STATEMENT OF FINANCIAL RESPONSIBILITY

The staff at First Rehab appreciates the confidence you have shown by choosing us for your therapy needs.

As a courtesy to you we verified your insurance benefits. Depending on your coverage, we may bill your insurance on your behalf. However, you are ultimately responsible for the full payment of your bill for services rendered by First Rehab.

To help you better understand your obligations, please read the following. If you have any questions or are unsure about your responsibilities for services being rendered at First Rehab, please speak to the Receptionist. You can also request to speak to one of our Billing Specialists. Please make sure you understand your financial arrangement and First Rehab's policies before signing this agreement.

1. **MEDICARE PATIENTS:**

   After you met your annual deductible, Medicare typically covers 80% of our charges. You are responsible for the deductible, as well as the 20% co-insurance per visit. If you have a secondary insurance that covers the deductible and/or the 20% co-insurance, we will bill your secondary insurance on your behalf. If payment is denied, or we do not participate with your secondary insurance provider, you will be responsible for all services rendered by First Rehab.

2. **COMMERICAL INSURANCE:**

   First Rehab is out-of-network with most insurance providers. If your plan has out-of-network benefits, we may bill your insurance on your behalf. Each insurance plan varies (ex: some have a high deductible and/or co-insurance; some have a limit amount of visits per calendar year, etc.). After we have billed your insurance, payment of your deductible and co-insurance (which is determined by your insurance provider) remains your responsibility. If payment is denied by your insurance provider for any reason, you will be responsible for services rendered by First Rehab.

   In some cases, you may receive direct payment from your insurance provider. It is the patient's responsibility to submit the check endorsed, within 10 days of receipt. Failure to do so will result in a 5% processing fee.

3. **PRIVATE-PAY:**

   If First Rehab is not billing your insurance provider (ex: you do not have out-of-network benefits, or your deductible is too high) you can be treated at First Rehab as a private-pay patient. Private-pay patients are billed per timed visit. If you have not been made aware of your financial responsibilities please ask the Receptionist prior to receiving treatment.

   Since we bill private-pay patients by time, and not by billing codes, many insurance companies will not accept these charges. First Rehab is not responsible for submitting charges to insurance.

4. **MOTOR VEHICLE:**

   If you were in a Motor Vehicle Accident, and want us to bill your car insurance, please be advised you will be responsible for any deductible and/or co-pays required by your insurance. Our office has verified you have an "open case" and your insurance provider is willing to cover your treatment. Many insurance providers require prior authorization to continue treatment after your initial evaluation. We will submit an authorization request, until we receive the authorization, we will not schedule any further appointments.

   Receiving authorization from your insurance provider is not a guarantee of payment. Payment for our services can subsequently be denied. Denials may occur for various reasons (ex: receiving chiropractic services for treatment related to this accident; benefits have been exhausted; result of Independent Medical Exam (IME) deems treatment not medically necessary, etc.). It is your responsibility to understand your insurance benefits. If you receive notification that your benefits have been exhausted please let us know, as ultimately you will be responsible for all services rendered by First Rehab.

First Rehab requires payment at the time of services rendered. This includes deductibles, co-insurance, and charges for private-pay which has been set up with the patient. Payment for any services not covered or denied by your insurance provider is required within 15 days of being billed.

By signing below, you have read the above guidelines and policies regarding your financial responsibility to First Rehab Group LLC, for services rendered. You authorize your insurer to pay any benefits directly to First Rehab Group LLC.

Patient/Guardian Signature: ____ **Date:** ___________________

CREDIT CARD ON FILE

To collect payment in a timely matter, First Rehab requires every patient to keep a credit card on file. By signing below you authorize First Rehab to charge your card as described below:

- 30 days after any open balance you may have. This includes deductibles, denied services by your insurance, or any other charges you have incurred for services rendered by First Rehab.
- Failure to bring in checks from your insurance provider, for services rendered by First Rehab within 10 days of receipt. You may bring in the original check endorsed to First Rehab or write a personal check for the full amount. Please note, your credit card will be charged the check amount plus an additional 5% processing fee.

□ Please charge my card at the time of each visit.

Card Type: □ Visa □ MasterCard □ American Express □ Discover
Card Number: ____
Expiration Date: ____/____ Security Code:________ Billing Address:__________________________ Zip:__________

I authorize First Rehab to charge my credit card as indicated above. I agree to update any information regarding this account. The above information is complete and correct to the best of my knowledge.

Cardholder Signature: ____ **Date: ___________________**

CANCELLATION POLICY
Anytime you are unable to keep your appointment we would appreciate 24 hours advance notice, so we can cancel your appointment and use your appointment time for another patient. Failure to give 24 hour notice will result in a written warning. After the second occurrence you will be billed a $25.00 “Cancellation” or “No Show” charge.

I understand and will comply with First Rehab Group’s Cancellation Policy.

Patient/Guardian Signature: ____ **Date: ___________________**

PRIVACY RELEASE OF INFORMATION

I, _______________hereby give First Rehab permission to contact me and leave a message, at the phone numbers and/or email address listed below regarding my care.

- □ Home: ________________________
- □ Cell: __________________________
- □ Email: _________________________

The following individuals can receive information regarding my care from First Rehab:

	Name	Relationship
1.	____________________________	____________________________
2.	____________________________	____________________________
3.	____________________________	____________________________

PATIENT ACKNOWLEDGMENT OF PRIVACY PRACTICES (HIPPA)

I authorize First Rehab to release my information. First Rehab is committed to ensuring the privacy and confidentiality of our patient's Protected Health Information (PHI) which includes all billing information. First Rehab uses and discloses such information only according to our strict confidentiality policies and Federal and State laws. This information is used to treat you, receive payment and for other health care operations. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies. You have the right to review this notice prior to signing this consent. You may ask us to restrict the use and disclosure of your PHI. However, we are not required to agree to such a request; but if we do agree, we are bound by law to the agreed upon restrictions.

Patient/Guardian Signature: ____ Date: ___________________

MEDICAL HISTORY

Patients name: ________________________________ Date of birth:_____________

1. Reason for today's visit: ____
2. Hospitalization and surgical history: ____
3. List of medications: ____
4. Have you had any of the following conditions/ symptoms?

	No	Yes (Onset)
Asthma/Bronchitis/Emphysema		
Chest pain/Shortness of Breath		
Heart Disease/Angina		
Pacemaker		
High/Low Blood Pressure		
Heart Attack/Heart Surgery		
Blood Clot/Emboli		
Stroke/TIA		
Parkinson's Disease		
Pins or Metal Implants		Where?
Joint Replacement		Where?
Diabetes		
Infectious Disease		
Cancer/Radiation		Where?
Arthritis		Where?
Osteoporosis		
Hernia		
Epilepsy/Seizures		
Thyroid Condition		
Multiple Sclerosis		
Severe or Frequent Headaches		
Vision or Hearing Difficulty		
Numbness or Tingling		Where?
Sleeping Problems		
Dizziness		
Weakness or Energy Loss		
Recent Weight Gain or Loss		
Bowel or Bladder Problems		
Neck - Injury or Surgery		
Shoulder - Injury or Surgery		
Elbow/Hand - Injury or Surgery		
Hip/Knee - Injury or Surgery		
Ankle/Foot - Injury or Surgery		
Back - Injury or Surgery		
Other		

5. Have you had any of the following medical care for your injury?

	No	Yes (Onset)
Chiropractor		
General Practitioner		
Orthopedist		
Neurologist		
Podiatrist		
Massage Therapy		
Physical Therapy		
Occupational Therapy		
CT Scan		
EMG or Nerve Test		
MRI		
X-Ray		

6. For woman ONLY:

	No	Yes (Onset)
Pelvic Inflammatory Disease		
General Complicated Pregnancies/Deliveries		
Endometriosis		
Are you pregnant?		

Patient/Guardian Signature:

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Date: ____________________