INTEGRATED REHABILITATION SERVICES

Patient Registration

Patient Information

Patient Account # ______________

Last Name ________________________________ First Name ____________________________ MI ________

Date of Birth __________________ Sex: ☐ Male ☐ Female

Street Address ____

City, State & Zip ____

Cell Phone: __________________ Home Phone: _________________ Work Phone: _________________

Please provide your e-mail address if you would like to receive your home exercise program electronically, appointment reminders, or if you would like to receive our newsletter or other event information

Email Address: ____

Please send appointment reminders via: ☐ Text ☐ E-mail ☐ None

Employer ____

Employer's Address ____

Employer City, State & Zip ____

Employment Status ☐ Full-Time ☐ Part-Time ☐ Not Employed ☐ Retired ☐ Military

Student Status ☐ Full-Time ☐ Part-Time ☐ Not a Student

Referring Physician Last Name ___________________________ First Name ______________________

Primary Care Physician Last Name ___________________________ First Name ______________________

Person to Notify in Case of Emergency __________________________ Phone Number __________________

Who May We Thank For Referring You? ____

Guarantor Information

Is the Patient Responsible for the Bill? ☐ Yes ☐ No

Guarantor Name ____ Date of Birth __________________

Street Address ____

City, State & Zip ____

Best Contact Phone #: ____

Insurance Information

Primary Insurance Carrier _______________________ Secondary Insurance Carrier ____________________

Subscriber Name ______________________________ Subscriber Name ______________________________

Subscriber DOB _______________________________ Subscriber DOB _______________________________

Subscriber Employer ___________________________ Subscriber Employer ___________________________

Policy Number _________________________________ Policy Number _________________________________

Group Number _________________________________ Group Number _________________________________

Patient Relationship ☐ Self ☐ Spouse ☐ Child Patient Relationship ☐ Self ☐ Spouse ☐ Child

Above Information Reviewed - No Changes: Initial _______ Date _______ Initial _______ Date _______ Initial _______ Date _______ Initial _______ Date ______

Financial Statement and Acknowledgement

Financial Statement

As a patient of Integrated Rehabilitation Services, LP (IRS), your insurance coverage is verified to determine available benefits. Even though this information is reliable, it is not guaranteed. You are responsible for knowing the benefits, limitations, and/or restrictions that your policy may stipulate.

We base our information regarding your insurance coverage on what we are given by your insurance company when we verify your coverage. We then convey this information to you as a courtesy when we file insurance claims on your behalf. The exact determination of benefits occurs at the time your insurance company pays the claim. Every effort will be made to notify you should a difference occur between what was expected and what was actually paid. You do however, receive notification directly from your insurance carrier what they paid to us, and it is reflected on your monthly statement.

We must emphasize that as medical providers, our relationship is with you. While the filing of insurance claims is a service that we extend to our patients, it is your responsibility to see that your charges are paid in full. Any known deductions including deductibles, co-pays, co-insurance, or non-covered services/supplies are due at the time of service. Any amounts rejected for any reason by your insurance company are due at the time of their rejection. Outstanding patient balances over 60 days are subject to an 18% APR finance charge. Delinquent accounts will be referred to our attorney, collection agency, or small claims court.

Patient Acknowledgement

I agree that, all costs incurred for collections including finance charges, collection costs, reasonable attorneys' fees and court costs are my responsibility.

Payment is expected at the time of treatment for all deductibles, co-pays, and co-insurance. Due to carrier requirements for treatment/authorization, failure to provide active coverage prior to your visit will result in your financial responsibility for those services. I understand and agree that I am financially/legally responsible for full payment of my bill for services and that any failure of my insurance carrier to pay for all or any part of my bill does not constitute a reason for me not to pay. I understand that my insurance policy is a contract between me and the carrier, and that Integrated Rehabilitation Services, LP is not responsible for settling disputed claims. IRS will provide the necessary information regarding my treatment in order to facilitate payment of my claim for benefits.

In addition, I have been advised that my failure and/or denial to provide accurate insurance information prior to, or upon my initial visit constitutes my classification as a self-paying uninsured cash patient. This classification will cause me to forfeit and or relinquish all subsequent discounts, agreements, adjustments, benefits, and arrangements that IRS may have contractually accepted with any or all third party insurance carriers. This will supersede and replace any prior obligation that IRS may have.

In the unlikely event my insurance carrier determines that care provided to me under the referral of my physician is "not medically necessary", I hereby have been provided prior notice that I am fully responsible for any charges not paid by my insurance carrier based on their decision.

I also understand that IRS requires 24-hours' notice for cancellation of scheduled appointments and I may be financially responsible (not my insurance carrier) for late cancellations and missed appointments (no shows).

I have read and understand the Integrated Rehabilitation Services, LP Financial Statement and Patient Acknowledgement.

_______________________________ Patient/Responsible Party's Signature

_______________ Date

Patient Name ________________________ DOB ____________

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for **Integrated Rehabilitation Services, LP,** to furnish medical care and treatment considered necessary and proper in evaluating and/or treating his/her physical condition.

X____ **X____________________**

Patient/Guardian/Responsible Party **Date**

Medicare Lifetime Signature on File

I request that payment of authorized Medicare benefits be made on my behalf to **Integrated Rehabilitation Services, LP**, for any services furnished me by the therapist. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information to determine these benefits payable for related services.

X____ **X____________________**

Patient Signature **Date**

Private Insurance Authorization for Assignment of Benefits/Information Release

I, the undersigned, authorize payment of medical benefits to **Integrated Rehabilitation Services, LP**, for any services furnished me by the therapist. I understand that I am financially responsible for any amount not covered by my contract. I also authorize you to release to my insurance company or their agent information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purpose of evaluating and administering claims of benefits.

X____ **X____________________**

Patient or Parent/Guardian Signature (if child is under 18 years old) **Date**

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare Operations (HIPAA)

I, the undersigned, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

*A basis for planning my care and treatment
*A means of communication among the many health professionals who contribute to my care
*A source of information for applying my diagnosis and surgical information to my bill
*A means by which a third-party payor can verify that services were actually provided,
*A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change its notice and practices and, prior to implementation, will mail a copy of any revised notice to the address that I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restriction to use for disclosure of my health information:

____

I, ____ fully understand the terms of this contract.

(Print Patient/Guardian Name)

X____ **X____________________**

Patient or Parent/Guardian Signature (if child is under 18 years old) **Date**

INTEGRATED
REHABILITATION SERVICES

Medicare Secondary Payor Questionnaire (MSP)

As part of our participation in the Medicare program, we are required to ask each of these questions to confirm that Medicare should act as your primary insurance coverage. Under our agreement with Medicare, we must also reverify the answers to these questions every **90 days** or at the start of a new injury.

This form is not required if you are enrolled in a Medicare Advantage Plan.

Patient Name: ____ **DOB:** __________________

Account Number: _________________________

☐ YES ☐ NO 1. Are you receiving Black Lung Benefits?

☐ YES ☐ NO 2. Are your services to be paid for by a Governmental Research Program?

☐ YES ☐ NO 3. Are you entitled to benefits through the Department of Veteran Affairs?

☐ YES ☐ NO 4. Is your therapy related to a non-work accident?

☐ YES ☐ NO 5. Is your therapy related to a work-related accident or condition?

☐ YES ☐ NO 6. Is your therapy related to an injury or illness covered under an automobile or premise (Home or Business) insurance? If YES, what is the name of the Insurance and claim number?

Ins. __________________________ Claim No. ____________________

☐ YES ☐ NO 7. Do you believe that another party is responsible for your injury/illness? If YES, what is the name of the insurance and claim number?

Ins. __________________________ Claim No. ____________________

☐ YES ☐ NO 8. Do you have a group health plan insurance based on your own current employment, or the employment of either your spouse or other family member? If YES, how many employees, including yourself or spouse work for the employer from whom you have Group Health Insurance.

☐ **1-19** ☐ **20-99** ☐ **100 or more**

☐ YES ☐ NO 9. Are you under 65 and on Medicare due to DISABILITY and covered by Group Health Insurance?

☐ YES ☐ NO 10. Are you under 65 and on Medicare for an End State Renal Disease (ESRD) Diagnosis?

If YES, what was the date of your diagnosis? ______________

Have you received maintenance dialysis treatments? ________

If YES, what date did your dialysis begin? ______________

Have you received a Kidney Transplant? ______________

If YES, what was the date of your transplant? ____________

PATIENT SIGNATURE: ____ DATE: __________

PATIENT INITIALS REVERIFICATION IF ABOVE SIGNATURE IS >= 90 DAYS: _____________ DATE: __________

INTEGRATED REHABILITATION SERVICES

Medical History

Name:____ Date of Birth: ____________________________

Have you had any Home Health Care within the past year? ___ YES ___NO

If you are under the care of a physician, please describe the condition and its duration:_____________________________________

____

OTHER: ____

PAIN SCALE: Please indicate/mark the level of your pain, when it is at its *least* level and *worst* level:

0________1_________2__________3__________4__________5_________6_________7_________8__________9_________10________

No pain at all as bad as it can be

Please check if you have had any of the following within the last year

- ___ Bowel problem
- ___ Chest Pain
- ___ Coordination problems
- ___ Cough
- ___ Difficulty sleeping
- ___ Difficulty swallowing
- ___ Difficulty walking
- ___ Dizziness or blackouts
- ___ Excessive thirst
- ___ Feel down or hopeless
- ___ Fever/chills/sweats
- ___ Hearing problems
- ___ Hoarseness
- ___ Joint pain/swelling
- ___ Loss of Appetite
- ___ Loss of balance
- ___ Lost pleasure in things you enjoy
- ___ Nausea/vomiting
- ___ Numbness
- ___ Pain at night
- ___ Prolonged fatigue
- ___ Seizures/epilepsy
- ___ Shortness of breath
- ___ Stress/tension
- ___ Urinary problems
- ___ Vision problems
- ___ Weakness in arms or legs
- ___ Weight loss/gain

Please check if any of these are applicable to you

- ___ Arthritis
- ___ Asthma
- ___ Blood disorders
- ___ Broken bones/fractures
- ___ Cancer
- ___ Depression
- ___ Developmental/growth problem
- ___ Diabetes
- ___ Emphysema
- ___ Head Injury
- ___ Headaches
- ___ Heart Disease
- ___ Hypertension
- ___ Infectious disease (eg TB, hepatitis)
- ___ Kidney Problems
- ___ Low Back Pain
- ___ Multiple Sclerosis
- ___ Muscular dystrophy
- ___ Osteoporosis
- ___ Parkinsons Disease
- ___ Peripheral neuropathy
- ___ Repeated Infections
- ___ Skin diseases
- ___ Stomach problems/ulcers
- ___ Stroke
- ___ Thyroid problems
- ___ HIV/AIDS
- ___ Are you pregnant?
- ___ Do you use tobacco?
- ___ Do you have Pacemaker/Defibrillator?

Please list any surgeries you have had ____

Do you have any allergies? If yes, please list :____

Are you Latex Sensitive? ___ YES ___NO

Do you take any blood thinners (e.g. Coumadin, Plavix, etc.)? ___ YES ___NO

Check if you have seen any of the following providers in this calendar year: __Chiropractor __Podiatrist __Neurologist __Orthopedist __Speech Therapist __General Practitioner __Rheumatologist __Physical Therapist __ Other:______________________________

Check if you have had any of the following in the past 3 years: ___CT scan __Myelogram __Blood Test __EEG __Biopsy __MRI ___Echocardiogram __Pulmonary Function Tests __ER Care __Angiogram __Nerve Conduction Test ___Stress Test ___Doppler US ___Mammogram __ Urine Test

Have you fallen in the past 12 months? ___No _____Yes If Yes, how many times? _____

Have any of your falls in the past 12 months resulted in injury? ___No ___Yes

Do you feel unsteady when standing or walking? ___No ___Yes Do you worry about falling? ___No ___Yes

GENERAL HEALTH: (check one) __ Excellent __Very Good __ Good __ Fair __ Poor

Please list any other information that would assist us in your care:____

Are you aware of what your diagnosis is? __Yes __ No

Based upon your awareness, what are your expectations/goals while in this program?__________________________

Patient/Guardian signature: ______________________________________ **Date**: _______________________

FOR OFFICE USE ONLY: Reviewed and discussed by therapist: (PT initial) _____________ Date: ______________

INTEGRATED
REHABILITATION SERVICES

Medication List

Name:______________________________ Date of Birth: ____________________

Prescription Medications

Medication Name	Dosage	Frequency	Route of Administration (e.g. Oral, Intramuscular)

Over-the-Counter Medications

Medication Name	Dosage	Frequency	Route of Administration (e.g. Oral, Intramuscular)

Herbal/Vitamin/Mineral/Dietary Supplements

Medication Name	Dosage	Frequency	Route of Administration (e.g. Oral, Intramuscular)