

THERAPY REGISTRATION FORM

Date: _____ Dr. Order Rec'd: PT ST OT Location: Clinic or Home or Care Facility

Patient's Name: _____ **Date of Birth:** _____ **Sex:** M F

Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____

SSN: _____ **Home Ph:** _____ **Cell Ph:** _____ **Marital Status:** S M D W

Employed: Y N **Employer:** _____ **Job Title:** _____ **Email:** _____

Employer Address: _____ **Phone Number:** _____

Contact Person/Legal Guardian: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____ **Phone:** _____

Patient's Insurance:

Medicare #: _____ **Medicaid #:** _____ **If Medicaid, Medipass Physician:** _____

Other Carrier Name: _____ **Group #:** _____ **ID #:** _____

Insured Name: _____ **Insured DOB:** _____ **Rel:** _____

Address of Insurance Carrier: _____

City/State Zip: _____ **Phone:** _____

Medical:

Illness/Injury Work Related? Y N

Involved in car or other type accident? Y N

Patient undergoing kidney dialysis or kidney transplant? Y N

Paid by Government program? Y N

Patient/spouse/guardian employed and covered by Employer's

Group Health Plan (EGHP)? Y N

Additional Information: _____

Covered by Work Comp plan? Y N

Another party responsible? Y N

Disabled Medicare Beneficiary under age 65? Y N

Entitled to Black Lung Medical Benefits? Y N

EGHP more than 100 Employees? Y N

Primary Physician: _____ **Address:** _____ **Phone:** _____

Referring Physician: _____ **Address:** _____ **Phone:** _____

Diagnosis: _____ **Onset:** _____

Medical History: _____

Primary Concern: _____

Patient lives in what setting? _____ **Patient lives with** _____

(private home, independent living apt, etc.)

Receives help from: _____ **Help received includes:** _____

Any other funding support/agency services you are receiving: _____

How did you hear about our Clinic? _____





Conditions of Admission

This Agency does not discriminate on the basis of race, color, national origin, disability or age.

RELEASE OF INFORMATION: This agency may disclose all or any part of the patient’s record to any person or corporation which is or may be liable under a contract to this agency, patient, family member or employer of the patient for all or part of this agency’s care, including but not limited to medical service companies, physicians, insurance companies, workman’s compensation carriers, welfare funds, or the patient’s employer. The patient understands and agrees to allow this agency to use their Patient Health Information for the above purposes. We want you to know how your Patient Health Information is going to be used and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE, that is available to you at the front desk or from our staff, before signing this consent.

TREATMENT CONSENT: The patient is under the control of his/her physician and consents to any treatment or procedures rendered the patient by this agency under the general and specific instructions of the physician. It is further understood that the agency is hereby relieved of any and all liability occurring from the performance of the physician’s instructions. I request and authorize the staff to provide me with physical, occupational and/or speech therapy and to perform any procedures now ordered or such additional procedures as may be authorized by my physician.

AGREEMENT ACCEPTANCE: The undersigned certifies that he/she has read the foregoing and is the patient, or is duly authorized by the patient as the patients’ general agent to execute the above and accept its terms.

METHOD OF PAYMENT:

1. Medicare- 80% of charge is covered after the annual deductible has been met. The remaining 20% of the charge may be covered by supplemental insurance, Medicaid or by the patient.
2. Private Insurance- exact coverage will vary by plan.
3. Medicaid- (Title XIX) covers in full for children and nursing home patients and with a co-pay for some adults who are eligible.
4. Patient- will be responsible for treatment cost not covered by Medicare, Insurance and/or other available coverage. The patient will be billed for missed treatment time unless canceled a minimum of 4-5 hours prior to the scheduled treatment session.

FINANCIAL ACCEPTANCE: I hereby accept all responsibility for treatment costs not covered or reimbursed by third-party payers unless covered by Medicaid.

ASSIGNMENT OF BENEFITS: I hereby authorize Medicare, Insurance, Medicaid and/or other responsible coverage to make direct payment to this agency for benefits due me, if any, for services described in the statement rendered, and as provided for in the above agreement. I authorize any holder of medical and other information about me to release to Medicare, Insurance, Medicaid and/or other responsible coverage any information needed to determine these benefits or benefits for related services.

Signature of Patient or Responsible Party

Date

Witness (Person Securing Request)

I certify that I have received or been offered the checked forms below.

Privacy and Patients Rights Policy
Advanced Directives Information

Signature of Patient or NOK

Relationship to Patient

Date

Our Agencies' mission is to provide therapy that promotes the highest optimal quality of life for our patients, regardless of race, gender, age, creed, nationality, diagnosis or source of payment for care. This policy informs patients, families and facilities of the methods of collection, use, retention and security of information collected in the course of providing patient care.

Privacy and Patient Rights Policy

Health Care: Patients have the right to accepted treatment standards, to participate in planning therapy. Patients have the right to obtain their medical records and have access to treatment and billing information.

Respectful treatment: Patients have the right to considerate and respectful therapy, with recognition of personal dignity.

Privacy and security: Patients have the right to privacy during the provision of treatment within the law. A written release must be signed by patients or designated parties to permit their records to be released. Information needed to provide treatment to patients is collected and maintained with security procedures in place.

Confidentiality: Patients have the right to expect all communications and records pertaining to their healthcare to be treated as confidential, and are kept in locked file cabinets.

Identity: Patients have the right to know, at all times, the professional status and credentials of healthcare personnel, as well as the name of the healthcare provider primarily responsible for their care.

Explanation of Care: Patients have the right to an explanation concerning their diagnosis, treatment, procedures, and prognosis in terms patients can understand.

Explanation of Patient Billing: Patients have the right to an explanation concerning the therapy received and the billing of these services.

Informed Consent: Patients have the right to be advised in a non-medical term on information needed in order to make knowledgeable decisions for consent or refusal of treatment. Such information should include significant complications, risks and benefits.

Safe and Secure Environment: Patients have the right to therapy in a safe and secure environment.

Refusal of Treatment: Patients are responsible for at-risk situations when they refuse evaluations or treatment and, therefore, assume responsibility for complications.

Rules and Regulations: Patients have the right to be informed of Agencies' rules and regulations including the building's "No Smoking" policy.

Resolution of Complaints: Patients have the right to be informed about Agencies' policies and procedures for the initiation, review and resolution of patients' complaints.

Communication: Patients have the right to timely and informative communication regarding treatment.

Advanced Directives: Patients have the right to formulate advance directives, such as Living Will or Durable Power of Attorney for Healthcare during the admissions process.

Patient Responsibilities

Providing Information: Patients have the responsibility to provide, to the best of their knowledge, accurate and complete information about complaints, past illnesses, hospitalizations, medications and other matters relating to their health. Some or all of the information are collected in order to provide services. Patients have the responsibility to let their therapist know whether or not they understand the treatment and what is expected of them.

Respect and Consideration: Patients have the responsibility for respecting the rights of other patients and the therapist. Patients are responsible for being respectful of the property of the Agencies.

Compliance with Medical Care: Patients have the responsibility for complying with treatment plan, including reinforcement or maintenance plans by the therapist. This includes keeping scheduled appointments and providing the therapist or Agencies with twenty-four (24) hour notice when appointments cannot be kept.

Insurance Information: Patients have the responsibility for providing Agencies with necessary information regarding insurance or changes in coverage of therapy charges.



Further concerns, questions or problems may be reported to the Agency's Administrators at (319) 352-4544

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