Patient's Name (Last)_____ **(First)**_____**(MI)**___

SSN_____-_____-_____ **Sex** ☐ Male ☐ Female **Date of Birth**_____

Language _____ **Interpreter Needed?** ☐ Yes ☐ No

Marital Status ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Domestic Partner

Referring Physician _____**Date of Injury/Onset of Symptoms**_____

PRIMARY INSURANCE

Name of Insurer_____

Address of Insurer_____

City, State, Zip_____

Phone_____

Insured's name_____

Relation_____

Insured's DOB_____

ID/Group#_____

SECONDARY INSURANCE

Name of Insurer_____

Address of Insurer_____

City, State, Zip_____

Phone_____

Insured's name_____

Relation_____

Insured's DOB_____

ID/Group#_____

Is your condition you are being referred to therapy for related to?

☐Employment ☐Auto Accident ☐Other Accident ☐Non-Accident ☐ Other _____

Recommended by: (*List name)*_____

☐Medical Professional ☐Relative/Friend ☐Newspaper ☐Internet ☐ Other _____

May we contact you regarding your appointments and to provide appointment reminders? ☐ Yes ☐ No

If yes, how would you prefer to be contacted: ☐ By phone message ☐ By text message ☐ By email

Please note that reminders sent via text message or email may not be secured

Patient's Home Address_____

City_____ **State**_____**Zip**_____

Home Phone_____**Cell Phone** _____

Work Phone _____**Email Address**_____

Employer_____

Employer's Address_____

City_____ **State**_____**Zip**_____

Spouse's Name _____**DOB**_____**Employer**_____

In Case of Emergency, please call:

Name_____**Relation**_____**Phone**_____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage as listed and assign directly to Prairie Rehabilitation all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Prairie Rehabilitation to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

MEDICARE AUTHORIZATION

I authorize any holder of medical or other information about me to release to the Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request of payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated above or on the HCFA-1500 form, my signature authorizes release of the information to the insurer or agency shown.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. The notice describes how my health information may be used or disclosed and outlines my rights with respects to such information.

MEDICALLY INFORMED CONSENT

I voluntarily consent to therapy treatment and services deemed necessary by my therapist and/or physician. I am aware that the practice of physical, occupational, and speech therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at Prairie Rehabilitation. It is Prairie Rehabilitation's sincere intent to educate me on every process from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them.

RELEASE OF RECORDS

I hereby authorize other healthcare providers who are or have been involved in my care to release my medical records to Prairie Rehabilitation. I hereby authorize Prairie Rehabilitation to transfer copies of my medical records to any other healthcare provider that is involved with my care while I am a patient of Prairie Rehabilitation or to whom I may be transferred to during my course of treatments. I hereby authorize Prairie Rehabilitation, any insurance company, claims or benefits administrator, pre-payment organization, governmental agency or health care provider to obtain information and provide information (including medical information and financial records) necessary to process an application for insurance, Medicare or Medicaid benefits, to determine availability for benefits that may be available and to obtain required pre-authorizations.

INTERPRETING SERVICES

If I were in need of an interpreter, I will inform Prairie Rehabilitation of this need. If Prairie Rehabilitation provides an interpreter for me, I give my consent to let Prairie Rehabilitation provide my insurance information to that interpreter for their billing purposes. Prairie Rehabilitation may choose to utilize a phone service for interpreting versus an in person interpreter.

BY SIGNING BELOW I INDICATE: ALL THE INFORMAITON I PROVIDED IS CORRECT AS WRITTEN, I HAVE GIVEN AUTHROIZATION FOR INSURANCE PAYMENTS TO BE DIRECTED TO PRAIRIE REHABILITATION, I CONSENT TO THERAPY SERVICES AS DEEMED NECESSARY, I HAVE AGREED TO THE RELEASE OF MY MEDICAL RECORDS, AND INTERPRETING POLICY (IF APPLICABLE) AS STATED.

X _____ _____

Patient Signature ***Date***

_____ _____

Witness Signature ***Date***

FINANCIAL POLICY

Prairie Rehabilitation has found that communication with our patients regarding our financial policy assists us in providing the best service to you and helps keep our charges as equitable as possible. Please take time to read the following and sign at the bottom of the page.

INSURANCE: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance company as a courtesy if provided with the appropriate billing information and forms. We will allow 60 days for receipt of your insurance payment. If your insurance company fails to pay within 60 days, we will expect you to pay the balance of the bill in full and seek reimbursement from your insurance company as a courtesy. We will file secondary insurance if information is provided.

VERIFICATION OF INSURANCE: We accept and are in-network with most major insurance plans but because of the wide range of insurance plans in effect, Prairie Rehabilitation will verify insurance coverage, deductibles, and other limitations as a courtesy to the patient. However, the verification of insurance quoted to us by your insurance company is not a guarantee of payment. This is why we encourage all patients to check their benefits. Should your insurance company withhold payment of your claim for any reason, we will be glad to assist you in obtaining an explanation from them. However, again, we cannot guarantee payment of your claim. Payment will be due from you at the time of service for any non-covered services or co-pays. If circumstances warrant an extended payment plan, our Patient Accounts Manager is available to assist you with such arrangements.

SUPPLEMENTAL INSURANCE: For Medicare patients, we will make sure that your claim is filed with your supplemental insurance policy as a courtesy. We will file secondary insurance if information is provided.

CO-PAYMENTS: Co-payments must be paid upon the patient's arrival. We accept cash, check and VISA/MasterCard/Discover. Debit cards and Flex cards are also accepted.

PERSONAL INJURY: We will bill your liability insurance carrier for you. However, because liability coverage may be limited and lawsuits can go on for years, you must provide a copy of your private insurance card.

NO INSURANCE: Payment is expected at the time services are rendered.

STATEMENTS: Statements will be mailed to you on a monthly basis around the 20th of each month. These statements are for your records. Your insurance company will receive a separate form from us.

PAST DUE ACCOUNTS: A service charge of .6% per month (7.2% annually) will be assessed to accounts over 60 days.

RETURNED CHECKS: There will be a $30.00 fee for all returned checks.

PAYMENT METHODS: We accept cash, personal checks, and Novus/Discover, MasterCard and VISA credit cards as well as Flex cards.

SPECIAL NEEDS: Special needs are understood by us. It may be necessary to set up a payment plan for a patient requiring extensive treatment. If this situation is necessary for you, please let the receptionist know before your treatment and arrangements can be made.

I understand and agree that I am responsible and liable for payment of all charges assessed for professional services rendered. I understand that insurance claim forms will be submitted to my insurance company as a matter of convenience only and that I am primarily responsible for all charges regardless of my existing medical coverage. In the event my insurance company forwards payment directly to me, I will deliver such payment to Prairie Rehabilitation.
I understand and agree that if it becomes necessary for Prairie Rehabilitation to retain an attorney or commence any legal action for collection of outstanding charges on my account, I will be responsible for all reasonable fees incurred by Prairie Rehabilitation in addition to such outstanding balance.

I understand and agree to the above.

Patient Signature X_____ **Date**_____

PATIENT GUIDELINES

Welcome and thank you for selecting Prairie Rehabilitation for your physical, occupational, or speech therapy care. Our mission is to be a leader in rehabilitation and wellness and, through a steadfast quest for excellence; we will have a positive impact in the lives of those we serve. Listed below are some guidelines for your review. Throughout the time you receive services from our organization, please feel free to contact any member of our teams with questions or if you need any information.

- **PRIMARY CARE REFERRALS—**Please obtain all necessary referral forms (if required by your insurance) from your primary care physician in advance of your visits. Unfortunately, patients cannot be seen without the appropriate referral.

- **NON-COVERED SERVICES—**Most insurance companies do not cover supplies and equipment so these items must be paid for at the time of service, with the exception of workman's compensation which we will submit for payment.

- **ATTIRE FOR THERAPY—**Shorts or sweatpants with an elastic waistband may be ideal particularly if we are treating the lower extremities. Loose-fitting clothing is recommended for treatment of the upper extremity.

- **TARDINESS—**Please call if you are running late. Therapy treatments may be abbreviated for patients arriving 10-15 minutes late. Patients arriving more than 15 minutes late may be asked to reschedule. Obviously, we try to deliver the same respect for your time—if we are running late, the session will be completed in its entirety.

- **CANCELLATIONS—**We request that patients who are unable to keep an appointment contact our office at least 24-business hours prior to the scheduled appointment time since there are usually other clients that could benefit from this treatment slot. If a cancellation and/or missed appointment without notification is made the same day as the appointment, a $25.00 charge will be assessed. Assessed fees must be paid for prior to receiving the next treatment.

- **REPEATED MISSED APPOINTMENTS—**We will be unable to schedule future appointments for patients having three (3) missed appointments and/or cancellations without appropriate notice, particularly if we feel that these missed appointments are adversely affecting our treatment plan.

I have read and understand the above guidelines.

Patient Signature X_____ **Date**_____

Prairie – REHABILITATION –

PATIENT HISTORY

Please Print and Complete All Sections

Patient Name: _____ **Age:** _____

Today's Date: ____/____/____ **Last MD Visit:** ____/____/____ **Next MD Visit:** ____/____/____

PAST MEDICAL HISTORY *(Please mark if you have had any of the following)*

☐ High Blood Pressure	☐ Cancer	☐ Back Injury
☐ Diabetes	☐ Heart Problems	☐ Neck Injury
☐ Osteoporosis	☐ Lung Problems	☐ Depression
☐ Arthritis	☐ Unexplained Weight Loss	☐ Other Serious Injury/Medical Condition

Please explain those marked above: _____

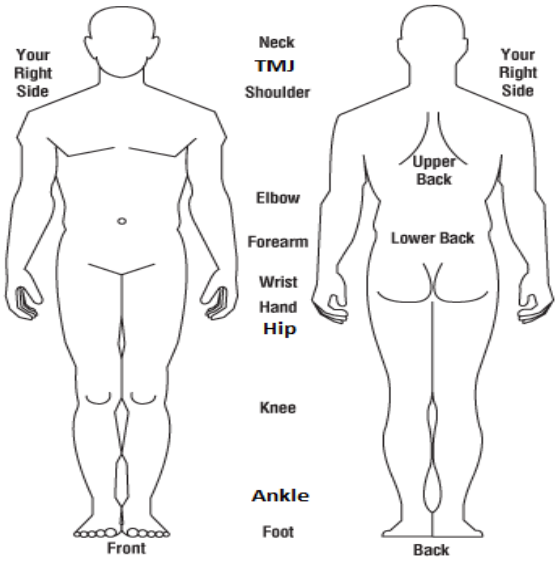
Please list any medications you are currently taking: _____

CURRENT CONDITON

Briefly describe your injury or symptoms (what happened, how long before seeing a doctor, changes in severity of symptoms, etc.) _____

PAIN

Using the diagram to the right, please indicate any areas of pain or numbness:



Please rate the intensity of your pain (*Circle One)*

- ***At its lowest:*** ***0 1 2 3 4 5 6 7 8 9 10***
- ***At its highest:*** ***0 1 2 3 4 5 6 7 8 9 10***
- ***Right now:*** ***0 1 2 3 4 5 6 7 8 9 10***

Describe your pain (sharp, dull, achy, constant, changing, etc.)

What increases your pain? _____

What relieves your pain? _____

FUNCTION

Are you working right now? ☐ **Yes** ☐ **No**

Please list your job requirements/expectations: _____

What activities are you NOT able to do now? _____

What goals do you hope to achieve by coming to therapy? _____

Signature: _____ **Date:** _____

For Therapist Use Only: **Has patient had PT or OT in the last 12 months?** _____

Surgeon: _____ **Date of Surgery** _____

ICD-10 Codes: _____ **Diagnosis:** _____ **Insurance:** _____