

VALLEY REHABILITATION OF SUN CITY WEST, LLC

PATIENT REGISTRATION FORM

Please PRINT and provide complete information for each item

Today's Date: _____

Legal Name

First Name: _____ MI: _____ Last Name: _____

Name you prefer to go by: _____ DOB: _____ Age: _____ Gender: M F

Social Security #: _____ Email Address: _____

Mailing Address: _____
Street City State Zip

Billing Address: _____
Street City State Zip

Home #: _____ Cell #: _____ Work #: _____

Referring Physician: _____ Primary Physician: _____

How did you hear about us? Physician Friend/Relative Internet Other _____

ARE YOU HERE DUE TO ACCIDENT? YES NO Type: Worker's Comp MVA Other: _____

Date of injury: _____ State injury occurred: _____

Will an attorney or liability insurance be involved in payment of charges? YES NO If yes, please inform front office

Have you had **ANY** Physical or Speech Therapy this year? YES NO

If yes when? _____ Where? _____ How many visits? _____

Are you currently receiving **ANY** Home Health Care Services? YES NO *If yes, please inform front office there may be a denial of claims.*

PERSON TO CONTACT IN CASE OF AN EMERGENCY: _____

(First & Last Name)

Relationship to Patient: _____ Phone Number: _____

****IF PATIENT IS A MINOR PLEASE PROVIDE THE FOLLOWING INFORMATION:**

PARENT/GUARDIAN NAME: _____ SSN: _____

CONTACT NUMBER: _____ DATE OF BIRTH: _____

INSURANCE INFORMATION – TO BE COMPLETED EVEN IF INSURANCE CARD IS ON FILE

PRIMARY INSURANCE

Insurance Co Name: _____

Policy Holder: _____

Policy Holder Birth Date: _____

Relationship to Patient: _____

SECONDARY INSURANCE

Insurance Co Name: _____

Policy Holder: _____

Policy Holder Birth Date: _____

Relationship to Patient: _____

PAST MEDICAL HISTORY FORM

Patient Name: _____

Date: _____

Date of injury / Surgery **or** start of symptoms:

(e.g.: pain, unsteady balance, fall, etc.)

Have you had a related surgery for the reason you are seeking treatment? YES NO

If yes, list type of surgery: _____ Date: _____

Are you presently taking Medication? Yes No

List ALL medications including: Prescription, Over-the-counter, Herbal & Vitamin/Mineral/Dietary supplements.

MEDICATION NAME	DOSAGE	FREQUENCY	ROUTE OF ADMINISTRATION

Are you taking Vitamin D? YES NO

List prior surgeries:

SURGERY	DATE

Allergies: Are you Latex sensitive? YES NO List any additional allergies below.

- | | |
|----------|----------|
| 1. _____ | 4. _____ |
| 2. _____ | 5. _____ |
| 3. _____ | 6. _____ |

Patient's Signature

Date

Therapist Signature

Date



Read and initial each section below.

_____ **CONSENT TO TREAT** By signing this form, I am giving my consent to receive physical therapy treatment for my medical condition. The nature of physical therapy is to help aid in my recovery and to help me return to my former state of health, as much as possible. If I comply with my therapist's treatment protocol, I should not experience detrimental side effects. However, I am also aware that, as in many types of medical treatment, rare but unforeseen complications such as: soreness, skin rash, skin reddening, blisters, ect. may result. Should I choose to proceed with the therapy treatments, I understand my therapist will explain the goals that he/she has established for me. The therapist encourages my taking an active role in the therapy regimen and welcomes my questions at any time.

_____ **FINANCIAL POLICIES** We accept most insurance and we file claims with your insurance carrier as a courtesy. Insurance coverage is a contract between you and your insurance carrier. If your insurance company does not remit payment within 60 days, you will be responsible for the amount due in full. If an insurance problem occurs, we ask you to assist in the resolution of any insurance problems. Returned checks and balances older than 30 days may be subject to additional fees and accounts sent to collections will incur an added 35%, you will be responsible for any charges incurred due to collection proceedings, attorney fees or court cost. I certify that the information I have provided to Valley Rehabilitation of Sun City West, LLC for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

_____ **ASSIGNMENT OF BENEFITS** I authorize direct payment of medical benefits from my insurance carrier(s) to Valley Rehabilitation of Sun City West, LLC for all services delivered and I agree to promptly pay Valley Rehabilitation of Sun City West, LLC any monies paid directly to me for said services. I authorize the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents. I understand that any and all payments designated as "the patient's responsibility" / "not covered" such as co-insurance and co-payments are due at the time of service or statement receipt.

_____ **PRIVACY NOTICE / PATIENT RIGHTS / HIPAA ACKNOWLEDGEMENT** I acknowledge that I have received a copy of Valley Rehabilitation of Sun City West, LLC Notice of Privacy Practices and PHI disclosure and use.

CANCELLATION / NO SHOW POLICY

If you need to cancel an appointment for any reason, we require at least a 24-hour notice.

Cancellation requests received less than 24 hours or missed (no show) appointments will be charged \$50.00. By giving us a 24 hour notice, you enable us time to notify and provide services to another patient who may currently be waiting for an appointment time. Exceptions may be made for unexpected illnesses or other unforeseen circumstances. These will be handled on an individual basis.

We do not bill insurance for any of the above charges – these charges are the responsibility of the patient. WE REQUIRE A CC TO BE KEPT ON FILE TO BE CHARGED ON DOS FOR ANY CO-PAYS, CO-INSURANCE, AND OR DEDUCTIBLES. THIS CARD WILL ALSO BE CHARGED FOR ANY LATE CANCELATIONS OR NO SHOWS.

We want all of our patients to receive the maximum possible benefit from physical therapy but this can only happen if you attend the appointments.

Your signature acknowledges receipt, acceptance, and your understanding of the above material and information.

PATIENT NAME (PRINT)

PATIENT / GUARDIAN / RESPONSIBLE PARTY SIGNATURE

DATE

PRIVACY NOTICE / PATIENT RIGHTS

This notice is to advise you of how your Protected Health Information (PHI) may be used and disclosed. Rehabilitation and Performance Center, LLC is committed to keeping your health information secure. We are legally obligated to give you this notice. Please review this information carefully.

Our Uses and Disclosures

- The law permits us to disclose information to those involved in your treatment
- Run our organization
- We may disclose information for billing purposes, seeking insurance or health benefits information, insurance authorization and payment services
- Help with public health and safety issues
- We may use your information to contact you, to remind you of your appointments, for scheduling purposes, leaving messages on a machine or with a person, or to inform you of insurance benefit.
- We will release some or all of your information when requested by law, which includes but not limited to lawsuits / legal actions.
- Address workers' compensation, law enforcement, and other government requests
- Your authorization is required to disclose your health information to other healthcare providers, individuals, or third parties requesting information about you.

You have the Responsibility to:

- Give complete, and accurate and timely medical, personal demographic and payer information to this facility
- Comply with the plan of care to the best of your ability which includes but is not limited to, following home program/instruction, punctually attending scheduled sessions and adhering to known limitations and precautions.
- Advise the therapist when rehabilitative goals or treatment approach requires modification secondary to external complicating factors including but not limited to physical or mental health, family, work or religious conflicts or commitments.
- Adhere to obvious department guidelines while at the facility including but not limited to, courteous interaction with staff, other patients/clients/visitors, conscientious personal hygiene and modesty and respect for treatment and clinical record confidentiality for self and others.
- Provide objective complaint notification to the Owner or designated staff as well as the state Licensing Boards and/or other regulatory agencies if indicated.

Individual Rights – *You have the Right to:*

- Request a paper / electronic copy of this notice and/or a copy of your medical records at any time.
- Submit a written request to amend incorrect data. Note that an addendum will be added to the record if agreed to amend.
- An accounting of all disclosures and request confidential communications.
- Opt-out of marketing and fundraising efforts. We will not sell personal information without your written permission.
- Restrict certain disclosures of PHI including the right to limit disclosures of information to Medicare or any other payer related to services the individual(s) have paid for out of pocket.
- Choose someone to act for you.
- File a complaint with us, without fear of penalty, if you believe your privacy rights have been violated.

If you believe that your rights have been violated you may also contact:

Department of Health and Human Services
200 Independence Ave. SW, RM 509F
Washington, DC 20201
1-877-696-6775 or visit on the
www.hhs.gov/ocr/privacy/hipaa/complaints/

You will not be penalized for filing a complaint. Before filing a complaint, we request you ask for assistance regarding the privacy of your healthcare information by contacting Lake Oconee Rehabilitation and Performance Center, LLC at 706-454-1811 or 706-395-3628.

Breach Notification: If PHI is breached, either through a covered entity or a covered business associate, updated rules establish mandatory reporting to include the affected individual(s), the Secretary of the US, Department of Health and Human Services, and in some cases the media when covering a breach of unsecured PHI.

A full copy of our Privacy Notice is available upon request.