas those that miss even one visit have a lower potential for recovery. We are happy to share a copy of this study with you but want to make sure that you understand that it is extremely important that you attend all of appointments. This policy ensures that all patients have the opportunity to receive the care they need.

Please read our policy and sign at the bottom indicating you understand our expectations and our policy.

1. As experts, we know that **you will not reach full recovery if you do not attend your appointments**. To help ensure you have the best chance at recovery, we will work with you to schedule out all of your appointments after your evaluation today and in order to have the best chance at recovery, you will need to attend each visit.
2. Please note: Our goal is to begin your treatment sessions on schedule. For all appointments after your evaluation, we expect that you will arrive at least 5 minutes prior to your appointment time, dressed for your session, and ready to begin at on time. This will allow our front office to handle their responsibilities and our specialists to provide the care you need and deserve.
3. If you're late for your appointment, you're missing the time that we have specifically scheduled for your care and we cannot guarantee that we will be able to provide you with your full treatment as we have likely reserved the appointment time following yours for someone else.
4. If you're running late, we need you to call us immediately so we can prepare for your late arrival and consult with your clinician. If you are more than 15 minutes late, your session may need to be rescheduled and if that occurs, you will incur a missed visit charge. Chronically late patients will be asked to change their appointment times.
5. Our schedule is very full and certain time slots are not always available for patients who need them. If you need to cancel or change a scheduled appointment, for any reason, we require a day's notice **during business hours, so we have enough time to help someone else who needs an appointment time.**
6. When you call to cancel an appointment, have your schedule ready as we will reschedule you right away.
7. Same-day cancellations and appointment no-shows are not permitted as they keep other patients from getting the care they need.
8. There is a $50 charge **if you do not provide at least a days' notice of your appointment change or cancellation. This is non-negotiable and it's your responsibility as insurance will not cover it.**
9. While we understand that illness can strike at any time, we still expect that you will work to provide at least a day's notice if you cannot attend a scheduled appointment.
10. **To avoid our missed visit fee, call our office during business hours - at least ONE DAY in advance for any illness, appointment changes or cancellations.**
11. Patients who have multiple same-day cancellations or no-shows, will be removed from the schedule. If applicable, we will also notify your physician of your non-compliance.
12. If you're worker's comp, we are required to notify your claims adjuster if you cancel or no-show.

We look forward to working with you to meet your physical therapy goals.

Scott Christensen, Owner

I have read this policy and by signing below I am indicating that I understand and this policy.

Patient Signature	Patient Name	Date

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

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