ADMITTANCE SHEET

Name:_____ **Acct. #** _____ **DOB:** ____-____-____

Address:_____ **City:**_____ **Zip**_____

Phone: Home_____ **Work**_____ **Cell**_____

Email:_____

SS#:_____-____-_____ **Status:** □ **Married** □ **Single** □ **Divorced** □ **Widowed** □ **Student**

Primary Insurance: _____ **Name of policy holder:** _____

Who is the policy holder: □ **Self** □ **Spouse** □ **Parent**

Secondary Insurance_____ **Name of policy holder:** _____

Who is the policy holder: □ **Self** □ **Spouse** □ **Parent**

Is this injury work related? □ **Yes** □ **No** **If yes, Worker's Comp. Insurance:** _____

Is this injury auto related? □ **Yes** □ **No** **If yes, Auto Insurance:** _____

Other: _____ **Injury Date:** _____ □ **Male** □ **Female**

Referring Physician: _____ **Return to doctor date:** _____

Primary Care Physician: _____ **Return to doctor date:** _____

Emergency Contact:_____ **Phone:** _____

- **HIPAA Policies are available upon request.**
- **If 24 hour cancellation notice is not provided, you will be subject to a $20 fee.**
- **I understand it is my responsibility to provide any additional information such as: living wills, medical records, do not resuscitate (DNR) orders, and etc.**
- **If you would like us to text message a reminder of your appointments, give us your cell # and carrier. Please note we are not responsible for any charges by your cell phone carrier. Cell Phone**_____**Carrier**_____

How did you hear about us? □ **Internet** □ **Friend/Family name** □ **Newspaper Ad** □ **Yellow pages** □ **MD** □ **VA** □ **Workers Comp** □ **SCHS/School Events** □ **EXPO/Health Fair** □ **Newsletter** □ **Other**_____

_____

Signature **Date**

_____

Guardian Signature (if minor) **Date**

ASSIGNMENT OF BENEFITS FORM

Patient Name: _____Account Number: _____

I hereby instruct and direct _____ Insurance Company to pay by check made out and mailed to Elite Physical Therapy. If my current policy prohibits direct payment to the provider, I hereby also instruct and direct you to make out the check to me and mail it to the temporary address as follows:

Elite Physical Therapy
1114 North Main St.
Shelbyville, TN 37160

For the professional medical therapy benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional therapy services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. The payment will not exceed my indebtness to Elite Physical Therapy, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

- I understand I will be legally responsible for any remaining balance, including co-payments and deductibles, not paid by my insurance company.
- I understand that should litigation become necessary, I will be responsible for all Elite Physical Therapy legal fees.
- I also understand I will be held responsible for any interest on delinquent accounts and collection fees.
- A photocopy of this Assignment shall be considered as effective and valid as the original.
  I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
  I authorize Elite Physical Therapy to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

_____ _____

Signature of the Policy Holder **Date** **Witness** **Date**

Agency Consent to Treat

Patient Name: _____ Account#_____Date:_____

Authorization for Treatment:

I consent and authorize Elite Physical Therapy., (the "Rehab Agency") to provide physical, occupational and/or speech therapy as ordered by my physician.

Release of Information

This authorization, or copy of same, authorizes the release to the Rehab Agency of any medical information necessary for treatment and/or to process claims for services rendered by the Rehab Agency.

Patient or authorized patient representative agree to execute any documents and perform any acts that the Rehab Agency may reasonably request with regards to therapy services.

The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the patient.

Reimbursement Coverage

The patient or authorized patient representative hereby assigns to the Rehab Agency all private medical insurance benefits (primary and secondary, including Medigap providers) or other benefits to which patient may be entitled, for any therapy services rendered by the Rehab Agency.

The patient or authorized patient representative authorizes and directs the Rehab Agency to apply and file for all such benefits on behalf of patient.

Both the patient and/or patient representative agree that in consideration for the services rendered to the patient, an obligation exists for charges incurred during these treatments, in accordance with the regular rates and terms of the Agency. Should this account be referred to collections, the patient shall be responsible for reasonable fees associated with collections, including reasonable attorney's fees (if applicable). All delinquent accounts shall bear interest at the legal rate. This guarantee/obligation shall include any charges not covered by insurance, Medicare and/or when Medicare Lifetime Reserve Days are not authorized to be billed.

The patient or authorized patient representative authorizes the Rehab Agency to represent the patient during the appeals process in the event of a denial of Medicare benefits.

Term

This patient consent and authorization given to the Rehab Agency as set forth above will remain in full force and effect per episode of care (initial assessment to discharge) until terminated in writing by patient or authorized patient representative. This termination will not be effective until the facility receives this request writing.

_____ _____

PATIENT SIGNATURE **DATE**

_____ _____

PATIENT REPRESENTATIVE SIGNATURE **DATE**