REHABILITATION TODAY

Meeting the needs of tomorrow...

Patient Information Sheet

Initial Registration Site: ☐Olean ☐ Cuba ☐ Bradford
☐ Arcade
Referral Date __/__/____ Initial Contact Date __/__/____
Date Scheduled __/__/____ Appt. Time _____ Therapist _____
Comments _____

Patient Name _____ Address _____ Gender M/F
Date of Birth ___/___/_____ Age _____ City, State & Zip _____
SSN ___-___-_____ Home Telephone Number ___-____-_____ Cell Phone ___-____-____
Emergency Contact Name and Phone Number _____
Patient's Employer _____ Work Phone Number ___-____-_____
Employer Address _____ City, State & Zip _____
Referring Physician _____ Last MD appt ___/___/____ Next MD appt ___/___/____
Date of injury or onset ___/___/____ Diagnosis _____ Surgery Date __/__/____
Is this a work related injury? ☐ YES ☐ NO
Motor Vehicle accident injury? ☐ YES ☐ NO
Have you been off work due to the injury?☐YES ☐NO If yes, what was the date last worked__/__/__
Are you able to leave the clinic independently? ☐ YES ☐ NO
Have you ever received any type of Home Health Care? ☐ YES ☐ NO
If yes, what was the name of the Home Health Agency? _____
When was the last date you received this care (approximate date)? ___/___/_____
Have you received any Physical/Occupational/Speech Therapy this year? ☐ YES ☐ NO
If yes, where were the services rendered and how long did you receive treatment? _____

Insurance Information

Primary Insurance Company _____ Telephone Number ___-___-_____
Insurance carrier name & relationship _____
Insurance carrier date of birth ___/___/___ Employer _____
Insurance ID# _____ Group # _____ Co-pay amt $_____
Referral required? ☐ YES ☐ NO Claim Handler _____ Ext. _____

Secondary Insurance Company _____ Telephone Number ___-___-_____
Insurance carrier name & relationship _____
Insurance carrier date of birth ___/___/___ Employer _____
Insurance ID# _____ Group # _____ Co-pay amt $_____
Referral required? ☐ YES ☐ NO Claim Handler _____ Ext. _____

Additional Insurance Information

_____

Please inform us and write below the name, phone/fax, and /or address of any additional physicians that you wish to be furnished with a copy of your evaluation. Referring physician will routinely be furnished with a copy.
Physician Information

_____

Workers' Compensation patients must initial, date and indicate yes or no below:

I hereby authorize Rehabilitation Today, Medical Provider to furnish my employer with a complete report of my evaluation, diagnosis, and treatment plan of care in regard to my Physical, Occupational and/or Speech therapy status. ☐ YES ☐ NO Initials _____ Date __/__/____

Welcome to Rehabilitation Today…

I am aware of my diagnosis and wish to receive treatment at Rehabilitation Today. I permit its employees and all other persons caring for me to treat me in ways they judge to be beneficial to me. I understand that this care may include evaluation, testing, and treatment. No guarantees have been made about the outcome of this care. **ALL PATIENTS MUST SIGN**

_____/__/____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

_____./../____
AGENCY REPRESENTATIVE DATE

Assignment and Release… **ALL PATIENTS MUST SIGN**

I, the undersigned, certify that I (or my dependant) have insurance coverage with the above company(s) and assign directly to REHABILITATION TODAY all insurance benefits, if any, otherwise payable to me for the services rendered. I herby authorize REHABILITATION TODAY to release any/all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I also agree that my insurance company may be billed electronically due to mandatory electronic billing requirements.

_____/__/____
RESPONSIBLE PARTY SIGNATURE RELATIONSHIP DATE

_____/__/____
AGENCY REPRESENTATIVE DATE

Financial Policy… **ALL PATIENTS MUST SIGN**

With the information provided below, we hope to answer any questions you may have regarding the insurance coverage, out of pocket expenses, referral obligations, etc. Of course you may have individual questions regarding insurance benefit and we urge you to contact your insurance carrier. Should you need further information, our billing staff will be happy to assist you.

HMO and PPO plans: Plans that require a referral from your PCP, we ask that you obtain this referral prior to scheduling your appointment. Plans that have a standard flat insurance co-payment, please note that PAYMENT IS EXPECTED AFTER EACH VISIT.

No insurance coverage or insurance that REHABILITATION TODAY is not participating with: Your account will be listed as "Self Pay" and you will be required to make payment at each visit unless other arrangements have been made with the billing office.

Both Primary and Secondary insurance: Our billing staff will submit statements to you. A statement of all transactions and any patient balance will be sent to you.

We ask that you notify us of any change in insurance type, policy number or PCP. In some cases those changes will necessitate a new referral. Please note, however, that failure to notify us of changes may result in your claim being denied.

You will be responsible for payment of services denied by your insurance. We reserve the right to forward all delinquent claims to a designated collection agency. Any and all additional fees incurred as a result of this action will be the responsibility of the patient or guarantor.

_____/__/____
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