Waite Rehab & Wellness, LLC

PATIENT INFORMATION – PLEASE READ CAREFULLY AND COMPLETE IN FULL

Patient Name: ____ Today's Date: _________________

Sex: ______ Age: ______ DOB: ______________ Home Phone: ________________________________

Cell Phone: _________________________ Email: ____

Address: ____

City: _______________________________________ State: ______ Zip: ____________________

Marital Status: S M W D Social Security # _____________________________________

Patient Employer: _______________________________________ Work Phone: _______________________

Emergency Contact: __________________________________ Phone: _______________________________

Is the patient under Home-Health or Hospice Care? Yes / No - Alert front desk immediately if yes.

Primary Insurance Company: ____

Subscriber Name (if not patient): ______________________________________ DOB: ____________________

Relation to Patient: ____

Secondary Insurance Company: ____

Subscriber Name (if not patient): ______________________________________ DOB: ____________________

Relation to Patient: ____

When is your follow-up appointment with your referring doctor? ___________________

Type of Accident / Injury / Surgery / Work / Auto / Other: ____

Date of Accident / Injury / Surgery: ______________________

Have you received therapy from any other provider during this calendar year? ☐ **Yes** ☐ **No**

THE ABOVE INFORMATION IS CONFIDENTIAL AND USED ONLY FOR TREATMENT PLAN AND FILING INSURANCE CLAIMS

Physical Therapy Evaluation and Treatment

I consent to the rendering of a physical therapy evaluation and treatment as deemed appropriate by the treating therapist. I have the right to decline treatment at any time. Your therapist will explain your physical therapy diagnosis and discuss treatment recommendations with you. We strive to provide the highest quality care with minimal discomfort, however, some conditions require "pushing into pain" and we will do our best to make you as comfortable as possible afterwards through the use of pain management modalities. Physical therapy as any other type of medical care is most effective if you participate according to the plan of treatment agreed upon with your therapist. If at any time you have questions concerning the type of services delivered or how your services rendered, please talk with your therapist. Remember, we are here to provide you with the best care available in order to improve your quality of life through physical therapy.

Medical Insurance Authorization and Release

I authorize Waite Rehab & Wellness to correspond to my insurance company(s) as the provider of physical therapy services received at our facility. Waite Rehab & Wellness shall act as an agent in collection of payment from your insurance company(s), not limited to submittals of medical records obtained at our facility as necessary for claim processing.

Patient Financial Responsibility

I accept full and complete financial responsibility for all medical services rendered to the registered patient and agree to any and all insurance co-payments, deductibles, and co-insurance that may be required under the terms of my medical insurance policies, as well as pay for any medical care that is considered a "non-covered" service under the terms of my medical insurance plan. I further acknowledge, understand and agree, that in the event that I fail to make payments in accordance with the expressed/implied payment policy of Waite Rehab & Wellness, or in the event of default of my financial obligation to pay for services rendered, Waite Rehab & Wellness reserves the right to forward all fees for-services to an external collection agency.

Insurance companies require co-payments as deemed by your policy for each visit. Your co-payments are due at the time of appointments unless other arrangements have been made.

By signing below, I have read and agree to the above.

Signature: ____ Date: ________________________

Print name: ____