

**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 #)

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FOR MEDICARE PATIENTS ONLY: Please answer the following 6 questions

1. Do you or your spouse work full or part-time?

_____ YES _____ NO

2. Do you or your spouse still have Primary Health Insurance coverage through an employer?

_____ YES _____ NO

3. Is your current medical condition related to an Auto Accident, Slip/Fall, or other Liability issue?

_____ YES _____ NO

Description of incident: _____

Date of incident: _____

4. Do you receive MEDICARE due to kidney disease?

_____ YES _____ NO

5. Have you received any prior therapy THIS YEAR (physical, occupational, or speech) prior to attending therapy at our facility?

_____ YES _____ NO

6. Are you currently receiving any form of Home Health Care? (This includes any form of therapy, blood pressure checks, blood samples, etc)

_____ YES _____ NO

Please advise our front office if you answered “YES” to any of the above questions.

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.

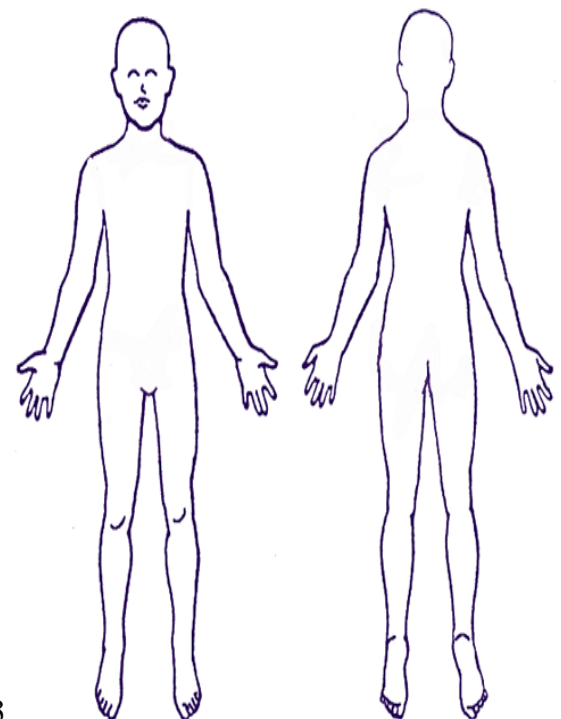
	No Problems	Mild Difficulties	Moderate Difficulties	Severe Difficulties	Unable To Perform
Sleeping					
Getting Up From Sitting					
Dressing & Bathing					
Walking					
Climbing Steps					
Lifting & Carrying					
Kneeling/Squatting					
Traveling					
Recreational & Social Activities					
Working					

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: _____

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Medicare 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.*

MEDICARE

There is a cap in effect for outpatient physical, occupational, and speech therapy. The allowances will be as follows:

\$1,870.00 allowed for Physical & Speech Therapy Combined

*Medicare Pays 80% of \$1,870.00, which would be \$1,496.00

*The remaining \$374.00 would be billed to your supplemental insurance.

\$1,870.00 allowed for Occupational Therapy

*Medicare Pays 80% of \$1,870.00, which would be \$1,496.00

*The remaining \$374.00 would be billed to your supplemental insurance.

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.

Medicare does not cover any form of maintenance treatment. Please refer to Chapter 15 of your Medicare Benefits Policy Manual for detailed information concerning the coverage of treatment. 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/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.

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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.