Comprehensive Rehab OF WILSON, INC.
Eileen Carter - Owner, President
Physical Therapy Occupational Therapy Speech Therapy
1811 Forest Hills Road • Wilson, NC 27893 • (252) 243-7400 • FAX (252) 243-3291

***We appreciate your cooperation in filling out this form.***

***Please give the Receptionist your insurance card to copy for our records.***

## PATIENT INFORMATION

**Date:**____/____/____

Last Name: _____ First Name: _____ MI: _____

Suffix: _____ Nickname: _____ ○M ○F DOB: ____/____/____

Address: _____

Home #: _____ Cell : _____

Work #: _____ Email: _____

SS#: ____-____-____ Marital Status: ☐S ☐M ☐D ☐W Driver's License#: _____

Occupation: _____ Employer: _____

☐Student ☐Full Time ☐Part Time ☐Retired ☐Disabled

Emergency Contact: 1)_____ Phone #: _____

2)_____ Phone #: _____

Relationship: _____ Referring Physician: _____

Primary Physician: _____ Pharmacy: _____

How did you hear about us? _____

Please describe reason for visit:

_____

_____

_____

Did you have surgery? ○Y ○N Date of Surgery: ____/____/____ Date of Onset: ___/____/____

Have you previously had Physical Therapy or Home Health? ○Y ○N From Where: _____

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## Billing Information

Primary Insurance: _____ Policy #: _____

Policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy holder's DOB: ____/____/____

Secondary Insurance: _____ Policy #: _____

Policy holder: ☐ Self ☐ Spouse ☐ Child ☐ Other Policy holder's DOB: ____/____/____

## Workers Compensation, Accidents, Etc.

Bill to: _____
(Name of Insurance Company) (Address)

Accident/Injury/Illness onset date: ____/____/____ Claim #: _____

Adjuster: _____ Contact #: _____
(Name)

Accident Description: _____ Accident State: _____

Employer at the time of accident: _____

HR Person: _____ Work #: _____

### *Financial Agreement and Assignment of Benefits*

I authorize treatment and understand that I am responsible for any and all fees incurred with ***Comprehensive Rehab of Wilson*** to file insurance claims as a courtesy to the patient. The financial responsibility for services rendered rests solely with the patient/guarantor. I understand that the agreement of the insurance company to pay for medical care is a contract between the patient ant the insurance company. I agree that it is my responsibility to determine whether services to be provided by ***Comprehensive Rehab of Wilson*** are covered by my health plan and I will pay for services that are not covered. I authorized my insurance benefits to be paid directly to ***Comprehensive Rehab of Wilson*** and I authorize the release of records to any agency involved in the payment of treatment. I understand that I am responsible for any medical records charge that is not paid for by my attorney or third party carrier. I acknowledge that balances over 30 days will be assessed a late charge and I understand that in the event that collection is necessary, I am responsible for ALL collection fees and attorney fees applied.

Signature: _____ Date: ____/____/____
(Patient/Responsible Party)

## MEDICAL HISTORY

| Allergies | Depression | HIV/AIDS |
|---|---|---|
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Anemia | Diabetes | Incontinence |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Anxiety | Dizzy Spells | Kidney Problems |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Arthritis | Emphysema/Bronchitis | Metal Implants |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Asthma | Fibromyalgia | MRSA |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Autoimmune Disorder | Fractures | Multiple Sclerosis |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Cancer | Gallbladder Problems | Muscular Disease |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Cardiac Conditions | Headaches | Osteoporosis |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Cardiac Pacemaker | Hearing Impairment | Parkinson's |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Chemical Dependency | Hepatitis | Rheumatoid Arthritis |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Circulation Problems | High Cholesterol | Seizures |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Currently Pregnant | High/Low Blood Pressure | Smoking |
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |

| Speech Problems | Thyroid Disease | Vision Problems |
|---|---|---|
| ○Yes ○No | ○Yes ○No | ○Yes ○No |
| | | |
| Strokes | Tuberculosis | |
| ○Yes ○No | ○Yes ○No | |
| | | |

Please list any allergies you may have such as latex, medications, etc.

_____

_____

_____

## Surgery/Procedures

| Date | Surgeon | Body Part |
|---|---|---|
| | | |
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Please use the space below for additional information that would help your therapist with your care. Thank you.

_____

_____

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_____

## Medications

| Name: | Dosage: | Frequency: |
|---|---|---|
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# WELCOME TO COMPREHENSIVE REHAB OF WILSON

Comprehensive Rehab of Wilson is committed to your successful rehabilitation. Please carefully read our financial policy and let our staff know if you have any questions or concerns.

**INSURANCE**
We will file your insurance claims according to the insurance information you provide. We will file your insurance and do not file third party insurance. Please inform us of any changes that occur in your insurance coverage. Any co-payment, deductible, or other amounts not covered by insurance should be paid at the time of each treatment unless arrangements are made with management. (Sometimes supplies and equipment are not covered by insurance)

**MEDICARE**
Comprehensive Rehab of Wilson is a Medicare certified rehab agency. We accept assignment. You are responsible for all co-insurance and all deductibles as allowed by law.

**WORKERS COMPENSATION**
Please provide employer information as requested so these claims can be correctly filed. These services require verification but no payment from the patient as long as we have approval in writing.

**PAYMENT POLICY**
Our office accepts the following methods of payment, cash, check, Mastercard, Visa, American Express, Discover or Extended Plan Payment. A finance charge of 1 1/2% per month (18%) will be added to all balances that remain unpaid more than 30 days past the statement. Please be advised if your account remains inactive 90 days, we will exercise our right to submit your balance to a collection agency.

**RETURNED CHECK POLICY**
We charge a $50.00 fee for any returned checks plus the amount of the check.

**RELEASE/PAYMENT POLICY**
To the best of my knowledge, the information on the registration for is correct. I hereby authorize treatment by Comprehensive Rehab of Wilson and/or any authorized agents or representatives and further allow them to file, release information, assign and collect benefits due from them for services until revoked by me.

I have read and understand that I am responsible for my balance. If necessary, I authorize Comprehensive Rehab of Wilson and/or any authorized agents or representatives to issue a complaint to the insurance commissioner on my behalf.

_____ _____
Patient (Parent or Guardian if under 18) Date

_____ _____
Witness Date

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# COMPREHENSIVE REHAB OF WILSON, INC
# NO SHOW/CANCELLATION POLICY

## NO SHOWS

Patients who fail to be present for a scheduled appointment without calling to cancel the appointment within 24 hours will be considered a "no show". Patients who consistently fail to be present for scheduled appointments will be considered a chronic "no show".

Time slots reserved for you prevent from offering it to others. If you "no show" we lose a time slot that could be used to help another patient. Our employees waste valuable time getting prepared for your visit. Therefore, we charge a "no show" fee for all who fail to give a 12 noon cancellation day before your scheduled appointment notice. **The fee for a new patient missed appointment will be $75.00. established patients will be charged $30.00.** These fees are not billable to insurance and the fee will be cash or credit/debit only. Chronic "no show" (3 or more) patients may be dismissed from the practice for failure to follow therapist recommendations.

## CANCELLATIONS

All cancellations require a 12 noon day before notice to the clinic. We realize that sickness plays a factor in having no choice but to cancel an appointment within the cancellation policy. However, please understand that chronic cancellation due to sickness may have to be considered for discharge due to no progression with therapy. The above fees will apply.

We do not waive cancellation and no show fees due to rain, transportation/work issues. Emergencies and snow/ice storms are reasons to waive fees and will be upon management discretion.

Our goal at Comprehensive Rehab of Wilson, inc., is to work with you to get better. In order to achieve this we must have your cooperation and participation in your plan of care. We are committed to serve you, our patient with the best care possible.

***I have read and fully understand the above written office policies and procedures for no-show appointments and cancellations by Comprehensive Rehab of Wilson, Inc.

PATIENT NAME/GUARDIAN DATE

revised 11/16/15

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# CLINIC/FITNESS POOL POLICY

1. Pool door is locked when not in use. (any break times or if sessions have ended)
2. Key is kept at pool location or at pool door at a safe height greater than 5 feet
3. Small sign is visible in pool are stating that unattended children are not allowed in pool area.
4. Only four clients allowed in pool at the same times
5. No diving (sign is posted)
6. Shower before entering
7. All incontinent clients must wear non permeable protection.
8. All clients with open wounds must have appropriate sealed wound dressing.
9. There is a one hour maximum time limit for your individual pool session if you are here for FITNESS
10. Shoes must be worn in/out of pool room.

I, _____ understand these listed polices

Signature:_____ Date:_____

revised 2/2/16

# COMPREHENSIVE REHAB OF WILSON, Inc.

## NOTICE OF PATIENT INFORMATION PRACTICES

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

### Comprehensive Rehab of Wilson's LEGAL DUTY

Comprehensive Rehab of Wilson is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

### USES AND DISCLOSURES OF HEALTH INFORMATION

Comprehensive Rehab of Wilson uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Comprehensive Rehab of Wilson may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Comprehensive Rehab of Wilson may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, Comprehensive Rehab of Wilson's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Comprehensive Rehab of Wilson may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

### PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Comprehensive Rehab of Wilson will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

If you are concerned that Comprehensive Rehab of Wilson may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Comprehensive Rehab of Wilson's health information practices or if you have a complaint, please contact the following person:

**Comprehensive Rehab of Wilson, Inc.**
***Eileen Rodri Carter, PT, MBA***
***1811 Forest Hills Road, Wilson, NC 27893***
**Telephone: 252-243-7400 Fax: 252-243-3291**

# COMPREHENSIVE REHAB OF WILSON, INC.

## PATIENT HIPPA AND CONSENT FORM

I have read and fully understand Comprehensive Rehab of Wilson, Inc's Notice of Information Practices. I understand that Comprehensive Rehab of Wilson, Inc. may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating 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 Comprehensive Rehab of Wilson, Inc., will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I herby consent to the use and disclosure of my personal health information for purposes as noted in Comprehensive Rehab of Wilson, Inc Notice of Information practices. I understand that I refrain the right to revoke this consent by notifying the practice in writing at any time.

_____ Patient Name

_____ Signature

_____ Date

I also authorize Comprehensive Rehab of Wilson to Text me and/or email me to remind me of my upcoming appointments

_____ Cell Number

_____ Email Address

I authorize _____ (name), my _____ (relationship) to obtain any information from Comprehensive Rehab of Wilson, Inc upon showing their ID.

_____ Patient Name

_____ Signature