

Patient Registration

(Please complete all pages. Thank you.)

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)			MAILING ADDRESS	
PHYSICAL ADDRESS			SOCIAL SECURITY NUMBER	DATE OF BIRTH
CITY	STATE	ZIP		
HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER	CELL PHONE NUMBER	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> (circle one)	

****If you have received HELP in the HOME (bathing, aide help, therapy, nurse visit) in the past three months please stop here, and speak to the Receptionist.**

Receptionist call (866) 211-5708 for Medicare patients _____ (initials)

How did you hear about us? Check one Doctor ____ Advertisement/Radio ____
 Friend/Relative (who?) _____ Other _____

WHO IS FINANCIALLY RESPONSIBLE FOR TREATMENT?

Myself My Spouse My Parent(s) Other Responsible Party _____

INSURANCE INFORMATION

Primary Insurance Company:	Secondary Insurance Company:
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POLICY HOLDER'S INFORMATION (If NOT the patient)

NAME	RELATIONSHIP TO PATIENT	SOCIAL SECURITY NUMBER
ADDRESS (if different from above)		DATE OF BIRTH
CITY	STATE	ZIP
HOME TELEPHONE (if different from above)		

IS THE POLICY HOLDER CURRENTLY EMPLOYED BY THE EMPLOYER PROVIDING INSURANCE? YES NO N/A **ON MEDICAL LEAVE?** YES NO N/A

EMPLOYER NAME _____ EMPLOYER TELEPHONE NUMBER _____

EMERGENCY CONTACT (not living with you)

NAME (Last, First, Middle Initial)	RELATIONSHIP TO PATIENT
ADDRESS	TELEPHONE #
CITY	STATE
ZIP	

Workers' Comp On-the-job Injury? <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of injury:
Employer Name & Contact Person
Employer Phone Number:

Informed Consent for Treatment

COMPLETE IF OVER THE AGE OF 18 YEARS OF AGE:

The undersigned, being over the age of eighteen (18) years and being under no disability or prohibition that would in any way prevent or affect the Consent and Release, does hereby represent that, I _____ (patient), consent to rehabilitation treatment as prescribed by my provider.

COMPLETE IF THE PATIENT IS A MINOR OR WHEN THE ADULT PATIENT IS NOT COMPETENT:

In the treatment of _____ (minor/adult patient), I _____, patient representative, of said minor/adult consent to rehabilitation treatment as prescribed by minor's/adult's provider. My relationship to the patient is (i.e parent, son, daughter, etc) _____.

I certify that the information I have provided is complete and true to the best of my knowledge.

I give my authorization for treatment records to be released to the responsible payor for reimbursement consideration, or medical facility necessary for treatment or further care. Additionally, I request that any medical records requested by this facility, necessary for treatment or further care, be forwarded to this facility upon its request.

I understand that I am financially responsible for all charges whether or not paid for by said insurance (i.e. deductible amounts, co-insurance, co-pay, or any other balance not paid by my insurance). If this account is assigned to an attorney for collection and/or suit, the facility shall be entitled to reasonable attorney's fees and costs of collection.

I request that payment of authorized benefits be made on my behalf to this facility. I assign the benefits payable to which I am entitled to this facility for services rendered. This assignment will remain in effect until revoked by me in writing. A photocopy and/or facsimile of this assignment is to be considered as valid as an original.

I have received a copy of the Notice of Privacy Practices for Integrity Rehab. Integrity Rehab reserves the right to modify the privacy practices outlined in the notice.

I have read the foregoing and I understand it. Any questions that have arisen or occurred to me have been answered to my satisfaction.

Patient or Patient Representative Signature

Date

Witness

Date

Financial Policy

This is an agreement between **Integrity Rehab**, as creditor and the Patient/Debtor named on this form.

In this agreement the words “you”, “your”, and “yours” mean the Patient/Debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we”, “us”, and “ours” refer to Integrity Rehab dba Integrity Rehab.

By executing this agreement, you are agreeing to pay for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. No more than 2 statements will be sent if payment is not received.

Payments: Unless we approve other arrangements, the balance of your statement is due and payable when the statement is issued, and is past due if not paid within 21 days.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

Required Payments: Any co-payments required by an insurance company must be paid at the time of service. This is required by your insurance. Any deductibles are due at the time of service. Coinsurance will be handled on a case by case basis.

Payment if you have no insurance:

You choose to pay cash, check or credit card (MasterCard or Visa) on the day that treatment is rendered.

Payment plans may be available on a case-by-case basis. Please let us know today if you will be needing arrangements for a payment plan.

Payment options if you have insurance:

1. You will be asked to pay deductible, co-pays and possibly coinsurance (i.e. % insurance does not cover) at the time of service. This is payable by cash, check or credit card. (MasterCard or Visa)
2. Your insurance will be called prior to treatment and we will attempt to contact you to discuss financial arrangements if your insurance policy benefits state that

you have a deductible, co-pay, or coinsurance amount in which you will be responsible for.

3. Any deductibles not yet met will be due and payable by you on the day of service.
4. Any co-pay will be due and payable by you on the day of service.

Insurance: Insurance is a contract between you and your insurance company. An insurance card must be made available to us before you are seen as a patient. Even though we may estimate what your insurance will pay, it is the Insurance Company that makes the final determination of your eligibility. You are responsible for any amount not paid by the insurance less the amount written off due to a contract we may have with your insurance company. If your insurance requires a referral or authorization, you are responsible for obtaining it. Often we can do this for you. Failure to obtain the referral or authorization may result in reduced payment from the insurance company.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment (signing consent) for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment cost, it is the authorizing parent’s responsibility to collect from the other parent.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your debt to a collection agency, you agree to pay additional collection costs incurred from address searches, credit reports or attorney fees which can possibly equal 50% of the balance due. We may also take the claim to Small Claims Court. You agree to pay any court fees incurred in trying to collect the past due balance. We have the option to report your account status to any credit reporting agency such as credit bureaus.

Returned checks: There is \$25.00 fee for any checks returned by the bank. We prefer payment in cash on accounts with history of a returned check.

Missed appointments: We strive to respect the rights of all patients to access therapy services by maintaining continuity of scheduling. The second time a patient does not show up on time for an appointment, or cancels with less than 12 hours

notice, we will need to schedule appointments one at a time (rather than a week at a time). Extenuating circumstances will be considered. Patients with three missed appointments may need to be discharged from therapy and a new referral obtained from the provider.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact that you receive treatment at our office may become a matter of public record.

Workers' Compensation: We require authorization by your workers' compensation carrier (not employer) prior to your initial visit. If your claim is denied, you will be responsible for payment in full. If your case is in dispute, we will require payment at the time of service until we receive information stating your employer's carrier will pay for services. Please remember that in order to receive your Work Comp benefits, you must keep your appointments.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require a Promise to Pay within 6 months letter from your attorney prior to your initial visit, or payments are to be made at the time of service. In addition to this, we require that you allow us to bill your health insurance. Payment of the bill remains your responsibility. We cannot bill your attorney for charges incurred due to a personal injury case. You also acknowledge that your signature also serves as an Assignment of Health Care Benefits and you authorize your attorney or liability carrier to pay those lien amounts to us out of any settlement proceeds without further authorization from you.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent changes.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect. This agreement applies to previous, current or future transactions.

Patient's name

Responsible Party's Printed Name

Responsible Party's Signature

Relationship to patient

Date

If you would like a copy of this agreement please ask for one and it will be provided to you.

Medicare/WorkComp:

Medicare/ WorkComp requires the patient see a provider at least every 60 and 30 days thereafter while receiving physical therapy. In order for Medicare/ Work Comp to continue to pay for your therapy, we must include verification of a provider visit in our chart by (date) _____.

Thank you.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of Integrity Rehab. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health

information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition.. We may also send you information describing other health-related products and services that we believe may interest you.

Fund-raising. Unless you request us not to, we will use your name and address to support our fund-raising efforts. If you do not want to participate in fund-raising effort, please check off the following box.

- ☐ Please do not use my information for fund-raising purposes.

Individual Rights

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your protected health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your protected health information
- the right to amend or submit corrections to your protected health information
- the right to receive an accounting of how and to whom your protected health information has been disclosed
- the right to receive a printed copy of this notice

Integrity Rehab Duties We are required by law to maintain the privacy of your protected health information and to

provide you with this notice of privacy practices.

We also are required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting receptionist or Lisa Lott. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Jeanice Mitchell
Integrity Rehab
PO Box 10340
Killeen, TX 76547

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Jeanice Mitchell
Integrity Rehab
PO Box 10340
Killeen, TX 76547
254-699-3933

Effective Date

This Notice is effective on or after July 20, 2003.

