

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

THERAPISTS: FAX TO 319-352-4655 WITHIN 24 HOURS OF EVAL DATE

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.

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

 X Privacy and Patients Rights Policy
 X Advanced Directives Information

X _____
Signature of Patient or Responsible Party *Date* *Witness (Person Securing Request)*

Relationship to patient if applicable