



Patient Information

Referred By: _____
Referring Physician: _____

Appointment
Date: _____
Time: _____

Patient Name: _____
Last First Middle Int.

Date of Birth: _____ SS#: _____

Street Address: _____

City/State/Zip: _____

Phone Numbers: Home: _____ Work: _____

Cell: _____ Email: _____

Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____

Type (Circle): Insurance Fitness Work/Comp Personal Injury Auto D/A: _____

Primary Insurance: _____ Phone: _____
ID/Claim #: _____ Group #: _____
Policy Holder Name: _____ DOB (if other than patient): _____

Spoke with: _____ on _____ 20____ Effective Date: _____

Copay/Co-ins: _____ Deductible: _____ Met: y/n \$ _____ Benefits: _____%

Secondary Insurance: _____ Phone: _____

ID/Claim #: _____ Group #: _____

Policy Holder Name: _____ DOB (if other than patient): _____

Notes: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby assign to Zarett Rehab & Fitness all payments made by any insurance company for physical therapy services rendered to myself or my dependents. I further hereby assign to Zarett Rehab & Fitness all payments for said physical therapy services are sent promptly and directly to Zarett Rehab. I understand that I am responsible for any amount not covered by insurance.

Signature

Date



Medical History Intake Sheet

Name _____

Date _____

Please check if you have had any of the following:

- | | | |
|---|--|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Atrial fibrillation |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Circulatory problems |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Broken bones | <input type="checkbox"/> Metal implants |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> GI problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Epilepsy/seizures | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Bowel/bladder changes |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other |
| <input type="checkbox"/> Diabetes (<input type="checkbox"/> Type 1 or <input type="checkbox"/> Type 2) | | |

Do you have a pacemaker? _____

Females: Are you pregnant? If so, how many months? _____

Please list relevant surgeries you have had _____

List any medications you are currently taking _____

Do you know of any medications to which you are allergic? _____



Patient Injury Information

PATIENT NAME _____ DATE OF BIRTH _____

AREA OF CONCERN _____

IS THIS DUE TO ACCIDENT OR INJURY? _____

WORK RELATED INJURY _____

AUTO RELATED INJURY _____

SPORTS RELATED INJURY _____

OTHER CAUSE OF INJURY _____

DESCRIBE HOW SYMPTOMS FIRST OCCURRED (please be specific)

DATE OF INJURY _____

HAVE YOU EVER BEEN TREATED FOR THE SAME INJURY IN THE PAST?

IF YES, WHEN, WHERE, AND UNDER WHICH INSURANCE COVERAGE?



Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Zarett Rehab & Fitness's Notice of Privacy Practices with an effective date of May 1, 2003.

Name of Patient _____

Address of Patient _____

Signature of Patient _____ Date _____

Name of Witness _____

Signature of Witness _____ Date _____



AUTHORIZATION/RELEASE OF MEDICAL INFORMATION AND PAYMENT

I authorize release of any medical information to determine and process Benefits payable for services rendered and noted on claim for the services. I also request payments of Government Benefits (such as Medicare or Medicaid) to be made on my behalf to Zarett Rehab & Fitness (who accepts assignments for these services).

SIGNATURE

DATE

AUTHORIZATION OF MEDICAL BENEFITS PAYMENT

I authorize payment of medical benefits directly to Zarett Rehab & Fitness for services indicated on the billing statement for these services.

SIGNATURE

DATE

***Please remember that insurance is considered a method of reimbursing a patient for fees paid to the provider of medical services and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance.

***This assignment will remain in effect until revoking by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by my primary health insurance center (if Medicare 20% of charges)



Billing and Insurance Information

I, _____ understand that if I am delinquent on my obligation to pay Zarett Rehab & Fitness, then I will be responsible for any late fees, interest charges, court costs, attorney fees, and collection charges should the balance not be paid in due diligence.

Billing Department

We here at Zarett Rehab & Fitness do our best effort in verifying your insurance coverage. However, it is ultimately your responsibility to call your insurance company for all your coverage needs. You will be responsible for any and all balance due to Zarett Rehab & Fitness.

_____ Patient Signature

_____ Date



Providing Your Credit Card Information

If you choose to pay with a credit card, we ask that you provide your credit card information for us to keep on file. We will provide you with the receipt after your credit card has been charged.

Your credit card will be charged if:

- A payment is missed at the time of service.
- A payment needs to be made towards your deductible (if applicable).
- A co-insurance payment needs to be made (if applicable).

_____ Yes, I will provide my credit card information.

****Please fill out all information below.**

_____ No, I will not provide my credit card information.

Name of Patient: _____

Name on Card: _____

Credit Card #: _____

Expiration Date: _____

Please Circle: VISA MASTERCARD DISCOVER

Billing Address: _____



Medicare Reimbursement

Please let this letter serve as a notice regarding Medicare guidelines on reimbursement for outpatient physical therapy. Currently the annual allowable reimbursement for physical therapy is limited to \$1840.00. Medicare will pay 80% of this amount; your secondary insurance will pay their responsibility. If that amount is exceeded the patient becomes responsible for the excess balance. ** Therefore, we make it our policy to inform the patient of an approximate time when that amount is reached. It generally takes about 12 visits, but it could take fewer or more visits based on the type of treatment and modalities that are used. If you have any questions, please feel free to address them with the front desk staff or the management.

Sincerely,
Zarett Rehab Management

**In a few cases the secondary insurance will continue beyond the point of allowable reimbursement limit being reached. We will make you aware of that and physical therapy may continue.

Patient signature _____

Date _____