

**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.**

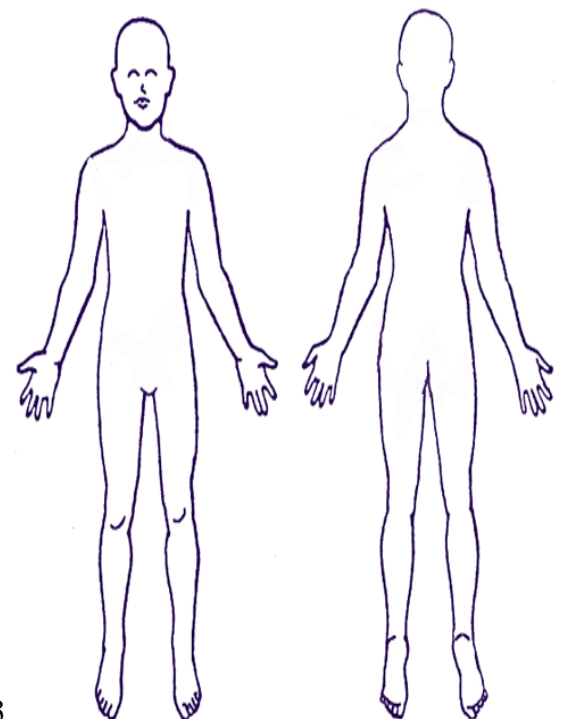
	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Sleeping					
Getting Up From Sitting					
Dressing & Bathing					
Walking					
Climbing Steps					
Lifting & Carrying					
Kneeling/Squatting					
Traveling					
Recreational & Social Activities					
Working					

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.



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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: \_\_\_\_\_

**MEDICAL & SPORTS  
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**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.