SIDNEY REHABILITATION & WELLNESS CLINIC

PATIENT REGISTRATION

NAME:_____

HOME ADDRESS:_____

CITY, STATE, & ZIP CODE:_____

HOME PHONE:_____ **CELL:**_____ **WORK:**_____

SOCIAL SECURITY NUMBER:_____ **SEX: MALE / FEMALE**

DATE OF BIRTH:_____ **AGE:**_____

EMERGENCY CONTACT:_____ **RELATIONSHIP:**_____

EMERGENCY CONTACT'S PHONE NUMBER: _____

EMAIL ADDRESS: _____

PRIMARY PHYSICIAN: _____

REFERRING PHYSICIAN: _____

PRIMARY INSURANCE: _____ **POLICY #:**_____

POLICY HOLDER'S NAME:_____ **DOB:**_____

SECONDARY INSURANCE:_____ **POLICY #:**_____

POLICY HOLDER'S NAME:_____ **DOB:**_____

OCCUPATION:_____ **EMPLOYER:** _____

EMPLOYER'S ADDRESS:_____ **EMPLOYER'S PHONE #:**_____

HAVE YOU HAD HOME HEALTH CARE? YES / NO IF YES, DISCHARGE DATE:_____

Is this a work-related injury or claim? YES / NO Did you file an accident report? YES / NO
(If NO, skip rest of box. If YES, complete rest of the questions in the box.)
Is this an injury or claim related to an auto accident? YES / NO

Who is responsible for payment? _____

Date injury or accident:_____ **Do you have a lawyer? YES/NO**

Name of lawyer:_____ **Phone Number:**_____

Is someone, other than you, responsible for this account? YES/NO If yes who:_____

SIGNATURE:_____ **DATE:**_____

1340 10TH AVENUE SIDNEY, NE 69162 PH: 308-254-4979 FAX: 308-254-5397 EMAIL: sidneyrehab@hotmail.com

SIDNEY REHABILITATION & WELLNESS CLINIC

PATIENT MEDICAL HISTORY

The purpose of this questionnaire is to help us understand your health status and to ensure you receive a complete and thorough evaluation. This form is considered part of your medical record.

Name:_____ **DOB:**_____ **Age:**_____

Diagnosis:_____ **Date of Onset:**_____

Chief Complaint:_____

How did injury or pain occur?_____

Please describe your pain:_____

_____

Circle on the scale below your level of pain TODAY. 0=No Pain 10=Pain would make you go to the ER

0 1 2 3 4 5 6 7 8 9 10

Circle the word or words below that best describe your pain.

Sharp Dull Stabbing Throbbing Spasm Shooting Numbness Pins/Needles

What increases the pain?_____ **Decreases?**_____

Is the pain: Constant or Intermittent (circle one) **Do you have pain with sleep? YES/NO**

What are you not able to do now as a result of this problem?_____

_____

Did you have any limitation in function prior to this problem: YES/NO If yes, explain:_____

Last date worked due to this problem:_____ **Date returned to work:**_____

List other treatment you have had for this problem:_____

_____

Have you had: X-rays or MRI or Special Tests (circle) Results:_____

Where were tests done?_____

Have you fallen in the last year? Yes / No

If yes, how many times have you fallen in the last year? _____

Were you injured in the fall? Yes / No

If yes, how were you injured? _____

(TURN OVER)

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PATIENT MEDICAL HISTORY CONT.

Do you have or have you had any of the following?

	YES	NO		YES	NO
Allergies or Asthma (circle)	___	___	Bronchitis or COPD (circle)	___	___
Cancer	___	___	Chest Pain	___	___
Depression	___	___	Diabetes	___	___
Dizziness/Fainting(circle)	___	___	Emboli/Blood Clot (circle)	___	___
Epilepsy/Seizures (circle)	___	___	Fractures	___	___
Heart Attack	___	___	Heart Disease	___	___
Hepatitis	___	___	Hernia	___	___
High Blood Pressure	___	___	HIV	___	___
Incontinence	___	___	Latex Allergy	___	___
Infectious Disease	___	___	Kidney Disease	___	___
Low Back Pain	___	___	Metal Implants	___	___
MS	___	___	Osteoarthritis	___	___
Osteoporosis	___	___	Pacemaker	___	___
Parkinson's	___	___	Rheumatoid Arthr.	___	___
Shortness of Breath	___	___	Sleep Disturbance	___	___
Stroke	___	___	Thyroid Problems	___	___
Weakness	___	___	Weight Loss	___	___

Do you smoke? YES/NO Do you consume alcohol? YES/NO Are you pregnant? YES/NO

Please list all surgeries: _____

_____

PLEASE COMPLETE SEPARATE MEDICATION/VITAMIN/SUPPLEMENT SHEET.

HEIGHT:_____ **WEIGHT:**_____

What are your goals?_____

_____

How did you hear about us?_____

Patient/Guardian Signature: _____ **Date:**_____

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PATIENT MEDICATION RECORD

PLEASE COMPLETE THIS MEDICATION RECORD AND BRING WITH YOU TO YOUR 1ST APPOINTMENT. IT IS REQUIRED BY MEDICARE AND OTHER INSURANCE COMPANIES THAT YOU DOCUMENT ALL MEDICATIONS INCLUDING VITAMINS, AND SUPPLEMENTS AND INCLUDE DOSAGE, FREQUENCY, AND ROUTE (oral, injection, IV, etc.). WE MUST THEN VERIFY THE MEDICATIONS WITH YOU DURING YOUR 1ST VISIT. IF YOU HAVE PREPARED YOUR OWN LIST, YOU CAN BRING IT IN AS LONG AS IT CONTAINS ALL OF THE REQUIRED INFORMATION. ATTACH ANOTHER SHEET IF NEEDED. THANK YOU.

MEDICATION NAME	***DOSAGE(mg, etc.)***	***FREQUENCY***	***ROUTE(oral, injection, etc.)***
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:**_____

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AUTHORIZATION FOR RELEASE/ASSIGNMENT OF BENEFITS/CONSENT TO TREAT

The undersigned hereby authorizes Sidney Rehabilitation & Wellness Clinic (SRWC) to release from my medical record requested information to appropriate health practitioners and any insurance company for the purpose of processing claims and obtaining payment for the account which services are/were provided to the patient. SRWC will accept assignment of benefits which means we will receive direct payment for any services provided and you will be responsible for any deductible, coinsurance, co-payment, and/or any procedure or visit that is not covered by insurance.

By signing this authorization, the patient, parent, or legal guardian hereby consents to medical treatment.

MEDICARE RELEASE

I certify the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made to me or on my behalf to Casey Cortney, MPT dba Sidney Rehabilitation & Wellness Clinic (PTAN#: NA1019). For services rendered to me by the provider, I authorize any holder of medical information about me to release to the Social Security Administration or its agents any information required to process the benefits payable for the related services.

FINANCIAL AGREEMENT

The undersigned hereby agrees that, in consideration of the services to be rendered to the patient, to pay SRWC in accordance with the regular rate and payment policy. The services of SRWC are billable services and are due by the patient. Interest will be charged to all account balances overdue by 30 days and accounts that are 90 days delinquent will be sent to collections. Please see SRWC's Financial Policy Agreement for further conditions and terms.

WORKMAN'S COMPENSATION

Please notify the receptionist if this is a workman's compensation injury. Any patient claiming worker's compensation must bring notice of injury from their employer, or must be received from your worker's compensation carrier, before the claim will be sent to workman's compensation insurance. If a notice is not received, the claim will be submitted to the patient or personal medical insurance.

Patient/Guardian Signature: _____ Date: _____

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SIDNEY REHABILITATION & WELLNESS CLINIC

Notice of Privacy & Disclosure Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Sidney Rehabilitation & Wellness Clinic (SRWC) is required by law to maintain the privacy of Protected Health Information and to provide notice of its legal duties and privacy practices with respect to Protected Health Information. This notice fulfills the "Notice" requirements of the Health Information Portability and Accountability Act of 1996 (HIPPA) Final Privacy Rule.

SRWC uses your health information primarily for treatment, processing claims and obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we provide. We use your health information to consult with any other practitioner involved in your care for the problem you are seeking current treatment for, and in addition, we may disclose your health information without prior authorization for public health purposes, auditing tracking, and research. In any other situation, SRWC will obtain your written authorization before disclosing your personal health information.

Your health record is the property of Sidney Rehabilitation & Wellness Clinic, but the content is about you, therefore belongs to you. You have the right to review or obtain a copy of your personal health information. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of instances where we disclosed your personal health information for reasons other than for treatment, payment, or other related administrative purposes. You must make a request in writing to obtain access to your health information. You may be charged a reasonable cost-based fee for expenses such as copies, postage, staff time, and other expenses as applicable. You have the right to request restrictions on the uses and disclosures of your health information, other than those required by law. Your request must be made in writing and must specify our additional restriction. You have the right to request communications of your health information by alternative means or at alternative locations should we need to contact you. This request must be made in writing and must specify the alternative means of communication. You have the right to revoke your authorization to use or disclose health information except to the extent that action has already been taken, or is limited by law. You may request a copy of our Notice of Privacy & Disclosure Practices at any time.

If you have questions about this notice or desire to have further information concerning the information practices at SRWC, please call us at 308-254-4979. If you believe your privacy rights have been violated, you have the right to file a complaint with us and/or with the U.S. Secretary of Health and Human Services with no fear of retaliation by this office.

Acknowledgement of receipt of this notice: I have been informed of the Privacy & Disclosure Practices of Sidney Rehabilitation & Wellness Clinic.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

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SIDNEY REHABILITATION & WELLNESS CLINIC

FINANCIAL POLICY AGREEMENT

Thank you for choosing Sidney Rehabilitation & Wellness Clinic! We are committed to provide you the highest standard of service and care. The nature of health insurance coverage is changing, with higher deductibles and co-payments meaning a greater portion of your services will be your financial responsibility. It is vital to our practice that we collect payments you are responsible for; therefore patients will be required to establish financial arrangements for payment of their account.

SRWC will verify your insurance benefits prior to beginning treatment. While we will take all reasonable action to provide accurate benefit information, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. We urge you to familiarize yourself with your "Schedule of Benefits" available in your insurance policy. It will help you understand the agreement you have with your insurance company. Understanding the nature of your coverage including preauthorization requirements, deductibles, co-payments, co-insurance, visit limitations, and annual limits will help you make informed decisions about your financial responsibilities.

Sidney Rehabilitation & Wellness Clinic (SRWC) will bill your insurance as a courtesy to you. SRWC 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 you regardless of the type of insurance involved. Depending on the type of agreement between SRWC and your insurance, any remaining balance after your co-pay and insurance has paid, including items classified as "above usual and customary", is due from you upon receipt of the explanation of benefits from your insurance carrier. Accounts will be charged at a rate of 1.5% per month for unpaid balances.

All per visit co-pays are due at every visit. The balance will be due in full at the time of service or upon receipt of the monthly billing statement. In the event you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. However, please be advised SRWC is not a credit grantor, and therefore, failure to maintain the agreed upon the arrangement may result in the placement of your account with a collection agency or attorney for collection. Accounts with no payment activity will be sent to a collection agency or attorney when they are 90 days delinquent. Once your account has been sent to the collection agency, we will not be able to reverse this action. You agree to pay all fees associated with the recovery of any debt including but not limited to collection services, attorney fees, and court costs. For your convenience, we accept cash, checks, and debt/credit cards are accepted. There will be a $30.00 service charge for returned checks.

It is your responsibility to inform SRWC of any and all changes in your insurance coverage. Failure to do so may result in denial of coverage from your insurance company. For "In-Network" patients, SRWC has contracted with your insurance company to accept the Preferred Provider maximum allowable charge as full payment for the services rendered.

There will be no balance billing for covered services. You are responsible to pay for any and all services not covered under your policy. For "Out-of-Network" patients, you are responsible for the difference of billed charges and your insurance company's maximum allowable charge.

(TURN OVER)

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FINANCIAL POLICY AGREEMENT CONT.

Fee-for-service is exclusively a non-insurance financial arrangement. Fee-for-service receipts CANNOT be submitted to insurance for reimbursement. SRWC will discount our standard fee schedule by 25% for fee-for-service arrangement. Full payment must be received at the time the services are rendered to be eligible for the discount. The discount is based upon a paperwork reduction discount for not filing your claim to an insurance company. Medicare and Medicaid recipients are not eligible for this arrangement unless the treatment is not normally covered by Medicare or Medicaid.

During the course of your treatment, your therapist or other medical provider may recommend specialized equipment or supplies. SRWC will not submit claims to your insurance company for these items, therefore full payment for these items is due at the time of issuance or as arranged between you and SRWC. You may submit receipts for these items to your insurance company on your own.

If you are claiming Worker's Compensation, you must provide SRWC with a copy of your personal insurance card and a current authorized claim number along with case manager contact information. SRWC will confirm your authorization. In the event your claim is denied by worker's compensation, the claim will then be filed with your personal insurance company. If your claim is denied by your personal insurance company, then you are responsible for the full payment of your bill.

In the case of a LEGAL SUIT, SRWC will accept a legal letter of protection if you meet the following criteria:

1. **Do not qualify for benefits under any insurance policy (medical or auto), and**
2. **Are indigent and cannot pay for charges using cash or credit card, and**
3. **Are awaiting settlement and subsequent payment of damages from a related legal case, and**
4. **Return our agreement, signed by both you and your attorney.**

Prior to your settlement, payment on your account will not be required unless your charges remain outstanding for more than 90 days from the date of the last treatment. Upon settlement of your legal case, your balance is due in full within 30 days. Our overdue and collection policy as noted above, will be in force on accounts over 90 days unless another written agreement is made.

Minor patients must be accompanied by a parent or legal guardian to the initial visit. The parent or legal guardian is responsible for full payment as previously outlined in this financial policy. The parent or guardian that accompanies the minor patient to the initial visit shall be fully responsible for payment of services rendered should a dispute arise between the parent and guardian.

I HAVE READ CAREFULLY AND AGREE TO THE PAYMENT POLICIES DESCRIBED HEREIN.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

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