TODAY'S DATE________________________ THERAPIST: ________APPT___________TIME_____________________

HOW DID YOU HEAR ABOUT US? *SPECIALIST* ☐ *YOUR DOCTOR* ☐ *FRIEND* ☐ *SELF* ☐ *YELLOW PGS* ☐
INTERNET WEBSITE ☐ *NURSE CASE MANAGER/VRC* ☐ *OTHER* ☐ _________

PATIENT NAME: ____ GENDER: M ☐ F ☐

ADDRESS: ____

CITY: ____________________________________ STATE: __________ ZIP CODE: ______________

HOME PH:(___)________________ WORK PH:(___)________________EXT______ CELL PH:(___)_____________

SOCIAL SECURITY #: ______________________________ DATE OF BIRTH: _____/_____/_______ AGE:_____

MARITAL STATUS: M S D W OTHER

CURRENTLY EMPLOYED? Y ☐ N ☐ EMPLOYER: ______________________________________

PERSON RESPONSIBLE FOR ACCOUNT____

PHONE #: (________)______________________ SOCIAL SECURITY #: ____________________________

REFERRING PROVIDER: ____ PHONE:_________________

PRIMARY CARE PROVIDER: ____ PHONE:_________________

INJURED/INVOLVED AREA ____

DATE OF INJURY/ONSET __________________ SURGERY? NO ☐ YES ☐… DATE: ________________

IS INJURY WORK RELATED? NO ☐ YES ☐….EMPLOYER DURING INJURY___________________________

PRIMARY INSURANCE:_________________________________ PRIMARY ID:__________________________

SECONDARY INSURANCE: ______________________________ SECONDARY ID: _____________________

SUMMIT REHABILITATION ASSOCIATES NOTICE OF PRIVACY PRACTICES

I have reviewed and/or been given the option to receive a copy of the Summit Rehabilitation Associates, PLLC Notice of Privacy Practices. I know the terms of this Notice and have been advised I can review it again at any time as I request.

Signature: ____ Today's Date:_____________

OFFICE USE ONLY

CM ______________________________________ PH # ___________________ FAX_____________________

VRC ______________________________________ PH # ___________________ FAX _____________________

ATTY ______________________________________ PH # ___________________ FAX ___________________

OFFICE USE ONLY

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CANCELLATIONS AND NO SHOWS: Cancellations or changes to an appointment must be requested 24 hours prior to scheduled appointment time. If you fail to show up for a scheduled appointment in excess of 3 times, your therapy will be discontinued and your physician, vocational counselor and claims manager (if applicable) will be notified. In addition, failure to comply with the cancellation policy or excessive no shows may result in an account charge of $25.00.

TIMELINESS: We value your time and strive to keep your wait time to a minimum. Occasionally, we are delayed by an unexpected event with another patient, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at its scheduled time so we may keep the next treatment times on schedule.

COPAYMENTS ARE DUE AT THE TIME OF EACH TREATMENT: Copayments are due on the day services are rendered. It is the responsibility of you, the patient, to pay the copayment at the time of check in. The front desk is not responsible for asking for this copayment each time.

MEDICAL SUPPLIES: Some of the medical supplies we provide to assist with your treatment are not covered by your health plan. You will be asked to pay for these items at the time services are rendered. We accept cash, checks and Visa/MC.

FINANCIAL POLICY: If our providers are preferred with your health plan, we are contractually obligated to bill your health plan. Secondary health plans are billed as a courtesy to you, but it is important that we be provided with the proper information.

Your insurance policy is a contract between you, your employer and the insurance company. We are not a party to that contract or the benefits provided by that contract. We do check your benefits and advise if there is anything “out of the ordinary”; however, it is your responsibility to check your own OUTPATIENT PHYSICAL THERAPY BENEFITS, talk to your Primary Care Provider for authorization if necessary and follow up with the insurance company if you have any questions regarding the way they have or have not processed your claims.

It is important to communicate any financial problems as soon as possible. Please contact the Accounts Receivables Department to discuss a mutually agreeable payment plan so you will not jeopardize your credit. If you do not have insurance, a discount can be offered, but you must talk to the Account Receivables Department to discuss your payment options.

We keep a record of the health care services we provide you. For a fee, you may ask for a copy of that record. Please refer to the NOTICE OF PRIVACY PRACTICES for further information regarding your rights in relation to your private medical records.

- I understand that Summit Rehabilitation Associates is not responsible for any personal belongings I bring to the clinic.
- I understand that I am ultimately responsible for all charges for services rendered regardless of litigation, insurance reimbursement or pending workers’ compensation claims. I understand that the parent/guardian responsible for any minor child or person is responsible for payment of services.
- I authorize Summit Rehabilitation Associates to release to my insurance company, any information necessary to adjudicate payment of my medical claims.
- I authorize payment to be sent directly to Summit Rehabilitation Associates for any benefits available as outlined by my insurance policy.
- I understand that this authorization, unless expressly limited by me in writing, will extend to all aspects of treatment, including testing and/or treatment for sexually transmitted diseases AIDS or HIV infection, alcohol and/or drug abuse, or mental health conditions.

I ACKNOWLEDGE THAT I READ AND UNDERSTAND THE POLICIES AS OUTLINED ABOVE.
SIGNATURE IS VALID FOR 90 DAYS OR FOR THE DURATION OF TREATMENT.

PATIENT SIGNATURE: ____ DATE: _________________

IF A MINOR, RESPONSIBLE PARTY:____ DATE:_______