Eileen Carter · Owner, President

Comprehensive Rehab OF WILSON

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: _____
Street City St Zip Code

Home #: _____ Cell : _____

Work #: _____ Email: _____

SS#: ____-____-____ Marital Status: ☐S ☐M ☐D ☐W

Occupation: _____ Employer: _____

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

Emergency Contact: 1) _____ Phone #: _____
(Relationship) _____

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)

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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 only your health insurance and we 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 will be paid at the time of each treatment unless arrangements are made with management.** (Supplies or equipment are not always covered by your plan)

Medicare

Comprehensive Rehab of Wilson is a Medicare certified rehab agency. We accept assignment-meaning Medicare will pay its portion and you are responsible for the remaining either deductible or coinsurance amount.

Workers Compensation

Please provide employer information as requested for claims to be filed correctly. These services require verification for coverage and an authorization from WC carrier. No payment will be collected from injured worker as long as we have the correct information and approval in writing.

Payment Policy

Our office collects payments at time of services with the following methods of payment-Cash, Check, American Express, Discover, MasterCard, Visa, HAS, or an extended payment plan (approved by management only). A finance charge of 1 ½% 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 for 90 days, we will exercise our right to submit your balance to a collection agency.

(RETURN CHECK POLICY-you will be charged a $50.00 fee if check is returned for NSF)

Release/Payment Policy

To the best of my knowledge, the information on the registration documents is correct. **I hereby authorize treatment by Comprehensive Rehab of Wilson** and/or any authorized agents/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 any balance on my account. If necessary, I authorize Comprehensive Rehab of Wilson and/or authorized agents/representatives to issue a complaint to the insurance commissioner on my behalf.

_____

Patient Name (Print)

_____

Signature (Responsible Party) Date

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NO SHOW / CANCELLATION / INSURACE POLICIES

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

INSURANCE VERIFICATION

Please make sure you are aware of your benefit plan in detail. Your insurance will be verified prior to your visit however as your insurance will state, this is not a guarantee of payment until services are sent to your insurance company. Please understand it may take up to 4 weeks for your insurance claims to be processed either at our facility or another facility. This process may make the information given to us inaccurate at the time we call. Ultimately, you the patient will be responsible for any insurance claims that your insurance company does not pay.

NO SHOWS

Our employees take valuable time in getting you scheduled and preparing for your visit. Patients who fail to be present for a scheduled appointment without calling to cancel within 24 hrs of appointment time will be considered a "no show". If you "no show" this not only takes away from your care but also could have been available for another patient's care. **Therefore, you will be charged for a "no show" fee of 30.00 if you fail to contact our office by 12 noon the day before your scheduled appointment.** These fees are not billable to the insurance company, will be the responsibility of the patient. Patients who consistently fail to present for scheduled appointments will be considered a chronic "no show" and will be discharged.

CANCELLATIONS

All cancellations require a 24 hr notice, however we realize that sickness could play a factor in this but you still need to contact the office to let us know what is happening. Please understand that chronic cancellations do to sickness may require you being put on hold or even discharged due to no progression with your therapy. Also above fees may apply.

We do not waive "no show" or cancellation fees due to rain, transportation/work issues. We realize emergencies such as snow/ice storms, death, family emergencies are reasons to waive such fees however will be decided upon management discretion. By signing this form, you fully understand the above statements and agree to the terms.

Print Name Signature Date

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Patient HIPAA / Notification Form

I have read and fully understand Comprehensive Rehab of Wilson, Inc. Notice of Information Practices (you may obtain a copy of this if you wish). I understand that Comprehensive Rehab of Wilson, Inc. may use of 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 such requests for restriction on a case by case basis, but does not have to agree to such requests.

I hereby give 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.

_____

Print Name

_____ Date_____

Signature

I also authorize Comprehensive Rehab of Wilson, Inc. to TEXT / EMAIL to remind me of my upcoming appointments.

Cell #_____ Email_____

(Please do not respond when receiving such reminder due to our office will not receive response that you send, call the office if you are not able to make your appointment.)

Release of Medical information

I authorize _____, my _____ to obtain any information from
(Name) (Relationship)
Comprehensive Rehab of Wilson, Inc. on my behalf upon showing Photo ID.

_____

Print Name

_____ Date_____

Signature

MEDICAL HISTORY/Existing or Relevant Previous Conditions

Answer/check yes or no to each condition

Allergies ◯Yes ◯No	Diabetes ◯Yes ◯No	Metal Implants ◯Yes ◯No
Anemia ◯Yes ◯No	Dizzy Spells ◯Yes ◯No	MRSA ◯Yes ◯No
Anxiety ◯Yes ◯No	Emphysema/Bronchitis ◯Yes ◯No	Multiple Sclerosis ◯Yes ◯No
Arthritis ◯Yes ◯No	Fibromyalgia ◯Yes ◯No	Muscular Disease ◯Yes ◯No
Asthma ◯Yes ◯No	Fractures ◯Yes ◯No	Osteoporosis ◯Yes ◯No
Autoimmune Disorder ◯Yes ◯No	Gallbladder Problems ◯Yes ◯No	Parkinson's ◯Yes ◯No
Cancer ◯Yes ◯No	Headaches ◯Yes ◯No	Rheumatoid Arthritis ◯Yes ◯No
Cardiac Conditions ◯Yes ◯No	Hearing Impairment ◯Yes ◯No	Seizures ◯Yes ◯No
Cardiac Pacemaker ◯Yes ◯No	Hepatitis ◯Yes ◯No	Smoking ◯Yes ◯No
Chemical Dependency ◯Yes ◯No	High Cholesterol ◯Yes ◯No	Speech Problems ◯Yes ◯No
Circulation Problems ◯Yes ◯No	High/Low Blood Pressure ◯Yes ◯No	Strokes ◯Yes ◯No
Corona Virus/Covid 19 ◯Yes ◯No	HIV/AIDS ◯Yes ◯No	Thyroid Disease ◯Yes ◯No
Currently Pregnant ◯Yes ◯No	Incontinence ◯Yes ◯No	Tuberculosis ◯Yes ◯No
Depression ◯Yes ◯No	Kidney Problems ◯Yes ◯No	Vision Problems ◯Yes ◯No

If you answered "yes" to any of those conditions, please explain and give approximate/dates when diagnosed also describe any other conditions you may be having:

_____

_____

_____

_____

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

_____

_____

Surgery/Procedures

Date	Surgeon	Body Part

Please use the space below for additional information that would help your therapist with your care. Thank you.

_____

_____

_____

MEDICATIONS

Drug Name	Dosage	Frequency:

You may use back side of this form to include any other medications, surgeries, etc.