PRS Physical Therapy Hands that heal. Hearts that care.

PATIENT CHECK IN FORM

Patient Name:__________________________________ Patient Number: _________________

_______ 1.**ATTENDANCE**: A course of Therapy has been prescribed. Consistency in treatment is essential and attendance to all scheduled appointments is expected. We make every effort to respect your time and provide treatment in a timely manner; therefore we ask that you assist in this integral part of your recovery by attending your therapy sessions at the time scheduled within the prescribed frequency. Our policy requires notification of the cancellation of a scheduled appointment **PRIOR** to the appointment time. **The cancelled appointment should be rescheduled at the time of the cancellation.**

_______ 2. **ASSIGNMENT INSTRUCTIONS FOR DIRECT PAYMENT TO PROVIDER & PERMISSION TO RELEASE INFORMATION:**

I hereby instruct and direct ____ Insurance Company to pay:

Central PA Rehabilitation Services, Inc.
75 Evelyn Drive
Millersburg, PA 17061

If my current policy prohibits direct payment to an agency, then I will be responsible to make payment for the professional or medical expense benefit allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered to:

Central PA Rehabilitation Services, Inc.
75 Evelyn Drive
Millersburg, PA 17061

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional services charged over and above this insurance payment.

In the event that I do not have coverage for the services provided, I understand that I am personally responsible for the payment of charges incurred. If I am unable to pay as a result of medical indigence, I will notify Central PA Rehabilitation Services, Inc upon receipt of first billing.

A photocopy of this Assignment shall be considered pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

PLEASE NOTE: Therapy supplies given to you by your therapist may or may not be covered by your insurance. Our Billing Department will assist you with any questions concerning insurance coverage.

_______ 3. **FINANCIAL RESPONSIBILITY:**
We would like to take this opportunity to remind you that we ask you to take responsibility for being aware and knowledgeable of the coverage and benefits offered by your health insurance. We will do our best to help you; however, because of the many different plans and benefits available, we cannot be fully knowledgeable about all aspects of your coverage.

The information below is the benefit information we were provided by your insurance company when we verified your outpatient physical therapy benefits. Your insurance company has informed us of the following patient payment responsibility as it applies to outpatient physical therapy benefits.

You will be responsible for:

CO-PAY $____________ per visit
$____________ Initial Evaluation
$____________ Re-evaluation

DEDUCTIBLE $____________ per year _________________________

CO-INSURANCE ____________ % per visit _______________________

LIMITATIONS ____
** This may include $ amount, visit limits or date span

SPECIAL CIRCUMSTANCES ____

SERVICE THAT MAY NOT BE COVERED:
□ Supplies
□ Iontophoresis/Phonophoresis
□ Other: ____

PLEASE NOTE: This information was quoted to us by your insurance company. This information is not a guarantee of your only patient payment responsibility.

Payment Agreement

Based on this information provided to us by your insurance company, you agree to pay the patient responsibility amount as follows:

CO-PAY □ $____________ per visit

Note: The Deductible and Co-Insurance will be billed to you as we receive payments from your insurance company. We ask that once you receive a bill from us you make payment within 30 days.

I also understand and agree that if my Private, Worker's Compensation, or Auto Insurance would deny my claims that I would be responsible for all charges on my account at Central PA Rehabilitation Services, Inc.

If I fail to pay any amounts due and owing to CPRS for services rendered to me, and CPRS is forced to institute collection actions, or a lawsuit, I agree to pay all collection fees, interest at 6% per year, attorney's fees and court costs. I intend to be legally bound hereby.

CPRS does NOT offer payment plans. Payment is due AT THE TIME OF SERVICE. CPRS is working with CareCredit® to offer **No Interest** payment plans (some restrictions apply) specifically designed to pay for healthcare expenses not covered by insurance. Ask a CPRS Associate if you are interested in learning more about CareCredit®.

_______ 4. **HIPAA PRIVACY ACKNOWLEDGEMENT:** I acknowledge receipt of CPRS' Notice of Privacy Practices

A. May we contact you by phone? **Y or N**

B. Do you want phone calls to come to a number other than your home phone number provided to us at intake? **Y or N**
If YES, __________________________________

C. May we leave a message on your answering machine or voicemail? **Y or N**

D. May we provide information to your family members? **Y or N**
Exclude the following people:____

E. Do you want your bills sent to an address other than your home address? **Y or N**
If YES, ____

____

FOR INTERNAL USE ONLY:
If unable to obtain a written acknowledgment, please indicate the reason for the failure below:

□ Patient or Responsible Person refuses to sign

□ Other (Please Describe): ____

____

____
Patient or Responsible Party Printed Name

____ _______ ___________________
Patient or Responsible Party Signature Initials Date

____
Witness Printed Name

____ ___________________
Witness Signature Date

INFORMED CONSENT

A proposed course of treatment based on the therapist's evaluation has been adequately explained to me.

I understand that the treatment may be subject to change based on my response to treatment, my symptoms, my physician's orders and the therapist's recommendations.

I agree to notify the appropriate staff member of any adverse affects to any aspect of my treatment immediately.

I agree to actively participate in discussions, decisions, objectives determination and goal setting to the extent possible and expected.

I understand what has been explained to me regarding the outlined treatment plan, have provided input to the extent possible into the development of the treatment plan and agree to proceed as outlined.

____
Patient or Responsible Party Printed Name

____ ________________
Patient or Responsible Party Signature Date

____
Therapist Printed Name

____ ________________
Therapist Signature Date