River Region Rehab
Physical Therapy

Serving
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Destrehan

PATIENT/INSURANCE INFORMATION

Patient's Name____ Patient's Birth Date_________Age____Sex_____
Mailing Address____Employer__________________________________
Physical Address____Address___________________________________
City____________________________Zip____________________City______________________Zip___________
Home #(_____)____Occupation________________________________
Work #(_____)____Patient's S.S.#____________________________
Diagnosis____Referring Dr._____________________________
Emergency Contact (Must be a relative):

Name_____________________________Phone_________________Relationship_____________

PRIMARY WORKERS' COMPENSATION / **SECONDARY/SUPPLEMENT**

Insurance Co.____ ____
Phone No.____ ____
Insured's Name_______________________________________ ____
Insured's Policy/Group No.___________________________ ____
Member No.______________Insured's DOB______________ ____
Employer's Name/School Name_________________________ ____
Relationship Insured_________________________________ ____

****

PATIENT'S CONDITION RELATED TO

Employment______Yes_____No
Auto Accident State (______)
_________Yes_________No
Other Accident_______Yes_______No
Date of Injury/Symptom/Surgery:
____

ATTORNEY INFORMATION

Name of Attorney________________________
Address_________________________________
____
Phone #:________________________________
Notes___________________________________

If YES to any of the questions above, Is thre an attorney involved? ________Yes_________No
If YES, please fill-out attorney information.

AGREEMENT TO PAY

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand the financial policy detailed above. I understand that I am primarily responsible for all charges (including late charges) regardless of my existing medical coverage or payment plan. In the event my insurance company forwards payment directly to me, I will deliver such payment to you. I understand that I am responsible for meeting my insurance deductibles and co-insurance, and any non-covered services. Should my account become past due, the balance becomes my responsibility, and should be remitted promptly. I will be responsible for all collection and legal costs.

____________________ ________________________________ ________________________________
Date **Signature** **Guarantor/Relationship**

RIVER REGION REHAB
12371 HWY 90, STE D, LULING, LA 70070 * (985) 331-1001 * FAX (985) 331-1005
1972 ORMOND BLVD, STE D, DESTREHAN, LA 70047 * (985) 307-0925 * FAX (985) 307-0826

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RIVER REGION REHAB FINANCIAL POLICY

We have found that communication with our patients regarding our financial policy assists us in providing the best service to you. Please take time to read the following and sign at the bottom of the page. Thank you!

PRIVATE INSURANCE – Our staff is pleased to bill your insurance company as a courtesy to you after your insurance coverage has been verified. It is your responsibility to remit any amounts not covered by insurance. A weekly payment plan for your portion of the bill will be established. Should you choose to bill your own insurance, the billing office can provide an itemized list of services rendered during each appointment, however, full payment will be required a the time of each visit to continue treatment. We will bill all commercial insurance companies as long as you provide us with the necessary information and forms. If your insurance company fails to pay within 60 days from the date of service, we will expect you to pay the balance of the bill in full and seek reimbursement from your insurance company.

WORKERS' COMPENSATION – All preauthorized bills will b sent directly to the worker's compensation carrier. In the event that your claim is denied, you will be responsible for payment. A payment plan can be arranged with the office manager, or we will be happy to file any other insurance claims for you.

MEDICARE – Since we are a Medicare certified facility, we will file a claim to Medicare on your behalf for covered services. You will be responsible for any co-insurances, deductibles, and non-covered services.

LITIGATION/ATTORNEY – In order for us to be able to meet our financial obligations, a letter of protection from your attorney will be requested, as well as a $250.00 down payment and an agreed payment plan. If you have insurance coverage for your personal injury, we will file your claims to your carrier for you. We will ask you and your attorney to sign this form, thereby allowing payment to be made directly to us. A monthly statement of charges and payments will be sent to your attorney. We will request a status update routinely from your attorney since we will need to know if your attorney is still representing you and if the case is still pending. If for some reason you change attorneys, we must be notified immediately. Should your lawsuit be dropped, payments of any unpaid balance will be your responsibility and due in full.

I___________________________hereby agree to pay $________________per_______________toward any unpaid balance for services rendered commencing _______/_______/________.

I___________________________also authorize my attorney to pay my balance of charges for services rendered as a result of injuries sustained by m on, ______________and I understand that no settlement proceeds will be disbursed to me without first paying my unpaid balance of charges owed to this facility for services rendered.

_______________________________________ ____

Patient's Signature Date Guarantor/Relationship

PPO'S SPORTS MEDICINE, AND CONTRACTS – We will honor the terms of our contract in effect.

PRIVATE PAY – Full payment is expected when services are rendered in order to continue treatment. In the event a payment schedule is needed for private balances after insurance, an agreed payment toward any unpaid balance will be required to continue treatment. If the agreed payments is defaulted, the full balance becomes due upon demand.

CONSENT FOR TREATMENT – RELEASE OF INSURANCE – MEDICAL INFORMATION
PLEASE CHECK YES OR NO TO THE FOLLOWING QUESTIONS, BEFORE SIGNING

Yes_____No_____, I, the undersigned, hereby authorize the above provider to render any and all therapy service or other related services that provider feels are necessary or advisable to the patient in conjunction with physician referral.

Yes_____No_____, I assign payment of medical benefits directly to this provider.

Yes_____No_____, I authorize the release of any medical information necessary to process this claim. I also give my authorization to release my records, progress notes, and verbal reports if and when needed. I also authorize the request of an appeal or a fair hearing with my insurance or Medicare carrier if payment is denied.

_________________ ______________________________ _________________________________

Date Signature Guarantor/Relationship

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MEDICAL HISTORY

Patient Name:_______________________________________Date____________________

DO YOU HAVE A HISTORY OF:	**YES**	**NO**	**REMARKS**
High Blood Pressure	____	____	_____________
Heart Disease	____	____	_____________
Diabetes	____	____	_____________
Respiratory Problems	____	____	_____________
Cancer	____	____	_____________
Broken Bones	____	____	_____________
Pacemaker	____	____	_____________
Metal Implants	____	____	_____________

PLEASE LIST ANY SURGERIES YOU HAVE HAD__________________________

____

IF YOU ARE ON ANY MEDICATION, PLEASE LIST THEM BELOW:

____

Patient Signature:______________________________________Date__________________

Therapist Signature:____________________________________Date__________________

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OCCUPATIONAL HISTORY

Patient's Name:____ Date:___________

Occupation:____

Employer:____

Job Responsibilities:____

____

Please list five critical demands that are performed on a daily basis and give details:
(Example: climbing eight foot ladders, walking/balancing on beams, sitting in front of a computer, answering the phone, crawling in elevator shafts, etc.)

1.____

2.____

3.____

4.____

5.____

Do you perform lifting activities on your job? Yes____ No____

If so, what is the maximum amount of weight lifted on our own? _____________lbs.

Thank you for your time in filling out this questionnaire which will allow us to better develop a well rounded program for you.

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PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand river Region Rehab's Notice of Information Practices. I understand that River Region Rehab may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that river Region Rehab will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in river Region Rehab's Notice of Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name (please print)

____
Patient Signature

____
Date

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DESIGNATED INDIVIDUALS AUTHORIZATION FORM

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of information.

Authorized Designees:

Name:____ Relationship:____________________

Name:____ Relationship:____________________

Name:____ Relationship:____________________

Name:____ Relationship:____________________

____
Patient Name (please print)

____
Patient Signature

____
Date