WELCOME

Patient Name: ____ Date: _____/_____/______

Thank you for choosing The Rehabilitation Center. We believe communication is essential to achieving the best possible patient outcomes. Understanding your needs and expectations is essential to our success. Likewise, it is vital for you to understand the services we offer and our expectations of you.

YOUR FIRST VISIT

You will be introduced to our facilities and our therapist. The purpose of this initial visit is to evaluate your condition, explain the treatment your physician has prescribed, and set rehabilitation goals that will help you enhance your health and quality of life. Your therapist will initiate your treatment plan, using the technologies and techniques that are appropriate for your condition.

INFORMATION REQUEST

You will be asked to provide us with information about yourself and your medical insurance. As a courtesy, our staff will contact your insurance provider to verify your coverage. Please keep in mind that any and all benefits quoted are not a guarantee of eligibility and/or benefits. If your insurance company requires a co-pay or co-insurance, we will collect this on each date of service.

PLAN OF CARE

We establish Plans of Care that reflect your physician's and your personal expectations for the results we intend to achieve. With a shared vision for the specific goals to be achieved, your therapist will manage your therapeutic care and document the progress you make each visit.

APPOINTMENTS

Your therapist will recommend how often you should schedule appointments and will also discuss home exercises you can do between appointments. It is beneficial to schedule several appointments in advance to ensure the most convenient treatment time and you should always confirm the date of your next appointment at the end of each treatment session. We will make every effort to accommodate your schedule and we will make every effort to stay on schedule. **Please keep your appointment and please be on time. Please refer to the Cancellation/No Show/Late Policy for more information.**

FEEDBACK

We welcome your feedback about the care and services you receive. We have a suggestion box that allows you to submit feedback whenever you feel it appropriate. If you ever have a question or concern, please speak with your therapist or call our office at (903) 893-7457 to speak with the Office Manager or Clinical Director.

NEW PATIENT INFORMATION

Patient Name: ____ Date: _____/_____/______

It is important that you thoroughly complete this form and provide a copy of both sides of your ID and insurance Card(s).

(Please Print)

<table>
<tr><td colspan="3">Patient's last name: First: Middle:</td><td>❑ Mr.
❑ Mrs.
❑ Miss
❑ Ms.</td><td colspan="2">Marital status:
❑ Single ❑ Married
❑ Divorced ❑ Separated
❑ Widowed</td></tr>
<tr><td>Is this your legal name?
❑ Yes ❑ No</td><td colspan="2">If not, what is your legal name(s)?</td><td>Birth date:
/ /</td><td>Age:</td><td>Sex:
❑ M ❑ F</td></tr>
<tr><td colspan="3">Street address:</td><td colspan="3">Social Security Number:
- -</td></tr>
<tr><td colspan="3">City:</td><td>State:</td><td colspan="2">ZIP Code:</td></tr>
<tr><td>Phone Number:
( ) -</td><td colspan="5">Email Address:</td></tr>
<tr><td colspan="4">Appointment Reminder: ❑ TEXT ❑EMAIL ❑NO THANKS</td><td colspan="2">Cell Phone Carrier:</td></tr>
<tr><td>Occupation:</td><td colspan="3">Employer:</td><td colspan="2">Employer Phone Number:
( )</td></tr>
<tr><td>Person responsible for bill:</td><td colspan="3">Address (if different):</td><td colspan="2">Phone Number.:
( )</td></tr>
<tr><td>Birth date:
/ /</td><td colspan="3">Social Security Number:
- -</td><td colspan="2"></td></tr>
<tr><td>Emergency contact:</td><td colspan="3">Relationship:</td><td colspan="2">Phone Number:
( )</td></tr>
</table>

INSURANCE INFORMATION

<table>
<tr><td colspan="4">(Please give your insurance card to the receptionist.)
Do you have Insurance? ❑ Yes ❑ No</td></tr>
<tr><td>Name of insurance (if applicable):</td><td colspan="2">Policy Number:</td><td>Group Number:</td></tr>
<tr><td>Subscriber's name:</td><td>Subscriber's Birth Date:
/ /</td><td>Subscriber's Social Security Number:</td><td>Patient's relationship to subscriber:
❑ Self ❑ Spouse ❑ Child
❑ Other</td></tr>
<tr><td>Occupation:</td><td>Employer:</td><td>Employer address:</td><td>Employer phone no.:
( )</td></tr>
</table>

SECONDARY INSURANCE

<table>
<tr><td colspan="4">(Please give your insurance card to the receptionist.)
Do you have Secondary Insurance? ❑ Yes ❑ No</td></tr>
<tr><td colspan="2">Name of insurance (if applicable):</td><td>Policy Number:</td><td>Group Number:</td></tr>
<tr><td>Subscriber's name:</td><td>Subscriber's Birth Date:
/ /</td><td>Subscriber's Social Security Number:</td><td>Patient's relationship to subscriber:
❑ Self ❑ Spouse ❑ Child ❑ Other</td></tr>
<tr><td>Occupation:</td><td>Employer:</td><td>Employer address:</td><td>Employer phone no.:
( )</td></tr>
</table>

TERTIARY INSURANCE

<table>
<tr><td colspan="4">(Please give your insurance card to the receptionist.)
Do you have Tertiary Insurance? ❑ Yes ❑ No</td></tr>
<tr><td colspan="2">Name of insurance (if applicable):</td><td>Policy Number:</td><td>Group Number:</td></tr>
<tr><td>Subscriber's name:</td><td>Subscriber's Birth Date:
/ /</td><td>Subscriber's Social Security Number:</td><td>Patient's relationship to subscriber:
❑ Self ❑ Spouse ❑ Child ❑ Other</td></tr>
<tr><td>Occupation:</td><td>Employer:</td><td>Employer address:</td><td>Employer phone no.:
( )</td></tr>
</table>

AUTHORIZATION

I have reviewed the above information and verify that it is accurate and current. I authorize the release of any medical or other information necessary to process an insurance claim. I understand that The Rehabilitation Center will attempt to get accurate information regarding my insurance benefits. I will not hold The Rehabilitation Center liable for insurance non-payment due to misquoted benefits. I acknowledge I am responsible for knowing and understanding my benefits plan. The Rehabilitation Center will file my insurance claims for me as a courtesy. I am ultimately responsible for all charges my insurance company does not pay, except for contracted network provider discounts that may apply. I request assigned benefits be paid to The Rehabilitation Center.

______________________________________ ______________________________

Signature (Parent/Legal Guardian) Relationship to Patient

______________________________________ ______________________________

Printed Name Date

IMPORTANT INFORMATION

Patient Name: ____ Date: _____/_____/______

ASSIGNMENT OF BENEFITS AND CONSENT FOR CARE

I herein assign my right to payment and/or benefits from any and all sources of payment, regardless of whether I am the policyholder or whether the payment source specifically identifies me as a beneficiary, and agree to have that payment remitted to an address that is named on a standardized UB-04 or CMS-1500 claim form. I herein assign my benefits in exchange for providing a service. I herein give consent to receive treatment from any therapist or assistant, employee or its agents, as determined by in conjunction with my plan of care and health care services ordered by an appropriate licensed health care professional.

FINANCIAL RESPONSIBILITY

I herein agree and understand that I am responsible for the cost of care or treatment and that I will make reasonable efforts to obtain payment for services. I also understand and agree that any discussion or printed document that is for the purpose of understanding what my payment source will pay is only an estimate based upon information received from my health plan. I understand that a health plan is any entity where they submit claims for payment on my behalf. I herein agree and understand that I am responsible for understanding the amount that is paid from my payment source, even if that amount is zero, regardless of what may have been explained to me by The Rehabilitation Center, its employees, agents or contractors. I also herein agree and understand that I am responsible for any and all costs of collection, should my account become delinquent as defined by including but not limed to late fees, attorney's fees, court costs or fees paid to a collection agency.

MEDICARE PATIENTS

I hereby certify that the information given by me in applying for payment for Medicare benefits under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Center for Medicare and Medicaid Services, or any of its intermediaries or carriers, any information needed for this or a related Medicare claim. I understand that unless I qualify for the cap exception, Medicare will not pay for therapy services that exceed the Medicare allowable caps – which in 2020 is $3000.00 for PT/SLP and $3000.00 for OT. If services qualify for the exception process, then standard Medicare deductibles and co-insurances will continue to apply toward my charges.

I have reviewed the above information and agree to the terms for treatment

____	________________________________
Signature (Parent/Legal Guardian)	Relationship to Patient
____	________________________________
Printed Name	Date

CANCELLATION/NO SHOW/LATE POLICY

Patient Name: ____ Date: _____/_____/______

Your success in rehabilitation is a direct result of the regular attendance to your therapy. When you schedule an appointment, we reserve that time just for you so that we may provide optimum treatment outcomes for all our patients. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. Should it be after regular business hours or a weekend, you may leave a message.

POLICY

- If you must change your appointment, we require at least 24-hour notice for Cancellation or Rescheduling.
- If you are more than 15 minutes late for your scheduled appointment time, we reserve the right to ask you to reschedule your appointment.
- If you CANCEL your appointment with less than 24-hour notice: 1st- Fee waived, 2nd-$20.00, 3rd-$40.00
- If you NO SHOW your appointment: 1st-$20.00 Fee, 2nd-$40.00 Fee
- After 2 violations of this policy, The Rehabilitation Center has the right to place patients on a same day scheduling policy for future treatments (which would not allow you to schedule any appointments in advance) or to discontinue therapy and notify your physician.
- Any fees accrued are charged to the patient, not the insurance company, and are due at the time of the patient's next visit.
- As a courtesy, when time allows, we make reminder calls/text for appointments. However, it is your responsibility as a patient to remember your scheduled appointments.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances, please contact our office as soon as possible.

I have read and understand the Appointment Cancellation/No Show/Late Policy and agree to its terms.

____________________________________	______________________________
Signature (Parent/Legal Guardian)	Relationship to Patient
____________________________________	______________________________
Printed Name	Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: ____ Date: _____/_____/______

Date of Birth: ___________________________________
Social Security #: ___________________________________
Address: ___________________________________

I hereby authorize The Rehabilitation Center to _____ **acquire** and/or _____ **release** protected health information (PHI) from and to my Physician and/or other professional personnel or agencies involved in the evaluation and management of requested and/or potential services. PHI may be subject to redisclosure by the recipient and is no longer protected under HIPAA's Privacy Rules.
I understand that I have the right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time. I also understand that such revocation must be in writing and received by the Center at 1216 Hillcrest, Sherman, Texas to be effective.

This disclosure of PHI and/or records is required for the following purpose(s):
____
____
____

This consent shall remain valid until revoked by you or sooner as indicated below:
____
You have the right to refuse to sign this form. The Center shall not condition treatment upon you signing this authorization.

I hereby release The Rehabilitation Center from all legal responsibility or liability that may arise from disclosure made pursuant to this authorization.

____ ________________________________
Signature (Parent/Legal Guardian) Relationship to Patient

____ ________________________________
Printed Name Date

____ ________________________________
Staff Witness Date

PHOTO RELEASE

Patient Name: ____ Date: _____/_____/______

I, ____________________________________ (Patient Name or Parent/Legal Guardian) hereby grant **The Rehabilitation Center** the right to use photography and/or videos for publicity, advertising, and any legal business purpose. I hereby relinquish all rights to any pictures and/or videos taken of _________________________________ (Patient/Childs Name) in connection with their activities at **The Rehabilitation Center** and give permission to publish and use the pictures and/or videos for any legal business purpose.

❑ I hereby **DO NOT** grant **The Rehabilitation Center** the Photo Release rights as explained above.

____ Signature (Parent/Legal Guardian)

_________________________________ Relationship to Patient

____ Printed Name

_________________________________ Date

HOW DID YOU HEAR ABOUT US?

- ❑ Physician Referral _________________________
- ❑ Personal Referral _________________________
- ❑ Company Employee _________________________
- ❑ Facebook _________________________
- ❑ Website _________________________
- ❑ TV/Radio _________________________
- ❑ Magazine _________________________
- ❑ Special Event _________________________
- ❑ Other _________________________