Clarion Wellness and Rehabilitation

Rehabilitation Services
Outpatient Therapy Treatment Agreement

This is a Therapy Treatment Agreement in which the patient consents to treatments upon the provisions hereof and the patient, responsible party, and the facility hereby agree as follows:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____

Sex: M F (circle one)

Primary Insurance Company: _____ Group #: _____
Address: _____ Phone #: _____
Subscriber Name: _____ Co-Pay Amount: _____

Secondary Insurance Company: _____ Group #: _____
Address: _____ Phone #: _____
Subscriber Name: _____ Co-Pay Amount: _____

Physician: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Responsible Party: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Please initial each section:

_____ **Financial Responsibility:** I do hereby guarantee payment of therapy services to _____ (Clarion Wellness and Rehabilitation). I understand that I am responsible for payment of my account and the facility does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, the facility will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has been received, is due and payable upon receipt.

Patient Name: _____

Interest of 1.5% monthly (18% per annum) will be added to all accounts 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_____ **Cancellation Policy:** 24-hour notice is required to cancel a therapy appointment. A cancellation fee of $25.00 may be charged to the responsible party if sufficient notice is not provided.

_____ **Treatment Consent:** I hereby consent to the examinations, treatments and medications ordered or recommended by my physician or designated alternate.

_____ **Authorization for Release of Information:** The institution rendering services is hereby authorized to furnish and release, in accordance with the facility's policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

_____ **Assignments and Authorization to Pay Insurance Benefits:** I hereby assign and authorize payment directly to the facility, herein specified and otherwise payable directly to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for charges not covered or paid by my insurance.

_____ **Assignments and Authorization to Bill Medicare:** I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible for 20% of the Medicare Part B services.

Patient and/or responsible party agree and have received a copy of this Outpatient Therapy Agreement.

Patient: _____

Date: _____

Responsible Party: _____

Date: _____

Facility Witness: _____

Date: _____

FOR CLINIC USE ONLY:

Admission #: _____

Admission Date: _____

_____ Copy of insurance attached

OUTPATIENT REHABILITATION
PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical records in this office.

Date: _____ Birthdate:_____ OP Med Rec #_____

Patient Name:_____ Patient Phone #_____

Reason For Therapy Referral: _____

Date of Onset/Injury/Surgery_____ Physician:_____

MEDICAL HISTORY:

Do you have/or have you had any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold (ice)	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problem	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other Injuries	Yes	No
Are you pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No

If Yes on any of the above, please explain and give approximate dates:_____

_____

_____

MEDICATIONS:

Yes No Are you presently taking medications?

If Yes, please list what medications, dosage and for what condition:

Medication Dosage Condition

_____

_____

_____

_____

_____

OTHER INFORMATION:

Yes No Have you had previous therapy for the present condition for which you are to receive treatment here?

Yes No Is this a work related injury or condition?

Yes No Has this injury been reported to your employer?