

**MEDICAL & SPORTS
REHABILITATION CENTER, INC.**

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

Local Address: _____
(Street) (Apt, Ste, Unit)

(City) (State) (Zip Code)

Northern Address: _____
(Street) (Apt, Ste, Unit)

(City) (State) (Zip Code)

Nickname: _____ **Referring Physician:** _____

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

Email Address: _____

Soc. Sec #: _____ **Date of Birth:** _____ **Age:** _____ **Sex:** ___M ___F
Month/Day/Year

Marital Status: _____ Single _____ Married _____ Divorced _____ Widow

Employment Status: _____ FT _____ PT _____ Not Employed _____ Retired _____ Student

Employer: _____ **Work Phone #:** _____

Emergency Contact: _____
(Name) (Phone #)

Emergency Contact Relation (spouse, friend, parent, etc): _____

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

_____ Auto Accident _____ Work Injury _____ Other Litigation _____ None of these

Is there an attorney involved in relation to your injury/illness? _____ YES _____ NO

If yes: _____
(Name of Attorney) (Attorney's Phone #)

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

Please indicate your present level of activity for each area listed below and mark the option that best describes each ability.

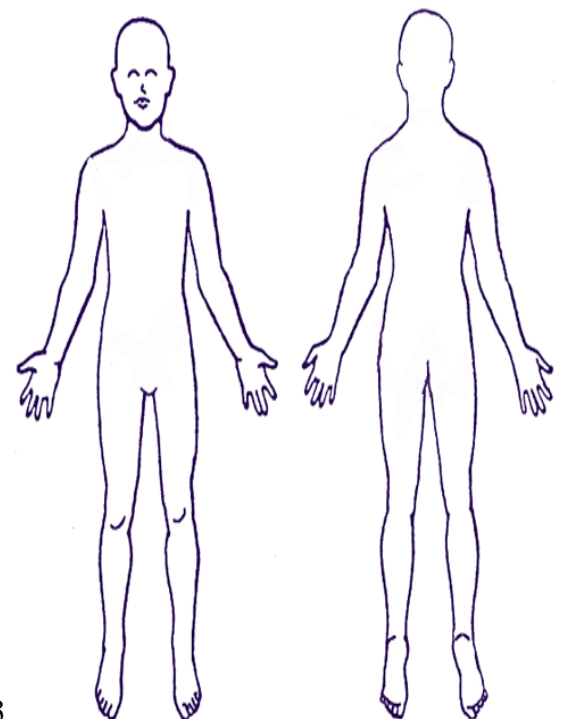
	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Sleeping					
Getting Up From Sitting					
Dressing & Bathing					
Walking					
Climbing Steps					
Lifting & Carrying					
Kneeling/Squatting					
Traveling					
Recreational & Social Activities					
Working					

Check the box that describes your pain level at rest
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10

Check the box that describes your pain level at with activity
(Zero = no pain & 10 = severe pain)

0	1	2	3	4	5	6	7	8	9	10



Place an "X" the areas on the body where you have pain or numbness.

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

Please tell us about your current and past medical history that could affect your therapy.

Place a "CHECK MARK" next to the condition/s that apply to you.

<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Neurological Disorder	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Depression
<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	Parkinson's	<input type="checkbox"/>	Panic Attacks
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	HIV/AIDS
<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Hearing Difficulties	<input type="checkbox"/>	Hepatitis
<input type="checkbox"/>	Lung Problems	<input type="checkbox"/>	Visual Difficulties	<input type="checkbox"/>	MRSA
<input type="checkbox"/>	Unexplained Weight Change	<input type="checkbox"/>	Stomach or Bowel Disorders	<input type="checkbox"/>	Staph

I have/had CANCER: _____ YES _____ NO Location: _____

I am still currently being treated for cancer: _____ YES _____ NO

I have been diagnosed with ARTHRITIS: _____ YES _____ NO Location: _____

I have been diagnosed with OSTEOPOROSIS: _____ YES _____ NO Location: _____

I have had a JOINT REPLACEMENT: _____ YES _____ NO Location: _____

Please describe any other problems not listed above: _____

**MEDICAL & SPORTS
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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.

_____ To the best of my knowledge the information I provided on the "History Questionnaire" is complete and factual.

_____ 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.

_____ I authorize **email messages** regarding my treatment & appointments to be sent to the email address I have provided.

_____ I have read, understand, and agree to the financial policies of Medical & Sports Rehabilitation Center, Inc.

_____ I authorize Medical & Sports Rehabilitation Center, Inc to discuss my account with the following person/s (for example: husband, personal assistant, etc). I understand that if I do not list anyone then my account may only be discussed with me.

_____ (Authorized Person)

_____ (Relation)

_____ (Authorized Person)

_____ (Relation)

_____ A copy of this facility's **Statement of Privacy Notice** has been provided to me. You may find this brochure in our waiting area.

_____ I hereby instruct and direct my insurance company to pay Medical & Sports Rehabilitation Center, Inc for services received. If my current policy prohibits direct payment to the above medical provider, I also instruct and direct the check be sent to Medical & Sports Rehabilitation Center, Inc. I authorize Medical & Sports Rehabilitation Center to deposit any check that is received for my account when it is made out to me. A photocopy of the Assignment shall be considered as effective and valid as the original.

Patient's Signature: X _____

Date: _____

Signature of Responsible Party: _____
(If different from patient)

Date: _____

Relation To Patient: _____



OFFICE OF INSURANCE REGULATION
Bureau of Property & Casualty Forms and 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, OCCUPATIONAL, HAND, or MASSAGE 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.

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 insured 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 guardian, **sufficiently** for that 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.**

Health Insurance, Private Pay, & Walk In Financial Policy

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. *The information below sets forth the financial policies of Medical & Sports Rehabilitation Center.*

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, debit cards, Visa, MasterCard, and Discover.

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. **You will be responsible for payment of today's visit if you choose to be seen without our office obtaining benefit information prior to your 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). **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. You will be responsible for these services should your insurance not cover them.
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.

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Health Insurance Financial Policy Continued—Page 2

ATTORNEY/AUTO ACCIDENT/OTHER 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. You must contact our billing department if you are unable to make a payment on your account.

RETURNED CHECKS: You will be assessed a \$25.00 fee for each check that is returned to us by your bank.

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, debit cards, Visa, MasterCard, and Discover. If you have any questions, please do not hesitate to contact our Billing Department at (239) 261-0291.