Farmington SPORTS & REHAB Physical & Hand Therapy

Registration Form

General Information

Have you been treated by us before? ☐ Yes ☐ No

Last Name _____ First Name _____ Middle Initial _____ Gender: ☐ Male ☐ Female

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Age _____ Occupation / Employer _____

Street Address _____ City _____ State _____ Zip Code _____

Cell Phone (_____)_____ Home Phone (_____)_____ Work Phone (_____)_____

E-mail Address _____ Marital Status _____

Parent / Guardian's Name (if under 18) _____ Parent's S.S.N. _____-_____-_____ Parent's D.O.B. _____/_____/_____

Emergency Contact _____ Relationship to Patient _____ Emergency Contact Phone Number (_____)_____

Primary Insurance (Insurance Cardholder Information)

Insurance Company _____ Member I.D. _____ Group Number _____

Last Name _____ First Name _____ Middle Initial _____ Gender: ☐ Male ☐ Female

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Age _____ Relationship to Patient _____

Street Address _____ City _____ State _____ Zip Code _____

Cell Phone (_____)_____ Occupation / Employer _____ Work Phone (_____)_____

Secondary Insurance (Insurance Cardholder Information)

Insurance Company _____ Member I.D. _____ Group Number _____

Last Name _____ First Name _____ Middle Initial _____ Gender: ☐ Male ☐ Female

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ Age _____ Relationship to Patient _____

Street Address _____ City _____ State _____ Zip Code _____

Cell Phone (_____)_____ Occupation / Employer _____ Work Phone (_____)_____

Office Policies

Appointment Reminder Service

☐ Please send me email messages to confirm my upcoming appointments to my email address listed on my patient registration.

☐ Please send me cell phone text messages to confirm my upcoming appointments to my cell phone number as on my patient registration. ***I recognize that normal text messaging rates may apply.***

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

☐ AT&T ☐ T-Mobile ☐ Boost Mobile ☐ US Cellular ☐ Cricket

☐ Verizon ☐ Nextel ☐ Virgin Mobile ☐ Sprint PCS ☐ Other:_____

Healthcare Privacy Notice

With my consent, Farmington Sports and Rehabilitation Center may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Farmington Sports and Rehabilitation Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Farmington Sports and Rehabilitation Center reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to **Farmington Sports and Rehabilitation Center, 602 Maple Valley Drive, Farmington, Missouri 63640.**

With my consent, Farmington Sports and Rehabilitation Center may call my home or other designated location and leave a message on my voicemail or in person in reference to any item that assists the practice of carrying out my treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Farmington Sports and Rehabilitation Center may mail to my home or other designated location any item that assists the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

With my consent, Farmington Sports and Rehabilitation Center may e-mail to my home or other designated location any item that assist the practice of carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Farmington Sports and Rehabilitation Center restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and healthcare services. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By singing this form, I am consenting to Farmington Sports and Rehabilitation Center's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Farmington Sports and Rehabilitation Center may decline to provide treatment to me.

Informed Consent

I have been informed that Farmington Sports and Rehabilitation Center is certified to provide outpatient rehabilitation services according to the plan of treatment established by my attending physician or the medical director of Farmington Sports and Rehabilitation Center and the facility rehab team. I understand and accept treatment accordingly.

Assignment of Benefits

I hereby assign medical and / or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans to **FARMINGTON SPORTS AND REHABILITATION CENTER**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am responsible for paying remaining charges that are not covered by said insurance company, if any. I hereby authorize said assignee to release all information necessary to secure payment.

Medicare Beneficiaries Only

Under Medicare Medical insurance (Part B), Medicare will pay Farmington Sports and Rehabilitation Center 80% of the rehabilitation fee schedule, if the client satisfies the following conditions:

A. The client must satisfy the deductible in the current year. Medicare will typically pay 80% of the bill after the deductible has been satisfied.

B. This form must be signed by the client or the responsible party, giving us permission to bill 80% to Medicare and 20% (co-insurance) plus any deductible not-met, to the client or the insurance company.

C. If the client does not have sufficient funds to cover the 20% coinsurance and deductible, a Medical Indigence Determination form may be requested and, if the client meets the criteria, no further requests for payment will be made.

Beneficiary Notification of the Therapy Cap: Medicare is expected to allow up to $1,980 annually for outpatient occupational therapy services and the same amount for outpatient physical and speech therapy services combined. The allowed amount is determined by the Medicare Physician Fee Schedule, less the coinsurance (20%) and any deductible. If the deductible has been met prior to submitting the therapy claim, then under Medicare Part B the client pays 20% and Medicare will typically pay 80% of the allowed amount. Therefore, the cap would limit incurred expenses for occupational therapy services to $1,980 per calendar year and the same amount for physical therapy and speech therapy combined, with the client being responsible for 20% (or $396) of the incurred expenses, and Medicare paying $1,584 (or 80%) of the $1,980. Although more therapy may be medically warranted beyond the caps, additional therapy will not be covered by Medicare unless Congress reinstates the therapy cap exceptions process to ensure that Medicare beneficiaries who qualify can continue to access the medically necessary therapy services they need under Medicare Part B. This provision for an extension of the therapy caps exceptions process, if passed by Congress, would ensure Medicare beneficiaries continued access to medically necessary therapy services. (Legislation has extended the statutory authority to continue the therapy caps exceptions process through December 31, 2017).

I authorize treatment and payment of medical benefits to Farmington Sports and Rehabilitation Center for services rendered as ordered by physician. I further authorize Farmington Sports and Rehabilitation Center to furnish medical or other information to all parties involved in the ordering, provision of, or reimbursement of these therapy services and to my physician, and / or any third party payors.

I understand that I am responsible for all charges (including charges the insurance does not cover).

Cancellation Policy

There is a $45 charge for missed or cancelled appointments without 24 hours advanced notice. We have scheduled an agreed upon time especially for you which is now lost. We are unable to bill your insurance for this amount. We want to get maximum results from therapy and this means attending therapy on a regular basis. If you have more than three “no shows” you will be discharged from therapy.

Financial Policy

We are committed to providing you the best possible care at Farmington Sports and Rehabilitation Center, and we are pleased to discuss professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask the administrative staff if you have any questions about our fees, financial policy, or your responsibility.

- Payment is due at the time services are rendered.
- All co-insurances, co-payments, and deductibles are due as services are rendered.
- We will submit all billing to insurance companies as a courtesy for our clients; however, we will collect co-insurance charges, co-payments, and deductibles at the time of each visit.
- Verification of insurance benefits does not guarantee payment. I understand that I am responsible for all charges including those not covered by insurance and all collection costs including agency fees and attorney fees.
- All Workers' Compensation injuries must be verified and approved for eligibility by the facility administrative staff prior to receiving treatment. Approved Workers' Compensation cases will be excluded from payment at the time of service.
- Your insurance coverage is a contract between you and your insurance carrier. We will help to explain your benefits to you.
- If your insurance dos not remit payment within 60 days, the balance will be due in full from you.
- Any money paid to you by your insurance company for services billed and rendered by Farmington Sports and Rehabilitation Center or any of its associates shall be paid to Farmington Sports and Rehabilitation Center immediately upon receipt. Failure to do so is illegal.
- I authorize payment of medical benefits from my insurance to **FARMINGTON SPORTS AND REHABILITATION CENTER** and release any medical information relating to all claims for benefits submitted on behalf of myself and / or dependents.
- By signing below, I understand my responsibilities as outlined in the above Financial Policy.

□ Your insurance deductible is $_____ per year. You have met $_____ of your deductible.

□ Your co-insurance amount is _____ per visit or approximately $_____ per visit.

□ Your co-payment is $_____ per visit.

□ Your insurance allows _____ visits per calendar year / per diagnosis. You have used _____ visits.

□Your insurance has authorized _____visits at this time.

THIS IS NOT A GUARANTEE OF PAYMENT.

THIS OUTLINE IS BASED ON INFORMAITON PROVIDED BY YOUR INSURANCE COMPANY.

Patient Consent and Signature

By my signature below I agree to abide by above policies and acknowledge that I have read, or have had read to me, and have received a photocopy upon my request of this document including the Health Care Privacy Notice, facility terms and conditions, financial policies (including Medicare policies if applicable), and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

_____
Print Name of Patient

_____ _____/_____/_____
Patient Signature (Parent / Guardian if patient is a minor) Date

_____ _____/_____/_____
Witness Signature (Staff Only) Date

Past Medical History

- What made you choose us for your therapy needs?_____
- What injury / symptoms brought you to therapy?_____
- What is the date of injury or recent onset of symptoms? _____/_____/_____
- Check which apply to your symptoms:

☐ Athletic / Recreational Injury ☐ Injury Related To Fall ☐ Injury Related To Lifting

☐ Recurrence of Previous Injury ☐ Cause Unknown ☐ Other:_____

☐ Work Related Injury. If checked, has your employer been notified? ☐ Yes ☐ No

☐ Motor Vehicle Accident / Auto Accident

- Have you retained an attorney regarding this injury? ☐ Yes ☐ No If yes, who?_____
- Description of injury:_____

_____

- Are you here because you had surgery? ☐ Yes ☐ No If yes, please describe:_____
- Date of next physician's visit: _____/_____/_____
- Do you have any special needs or requests?_____
- Do you have, or have you had, any of the following?

	Yes	No		Yes	No
Diabetes	☐	☐	Allergies to Aspirin	☐	☐
High Blood Pressure	☐	☐	Allergies to Heat or Cold	☐	☐
Heart Disease	☐	☐	Allergies to Latex	☐	☐
Heart Attack	☐	☐	Other Allergies	☐	☐
Heart Palpitations	☐	☐	Hernia	☐	☐
Chest Pain / Angina	☐	☐	Seizures	☐	☐
Pacemaker	☐	☐	Metal Implants	☐	☐
Headaches	☐	☐	Dizziness / Fainting	☐	☐
Are you Pregnant?	☐	☐	Surgeries	☐	☐
Cancer	☐	☐	Skin Abnormalities	☐	☐
Osteoporosis	☐	☐	Sexual Dysfunction	☐	☐
Bowel / Bladder Abnormalities	☐	☐	Nausea / Vomiting	☐	☐
Urine Leakage	☐	☐	Ringing in your ears	☐	☐
Asthma / Breathing Difficulties	☐	☐	Rheumatoid Arthritis	☐	☐
Liver / Gallbladder Problems	☐	☐	Osteoarthritis	☐	☐
Smoking-related Diseases	☐	☐	Hypoglycemia	☐	☐
Stroke / CVA	☐	☐	Special Diet Guidelines	☐	☐
Other:_____				☐	☐

Do you smoke or use tobacco products? ☐ Yes ☐ No Frequency: _____

Do you drink alcohol? ☐ Yes ☐ No Frequency: _____

If yes on any of the previous questions, please briefly explain and give approximate date:

_____
_____
_____
_____

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Do you have any drug allergies? ☐ Yes ☐ No If yes, please list:

_____
_____

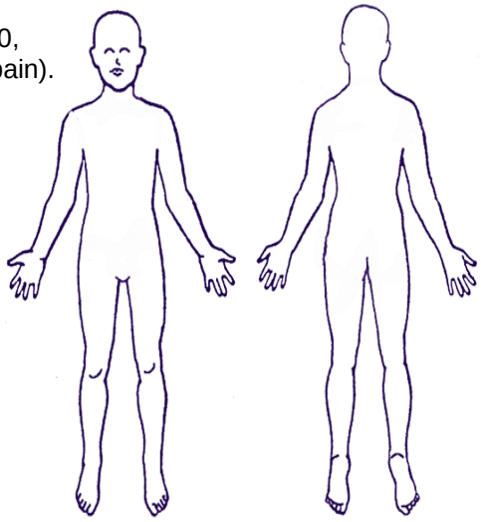
Do you participate in any sports, exercise programs, or activities on regular basis? ☐ Yes ☐ No

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, (with 0 being no pain and 10 being the worst pain possible, Emergency Room pain).

Pain Rating Now: _____

Pain Rating (Best): _____

Pain Rating (Worst): _____



Please indicate location of symptoms:

KEY:

======== Numbness
OOOO Pin & Needles
XXXX Burning Pain
////////// Stabbing Pain

_____ _____/_____/_____
Patient's Signature Date

_____ _____/_____/_____
Parent / Guardian if patient is a minor Date

I have reviewed the past medical history.

_____ _____/_____/_____
Therapist's Signature Date