Allcare Rehabilitation

Welcome to Allcare Rehabilitation, Inc. Please complete the following information as accurately as possible as it is necessary we have this information to effectively file your insurance claim and provide accurate information about your progress to your doctors' office.

PATIENT INFORMATION FORM Please Print & Complete All Entries

*Today's date*___________________

Name _____________________________________

Address ________________________________ *Date of Birth*_______________________________

City, State, Zip ____________________________ *Home Phone* _______________________________

*Social Security Number*______________________ *Spouse's Name*_____________________________

** Your privacy is very important to us; however your insurance company requires your social security number to process your claim.*

Employer ________________________________ *Work Phone* ______________________________

Date of Injury/Accident/Onset: _______________________________

Is your injury the result of an auto accident? ☐ *Yes* ☐ *No* *Are you in litigation?* ☐ *Yes* ☐ *No*

If yes, name of attorney _______________________________________ *Phone*______________________

Insurance Information

Are you having, or have you had any type of home health care within the last 60 days? _________________

*** Medicare WILL NOT cover physical therapy during ANY home health services.*

*If yes, last day of Home Health*___________________________

*Person responsible for paying bills, if other than patient*____________________*Phone*_________________

Emergency Contact, other than spouse ________________________________*Phone* _________________

Relationship ____________________________

Family Physician: ____ *Phone* ____________________

Referring Physician: ____ *Phone*_____________________

Who May We Thank For Referring You To Us? ____

Do you have a facebook page? ☐ *Yes* ☐ *No* *May we email you our newsletter?* ☐ *Yes* ☐ *No*

E-mail address _____________________________________

FINANCIAL RESPONSIBILITY

I,_________________________, understand that ALLCARE Rehabilitation will bill my insurance carrier for services rendered upon verification of coverage by my insurance company. I also understand that should my insurance company fail to render payment for services or if I do not have insurance, I am fully responsible for the payment of any and all services at the time the services are rendered. If any payment is made directly to me for services billed by ALLCARE Rehabilitation, I recognize an obligation to promptly remit the same to ALLCARE Rehabilitation. While I understand that ALLCARE Rehabilitation will take all reasonable actions to provide accurate therapy benefit information for my specific plan, I am aware that verification of benefits is not a guarantee of payment from my insurance carrier.

PRIMARY HEALTH INSURANCE: I understand that ALLCARE Rehabilitation will bill my primary health insurance as a courtesy to me. I also understand that ALLCARE Rehabilitation assumes payment of **insurance** benefits is **not** forthcoming on **charges older than 60 days. Charges outstanding for more than 60 days will be due in full from me regardless of the type of insurance involved.** I also understand that co-payment amounts must be remitted at the time services are rendered. Furthermore, I also understand that it is my (or my legal guardian's) responsibility to contact my insurance company and inform ALLCARE Rehabilitation of such co-payment amounts. I am aware that I am responsible for any fee not paid in full by my insurance carrier. I understand that secondary insurance will be my responsibility to file and collect. I further understand if it is determined that my condition is the result of an injury that results in litigation against a third party this in no way relives me of my obligation to pay for the services rendered, nor delay my obligation to remit payment when services are rendered. I understand that payment of the fees is not contingent upon settlement of litigation. However, I hereby instruct my attorney to pay ALLCARE Rehabilitation in full directly from the proceeds of any settlement or judgment on my behalf (including any interest that may have accrued at 1.5% per month or 12% APR). We reserve the right to charge interest on balances over 45 days old, charge return check fees, as allowed by state law, and charge a "no show" fee when adequate notice of cancellation is not provided (please see appointments on page 5).

MEDICARE: I understand that ALLCARE Rehabilitation will bill Medicare as a courtesy to me. I am aware that, in most cases, Medicare will pay 80% of the allowable charges. I also understand that ALLCARE Rehabilitation will bill my secondary insurance for me, if I have one. I will be responsible for any outstanding charges that have not been paid by my insurance companies.

SELF PAY: We require payment in full at the time physical therapy services are rendered. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Allcare Rehabilitation, Inc. is not a credit guarantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards (Mastercard, Visa, & Discover) are accepted for payment on your account.

WORKERS COMP: We will bill your Workers' Comp carrier for your charges. Please note that you will remain financially responsible for all of your charges if your carrier denies coverage.

AUTO: We will bill your Auto insurance claims to the company responsible for payment. You will be responsible for any charges that are not covered by the auto insurance company (this is usually a percentage). Please note, we will accept Letters of Protection for patient's portion of medical charges only. We WILL NOT accept a Letter of Protection on the entire bill.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

☐ Checking this box indicates that I have received the notice of **HIPPA's privacy policy and procedures** for my records, and that they have been explained to me.

Assignment of benefits/authorization to release medical information/consent to treatment: I hereby assign all medical benefits to which I am entitled to Allcare Rehabilitation, Inc. in the event they file insurance on my behalf; I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is there in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (12% annually) for unpaid balances over 45 days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Allcare Rehabilitation, Inc. as may be dictated by prudent medical practice for my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Patient Signature ____ Date ____

Witness Signature ____ Date ____

LIABILITY FOR USE OF PROPERTY AND EQUIPMENT

Every patient of ALLCARE Rehabilitation shall be liable for any damage or personal injury occurring at our facility, or during any activity or function operated, organized, arranged, or sponsored by our facility, that is caused by him, any of his guests, or any members of his family. Such patients shall pay for the cost thereof when a bill is presented to him/her.

I, ____, being a participant at ALLCARE Rehabilitation, acknowledge that failure to abide with instructions and safety precautions while in therapy at this facility will likely result in injury to myself and I expressly assume the risk for failing to abide with these instructions/precautions. I also acknowledge that improper or excessive use of the therapy treatment provided at ALLCARE Rehabilitation, or my failure to abide by limitations placed upon my use of such equipment will likely result in injury to me and I expressly assume the risks of injury associated with improper or excessive use of such equipment.

Should any party bound by these Rules and Regulations bring suit against the above entity for any claim or matter, and fails to obtain judgment therein against the facility, said parties shall be liable to the facility for all costs and expenses incurred by the facility in the defense of such suit including, but not limited to, attorney's fees.

Any patient, guest, or other person who in any manner makes use of or accepts the use of any apparatus, appliance, facility privilege or service whatsoever, owned or operated by ALLCARE Rehabilitation or who engages in any contest, game function, exercise competition, or other activity operated, organized, arranged or sponsored by the above facility either on or off the premises of the above facility, shall do so at his or her own risk and shall hold the facility, its directors, employees, representatives, and agents harmless from any and all loss, claim, injury, damage, or liability sustained or incurred by him or her resulting there from, and/or resulting from any act or omission of an employee, representative, or agent of the above facility, its directors, and owners hereunder with respect to any such loss, cost, claim, injury, damage or liability sustained or incurred by any guest of such patient.

I hereby state that I have read, understand and agree to the terms outlined above.

Patient/Guardian
Signature: ____ Date____________

Print
Name: ____ Date____________

Witness Signature:______________________________________ Date____________

A photocopy of this Assignment shall be considered as effective and valid as the original

APPOINTMENTS/SCHEDULING

All patients are scheduled for their appointments based according on their personalized Rehabilitation Program as prescribed by their physician. You are encouraged to keep all of your appointments as missing treatments may adversely affect your progress.

Cancellation of any appointment is required to be at least 24 hours before the actual appointment time. **Failure to do so will result in a $35.00 charge to you for that visit,** and each visit not attended. **Patients that have two absences without adequate notification will be discharged from physical therapy and their doctor will be notified.** Our treatment schedules are done weekly and it is impossible for us to fill an appointment without sufficient notice. Make-up visits will be offered to you whenever possible and must be scheduled for the same Monday through Friday week as the missed visit. Your rehabilitation program is specifically planned to meet your medical and physical needs. Based on your Doctor's prescription and your physical therapy evaluation, you will be on a Weekly Rehabilitation Program requiring visits several days per week. Our fees are billed at individual rates based on your individual requirements. As your condition changes, your weekly program will be adjusted (increased or decreased) according to your needs.

I fully understand that my insurance carrier will not provide reimbursement for missed visits and I agree to be financially responsible and will remit payment for any such missed visits as described above.

________________________________ ________________________

Patient/Guardian signature Date

PATIENT CONSENT FORM

I authorize the release of medical information necessary to process any claims. I also request payment of government benefits to the party who accepts assignment below. I hereby give my consent for ALLCARE Rehabilitation to perform the treatment of outpatient therapy as authorized and prescribed by the physician. Furthermore, I authorize any holder of medical and/or other information about me to release to ALLCARE Rehabilitation any information needed for the center's records and/or my treatment.

Patient/Guardian Signature ____ ***Date***__________

Patient/Guardian (Print name) ____ ***Date***___________

Witness Signature ____ ***Date***__________

ALLCARE REHABILITATION
1214 W Reynolds St. Suite 1
Plant City, FL 33563
Dan Manfre, PT

Phone: (813) 754-1062
Fax: (813) 759-8254

Patient Name______________________________________ DOB ______________

Diagnosis__________________________________ Date of Onset______________

Procedure________________________________ Date of Surgery______________

Precautions____

_____ Evaluate and Treat

Frequency ______ days per week **Duration** _____ weeks

☐ Aquatic Therapy ☐ Physical Therapy

Comments:

Physician Signature ______________________________ Today's Date ____________

Printed Name __________________________________

Thank you for your continued support and for giving us the opportunity to assist you with the treatment of your patients!