*Please call 24 hours in advance if you need to reschedule/cancel your appointment.*

**Patient Name**:___________________________________________________________________________

First                Middle Initial                Last                Suffix

**Soc Sec #:** _____________________________________ **DOB**:_______________________________________

**Mailing Address:** ______________________________________________________ **Unit:**_______________

**City:**________________________________________________ **State:**_________ **Zip:** _________________

**Primary Phone:** ___________________________________ (circle) Home   Work   Cell

**Secondary phone:** _________________________________ (circle) Home   Work   Cell

**E-Mail Address:** ___________________________________________________________________________

**Emergency Contact:** ______________________________________**Relationship:** _____________________

**Phone:** ___________________________________________ (circle) Home   Work   Cell

**Primary Care Provider/Physician:** __________________________________**Phone:**_____________________

*BACKGROUND HEALTH INFORMATION*

*Are you seeking Therapy due to an INJURY?   (circle)  Yes    No*

*If yes, was your INJURY related to:  (circle)    Work     Auto Accident     Accident in Home     Other*

*Have you had recent surgery?  (circle)  Yes    No       Date of Surgery:________________________________*

*Type of Surgery: __________________________________   Other Procedure:__________________________*

*Have you had any of these procedures or medical tests in the past 6 months?   (Circle all that apply)*

*Bone Scan     CT Scan     EMG     MRI     Mylogram     Nerve Block     Nerve Conduction Study     X-ray*

*Are you currently being treated by any of the following?   (circle)  Chiropractor     Osteopath    Dentist*

*Have you received HOME HEALTH SERVICES in the last 60 days?    (circle)  Yes    No*

*Have you received HOSPICE SERVICES in the last 60 days?    (circle)  Yes    No*

*Please list any allergies you have (food, seasonal, etc): ___________________________________________*

*FINANCIAL RESPONSIBILITY*

*Responsible Party: (circle)    Self     Spouse     Guardian     Other _______________________________*

*Primary Insurance: _____________________________ Group #______________________ Co-pay: $_____*

*Secondary Insurance: ___________________________ Group #______________________ Co-pay: $_____*

*Guarantor Information:  Name:____________________________________ Spouse    Guardian     Other*

*Primary Phone:_______________________________ Secondary Phone:______________________________*

*Please present your Insurance card and I.D. to staff for photocopying*

*Patient Name:*______________________________________________________________________

*First* *Middle Initial* *Last* *Suffix*

*Please Initial each section*

______ ***Treatment Consent:*** *I hereby consent to the examinations and interventions ordered or recommended by my physician or designated alternate.*

______ ***Joint Notice of Privacy Practices:*** *I have been provided with a copy of the Notice of Privacy Practices and afforded the opportunity to ask any questions. Any questions asked were answered to my satisfaction.*

______ ***Authorization for release of information****: The Agency rendering services is hereby authorized to furnish and release, in accordance with the Agency's policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party agents or agencies from the medical records compiled during treatment. The Agency is hereby released from all legal liability that may arise from the release of said information.*

______ ***Assignments and Authorization to pay insurance Benefits****: I hereby assign and authorize payment directly to the Agency, herein specified and otherwise payable directly to me, but not to exceed the Agency's regular charges for this period of treatment. I understand I am responsible to the Agency for charges not covered or paid by my insurance.*

______ ***Assignments and Authorization to bill Medicare:*** *I hereby assign and authorize payment directly to this Agency, herein specific and otherwise payable to me, but not to exceed the Agency's regular charges for this period of treatment. I understand I am financially responsible for 20% of the Medicare Part B services.*

______ ***Financial Responsibility:*** *I do herby guarantee payment if therapy services to Julia Temple Outpatient Therapy services. I understand that I am responsible for payment of my account and the Agency does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, the Agency will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has need received, is due and payable upon receipt. Interest of 1.5 % monthly (18% per annum) will be added to all accounts 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection cost in addition for all other sums due hereunder.*

______***Home Health/Hospice:*** *Patients receiving Home Health or Hospice services are not eligible for outpatient services under Medicare Part B. I acknowledge I am not currently receive Home Health or Hospice services. In the event I am found to be receiving Home Health or Hospice services at the time I am receiving outpatient therapy services, I understand I may be responsible for payment of the therapy services, in the event the Home Health Agency or Hospice agency declines to pay for it.*

______***Cancellation Policy:*** *24-hour notice is required to cancel a therapy appointment. A cancellation fee of $25.00 may be charged to the responsible party if sufficient notice is not provided. Patient will be discharged from therapy services after 3 consecutive missed/no show appointments.*

**Consent is given by: ☐ Patient ☐Guardian ☐Responsible Party**

______________________________________________________________________

*(Signature of Patient or Authorized Individual)* *(Relationship to Patient)* *(Date)*

**Witness:** ______________________________________________________________________

*(Name)* *(Title)* *(Date)*

***NOTE: This form must be witnessed by a staff member. If the patient's signature is by mark, there must be two witnesses.***