POST
REHAB + WELLNESS

Please call 24 hours in advance if you need to reschedule/cancel your appointment.

*Patient Name:*_____
First *Middle Initial* *Last* *Suffix*

Soc Sec #: _____ *DOB:*_____

Mailing Address: _____ *Unit:*_____

*City:*_____ *State:*_____ *Zip:* _____

Primary Phone: _____ *(circle) Home Work Cell*

Secondary phone: _____ *(circle) Home Work Cell*

E-Mail Address: _____

Primary Care Provider/Physician: _____Phone:_____

Emergency Contact: _____*Relationship:* _____

Phone: _____ *(circle) Home Work Cell*

BACKGROUND HEALTH INFORMATION

Are you seeking Therapy due to an INJURY? (circle) Yes No

If yes, was your INJURY related to: (circle) Work Auto Accident Accident in Home Other

*Are you seeking Therapy due to a surgery? (circle) Yes No Date of Surgery:*_____

Type of Surgery: _____ *Other Procedure:*_____

Have you had any of these procedures or medical tests in the past 6 months? (Circle all that apply)

X-ray MRI Bone Scan CT Scan EMG Mylogram Nerve Block Nerve Conduction Study

Have you received HOME HEALTH SERVICES in the last 60 days? (circle) Yes No

Have you received HOSPICE SERVICES in the last 60 days? (circle) Yes No

Please list any allergies you have (food, seasonal, etc): _____

How did you hear about POST Rehab and Wellness? _____

FINANCIAL RESPONSIBILITY

Responsible Party: (circle) Self Spouse Guardian Other _____

Primary Insurance: _____ *Group #*_____ *Co-pay: $*_____

Secondary Insurance: _____ *Group #*_____ *Co-pay: $*_____

*Guarantor Information: Name:*_____ *Spouse Guardian Other*

*Primary Phone:*_____ *Secondary Phone:*_____

Please present your Insurance card and I.D. to staff for photocopying

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Patient Name:_____

First *Middle Initial* *Last* *Suffix*

Please Initial each section

_____ ***Treatment Consent:*** *I give my consent to undergo any evaluations and treatments prescribed or recommended by my physician or their designated substitute.*

_____ ***Joint Notice of Privacy Practices:*** *I have been provided with a copy of the Notice of Privacy Practices and afforded the opportunity to ask any questions. Any questions asked were answered to my satisfaction.*

_____ ***Authorization for release of information****: POST Rehab and Wellness is authorized to disclose, in line with clinic policy, any professional and clinical information needed to process my medical claims by authorized third-party agents or agencies, based on the medical records created during my treatment. The clinic is released from any legal responsibility that may result from sharing this information.*

_____ ***Assignments and Authorization to pay insurance Benefits*** *I assign and authorize payment to be made directly to the clinic for services rendered, not to exceed the clinic's standard charges for this treatment period. I understand that I am responsible for any charges not covered or paid by my insurance.*

_____ ***Assignments and Authorization to bill Medicare:*** *I am currently not receiving Home Health Services. I understand that I cannot participate in outpatient therapy while I am receiving Home Health Services and will be accountable for payment if both are being received at the same time.*

_____ ***Financial Responsibility:*** *I acknowledge my obligation to pay for all therapy services provided by POST Rehab and Wellness. I understand that I am ultimately responsible for the payment of my account, and the clinic will not engage in negotiating settlements for any disputed insurance claims. As a courtesy, the clinic will submit claims to my insurance provider. I acknowledge that co-payments are required at the time of service, and any remaining balance, after insurance has made an initial payment, will be due immediately upon receipt. Should this account be referred to an attorney or collection agency, I agree to cover reasonable attorney fees, legal costs, and collection expenses in addition to the balance owed.*

_____***Home Health/Hospice:*** *Patients receiving Home Health or Hospice services are not eligible for outpatient services under Medicare Part B. I acknowledge I am not currently receive Home Health or Hospice services. In the event I am found to be receiving Home Health or Hospice services at the time I am receiving outpatient therapy services, I understand I may be responsible for payment of the therapy services, in the event the Home Health Agency or Hospice agency declines to pay for it.*

_____***No Show/Cancellation Policy:*** *In order to ensure we can provide the best possible care to all patients and manage clinic and staff resources accordingly, we assess a $25 no-show/late cancellation fee for any scheduled therapy visits that are not cancelled within 24 hours before the scheduled appointment time. This fee will be charged to the payment method on file.*

Consent is given by: ☐ Patient ☐Parent/Guardian ☐Responsible Party

_____

(Signature of Patient or Authorized Individual) *(Relationship to Patient)* *(Date)*

Witness: _____

(Name) *(Title)* *(Date)*

NOTE: This form must be witnessed by a staff member. If the patient's signature is by mark, there must be two witnesses.