

Name: _____
(First) (Middle) (Last)

Local Address: _____
(Street) (Apt, Ste, Unit) (City) (State) (Zip)

Northern Address: _____
(Street) (Apt, Ste, Unit) (City) (State) (Zip)

Phone: _____
(Home) (Work or Northern Phone) (Cell Phone)

Email Address: _____

Soc. Sec #: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** M F
Month/Day/Year Circle One

Marital Status (circle): Single Married Divorced Widow

Employment Status (circle): Full Time Part Time Not Employed Retired

Employer: _____
(Name) (Address)

In case of an emergency, Notify: _____
(Name) (Phone #) (Relation)

Is the illness/injury for which you are being seen the result of any of the following? Circle One:

Auto Accident Work Injury Other Litigation None of these

Is there an attorney involved in relation to your injury/illness? Circle One: YES NO

If yes: _____
(Name of Attorney) (Address) (Phone)

Please provide us with your insurance information. You will need to supply our office with a copy of each of your insurance cards as well as a copy of your driver's license. If you are unable to supply us with a copy of ALL of your insurance cards and we are unable to verify that your insurance is current you must pay for your visit by cash. We accept checks, cash, Visa, or Mastercard.

If you are not the insured person under your insurance policy please provide the INSURED's information.

Insured's Name: _____

Insured's Date of Birth: _____

Consent To Treat & Authorization To Release Information

Please read and initial the following:

_____ I consent to *evaluation & treatment* by Medical & Sports Rehabilitation Center, Inc and realize I have the right to refuse any procedure after having the risks & benefits explained to me.

_____ I authorize the **release of information** acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or third party payer.

_____ I authorize *phone messages* regarding my treatment & appointments to be left with persons or machines at the phone numbers I have provided.

_____ A copy of this facility's *Statement of Privacy Notice* has been provided to me.

FOR MEDICARE PATIENTS ONLY: Please answer the following 5 questions YES or NO

1. Do you or your spouse work full or part-time? _____
2. Do you or your spouse still have Primary Health Insurance coverage through an employer? _____
3. Was your injury/condition caused by an automobile, work, service-related, or any other accident for which someone else will be responsible for your medical expenses? _____
4. Do you receive MEDICARE due to kidney disease? _____
5. Have you received any form of therapy (physical, occupational, or speech) prior to attending therapy at our facility? _____

If you answered YES to any of the above questions please advise the front office. It may be possible that Medicare is not your primary insurance.

Please Sign Below

Patient's Signature: _____

Date: _____

Signature of Responsible Party: _____

Date: _____

(If different from patient)

Relation To Patient: _____

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

PERSONAL INFORMATION

Interests/hobbies/exercise: _____

Is there anyone who can assist you with doing home exercises or activities if needed? Yes No

Will you have any problems attending therapy sessions? No Yes If yes, please describe:

Next scheduled Dr Appointment: Date _____ Physician _____

KEY QUESTIONS ABOUT YOUR CONDITION

What is your **MAIN** complaint?

Darken the areas on the body where you are having problems

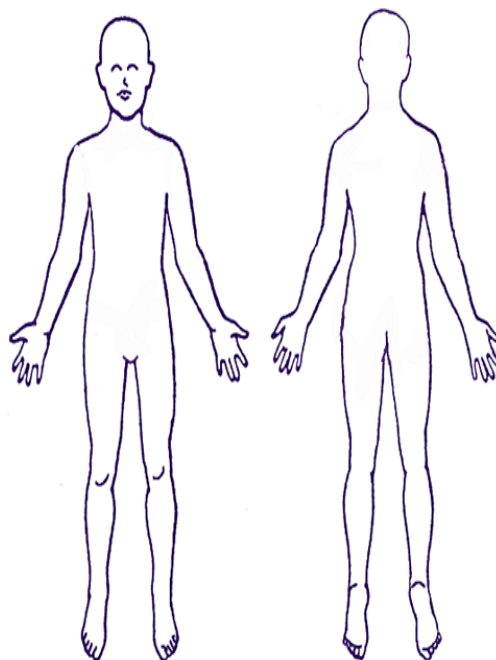
Please mark your level of pain with a **X** along the following lines:

What is your pain at rest?

No Pain Worst Pain
Imaginable

What is your pain with activity?

No Pain Worst Pain
Imaginable



GENERAL HEALTH

Are you having trouble sleeping? _____YES _____NO

Normal hours of sleep _____ hours Current hours of sleep _____ hours

Medical conditions you have or have had. Check all that apply.

- Fever, Chills, or Sweats Arthritis Stroke Visual Problems
- Bowel Dysfunction Cancer Stomach Disorders Hearing Problems
- Numbness Diabetes Anxiety Neurological Disorders
- Weakness Heart Disease Depression Osteoporosis
- Night Pain High Blood Pressure Panic Attacks Fibromyalgia
- Weight Change Lung Disease Pacemaker Epilepsy
- Fatigue Nausea/Vomiting Shortness of Breath Parkinson's Disease
- HIV Positive AIDS Vascular Disorder Hemophilia
- Other: _____

Are you taking any medications (prescription, over the counter, herbal preparations)? YES NO

If yes, please list or provide us with a list. _____

Do you have any allergies (adhesives, latex, cortisone, medications)? YES NO

If yes, please list with any reaction/treatments:

	Reaction/Treat _____
	Reaction/Treat _____
	Reaction/Treat _____

PERSONAL GOALS FOR THERAPY

What do **YOU** want to achieve from having therapy? Check all that apply.

- Improve home activities Improve mobility Improve range of motion
- Improve leisure/sports activities Decrease pain/discomfort Improve endurance
- Improve self care activities Return to work Improve balance/walking

Please include any additional information you feel would help us to provide your care. (What you think would help any apprehensions about treatment, special communication, language, spiritual or cultural needs). _____

To the best of my knowledge the above information is complete and factual.

Patient Signature

Date

Medical and Sports Rehabilitation Center, INC.
661 Goodlette Rd North, Suite 101, Naples, FL 34102
12840 Tamiami Trail North, Suite 200, Naples, FL 34110

Private Insurance, Medicare, Liability and Cash Fee Statement

Medical and Sports Rehab is very concerned about the cost of health care. Great care has been taken in setting fees for our services. Our charges accurately reflect the complexity of care rendered and the skill and expertise required for care. **One of the sections below will apply to your therapy coverage. Please read the applicable section & sign the back of this form.**

PRIVATE PAY (CASH): If you **DO NOT** have insurance coverage or **DO NOT** wish us to bill an insurance company, payment will be required at the time of each service. We accept cash, personal check, Visa, and Mastercard.

WALK-INS: Our office calls to verify benefits prior to any appointment. It is possible that your insurance company has certain restrictions that may limit payment if you chose to be seen as a walk-in. Pre-certification requirements may apply and treatment will not be covered unless our office obtains authorization prior to treating you. If you choose to be seen without our office calling on benefits prior to treating you, you may be responsible for today's treatment.

INSURANCE COMPANY: We bill your insurance company as a **COURTESY** to you, on the condition that you have provided us with the correct billing information including name, address, phone number, and claim/policy number(s). If your claim is denied or delayed you will be billed so you can submit the claim to your insurance company for prompt payment. **It is your RESPONSIBILITY to know what your plan covers and if there are any "special conditions" that your insurance company requires for payment. We will call your insurance company to verify benefits as a COURTESY to you, but frequently the information provided is not accurate. We will not know if the information is truly correct until we receive your first explanation of benefits, which is 30 days after your initial visit. Verification of benefits is not a guarantee of payment or your assigned patient responsibility. We recommend you contact your insurance provider to verify benefits for outpatient therapy services.**

You must also be aware that:

1. ***You are responsible for what your insurance does not pay, including applicable deductibles, co-payments and/or the percentage not covered by your plan. Payment is due AT THE TIME OF EACH VISIT.***
2. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your deductible has NOT BEEN MET for the plan year, you will be REQUIRED TO PAY for services as they are rendered. We will submit your claims to the insurance company as a courtesy to you so that they will be applied toward your deductible.

MEDICARE

Effective January 1, 2007 a cap will be in effect for outpatient physical, occupational, and speech therapy. The allowances will be as follows. The updated cap amounts as of January 1, 2008 are:

\$1,810.00 allowed for Physical & Speech Therapy Combined

*Medicare Pays 80% of \$1,810.00, which would be \$1,448.00

*The remaining \$362.00 would be billed to your supplemental insurance.

\$1,810.00 allowed for Occupational Therapy

*Medicare Pays 80% of \$1,810.00, which would be \$1,448.00

*The remaining \$362.00 would be billed to your supplemental insurance.

PLEASE TURN OVER & SIGN THE BACK OF THIS PAGE

(Medicare Section Cont)

You are responsible for keeping track of your medical expenses so that you do not exceed the cap. Medical & Sports Rehabilitation Center, Inc. will be happy to provide you with updates upon request. Medicare will cover 80% of physical and occupational therapy services. You will be responsible for the remaining 20% after Medicare. If you have a secondary insurance we will bill them **as a courtesy to you**, provided we have the correct name, address, and phone number for the insurance company. **Again, you will be responsible for what your co-insurance does not pay of the 20% and any deductibles.** If your secondary/supplemental insurance pays you for the 20%, then we require you to pay us the 20% or any deductible at the time of service. We will confirm this when we call to verify your benefits. Please remember that a quote of benefits from your insurance is not a guarantee of payment.

Under Medicare you must attend therapy at least **TWO** days per week in order for Medicare to cover. Attending therapy less than two days is considered maintenance treatment and may be denied by Medicare, leaving you responsible for the charges. If at any time you are advised that Medicare may not cover for treatment and you choose to continue therapy, you will be responsible for any charges not covered by Medicare and your supplemental insurance.

ATTORNEY/LIABILITY: In cases that involve an attorney, we require if possible, to file claims to an insurance company. We are not responsible for claims not received within their timely filing limits. We will no longer send these claims certified mail. If you wish to do so we will provide you with a copy of your bill. If there is NO such insurance to cover therapy claims, we will bill the attorney directly on the condition that our “Letter of Protection” (LOP) is signed. We will hold a file until the balance reaches \$1500.00 **with a signed LOP**, if you choose to continue therapy after this balance has been reached then it will be an out of pocket expense. **The patient is to FULLY UNDERSTAND that in case of NO SETTLEMENT, the patient is FULLY RESPONSIBLE for the TOTAL BALANCE on his/her account.** If payment IS NOT made, the account will be turned over to a collection agency.

LATE FEES: Medical & Sports Rehab Center has a 20-day billing cycle. You have 20 days from the date on the statement to make your payment. If payment is not received within the 20-day limit, a **\$10.00 late fee will be assessed each time** we must re-bill you for services rendered. If you are not able to make your payment within our time limits you must call us and advise us immediately.

We must emphasize as a care provider, our relationship is with you, not your insurance company. You are ultimately responsible for payment for services rendered, regardless of insurance, regardless of outcome. We accept cash, personal checks, Visa, and MasterCard. If you have any questions, please do not hesitate to contact our Billing Department at (239) 261-0291.

I have read, understand, and agree to the above listed policy.

Printed Name of Patient/Responsible Party

Signature of Patient/Responsible Party

Date



OFFICE OF INSURANCE REGULATION

Bureau of Property & Casualty Forms & Rates

Standard Disclosure and Acknowledgement Form
Personal Injury Protection – Initial Treatment or Service Provided

The undersigned insured person (or guardian of such person) affirms:

- 1. The services or treatment set forth below were actually rendered. This means that those services have already been provided.

Medical & Sports Rehabilitation Center Inc
Outpatient Physical and/or Occupational Therapy and/or Hand Therapy Services

- 2. I have the right and the duty to confirm that the services have already been provided.
3. I was not solicited by any person to seek any services from the medical provider of the services described above.
4. The medical provider has explained the services to me for which payment is being claimed.
5. If I notify the insurer in writing of a billing error, I may be entitled to a portion of any reduction in the amounts paid by my motor vehicle insurer. If entitled, my share would be at least 20% of the amount of the reduction, up to \$500.00

Insured Person (patient receiving treatment or services) or Guardian of Insured Person:

Name (Print or Type) Signature Date

The undersigned licensed medical professional or medical director, if applicable, affirms the statement numbered 1 above and also:

- A. I have not solicited or caused the injured person, who was involved in a motor vehicle accident, to be solicited to make a claim for Personal Injury Protection benefits.
B. The treatment or services rendered were explained to the insured person, or his or her legal guardian, sufficiently for that this person to sign this form with informed consent.
C. The accompanying statement or bill is properly completed in all material provisions and all relevant information has been provided therein. This means that each request for information has been responded to truthfully, accurately, and in a substantially complete manner.
D. The coding of procedures on the accompanying statement or bill is proper. This means that no service has been upcoded, unbundled, or constitutes an invalid or not medically necessary diagnostic test as defined by Section 627.732(14) and (15), Florida Statutes or Section 627.736(5)(b)6, Florida Statutes.

Licensed Medical Professional Rendering Treatment/Services or Medical Director, if applicable (Signature by his/her own hand):

Name (Print or Type) Signature Date

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of Claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree per Section 817.234(1)(b), Florida Statutes.

Note: The original of this form must be furnished to the insurer pursuant to Section 627.736(4)(b), Florida Statutes and may not be electronically furnished. Failure to furnish this form may result in non-payment of the claim.

Medical & Sports Rehabilitation Center, Inc.
Insurance Verification of Benefits Disclaimer

Dear Patient:

It is important for you to understand that Medical & Sports Rehabilitation Center will verify your benefits as a **COURTESY**. The information provided to us by your insurance company is often incorrect, which results in a discrepancy for patient responsibility. Verification of benefits is not a guarantee of payment or patient responsibility. We can only provide you with the information given to us by YOUR insurance company. We will not know if the information is truly correct until we receive your first explanation of benefits, which is 30 days after your initial visit. **You will be responsible for any changes in co-pays or co-insurance amounts as assigned to you by your insurance company. We highly recommend you contact your insurance provider to verify benefits for outpatient physical or occupational therapy.**