Red River Rehab

Patient Information

Date: _____

Please complete all fields.

Patient's Name: _____

Physical Address: _____
Street **City** **State** **Zip**

Mailing Address: _____
Street **City** **State** **Zip**

Home Phone: _____ **Cell Phone:** _____ **Work Phone:** _____

Sex: M or F **Date of Birth:** _____ **SSN:** _____

Emergency Contact Name: _____ **Relation:** _____

Home Phone: _____ **Cell/Work:** _____

Referring Doctor: _____ **Primary Care Doctor:** _____

May we contact your doctors? _____ **Yes** _____ **No**

When/how did problem start? _____

Describe physical problem: _____

_____

_____

Is this problem due to an accident? _____ **Yes** _____ **No**

Date of Accident: _____ **Auto** _____ **Work Related** _____

Have you received any Home Health Services in the past 60 days? **Yes** _____ **No** _____
Are you currently receiving any Home Health Services? **Yes** _____ **No** _____

If yes, what Home Health Agency provided these services? _____

When was the date of your last Home Health Service? _____

Red River Rehab

Insurance Information

Primary Insurance: _____ **Policy ID:** _____

Policy Holder's Name: _____ **DOB:** _____

Relationship to Patient: _____ **Employer:** _____

Secondary Insurance: _____ **Policy ID:** _____

Policy Holder's Name: _____ **DOB:** _____

Relationship to Patient: _____ **Employer:** _____

Worker's Compensation Carrier: _____ **Claim #:** _____

Adjuster: _____ **Phone #:** _____

Attorney's Name: _____ **Phone #:** _____

Guardian's Name (If patient is a minor): _____

Your Address (If different from patient's): _____

Date of Birth: _____ **Relationship to Patient:** _____

_____ _____

Patient/Guardian Signature **Date**

Red River Rehab

Consent to Communicate

Patient Name: _____ **Date:** _____

Consent to Communicate Via E-mail

I understand that authorized personnel from Red River Rehab may communicate with me regarding scheduling, the treatment being provided, educational information including newsletters as it relates to health-related products or services available at Red River Rehab, or alternative treatments, locations, or providers. I agree to receive such communication via e-mail at the following e-mail address:

_____

E-mail Address

_____ _____

Patient/Guardian Signature **Date**

Consent to Communicate to Others

I hereby authorize Red River Rehab, through its appropriate personnel, to communicate with the below listed individuals regarding scheduling, billing, and payment for services rendered on my behalf. I understand that Red River Rehab will attempt o verify the identity of those I authorize to communicate regarding scheduling, billing, and payment by way of seeking confirmation of the answers to the following questions: Full name of patient? Address? Date of birth? Phone number on File?

Optional at patient's request Password: _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Name: _____ **Relation:** _____

Red River Rehab

Consent and Statement of Financial Responsibility

1. **Consent for Treatment:** I consent to and authorize my physical therapist, occupational therapist, and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **Appointment Attendance Agreement:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that all treatment is by appointment only. **I agree to provide at least 24 hours' notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $35.00.**

3. **Worker's Compensation Patients:** *We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.*

4. **Responsibility for Payment:** You are responsible for the entire bill when the services are rendered. Red River Rehab requires that arrangements for payment of your estimated share are made at the date of service. If your insurance carrier does not remit payment within 60 days, the balance will be due in full by you. In the event that your insurance carrier requests a refund of payments made, you are responsible for the amount refunded. In the event your insurance company establishes an internal usual and customary fee schedule, you are responsible for the difference remaining if Red River Rehab is not in-network with the insurance carrier. If any payment is made directly to you for our services, you are to promptly submit the same amount to Red River Rehab. There is a $25.00 service fee for any returned check.
   Please note that refusal to sign this form does not change responsibility for payment in any way.

5. **Assignment of Benefits:** I hereby assign Red River Rehab all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish m y eligibility for such benefits. I hereby authorize Red River Rehab to release all information necessary, including medical records, to my insurance companies, health care providers, attorneys, or financial institutions in order to secure authorizations or payments.

6. **Financial Policy:** Red River Rehab bills your insurance carrier as a courtesy to you. I acknowledge that it is my responsibility to provide Red River Rehab with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as deductible, co-payment, co0insurance, or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ _____

Patient/Guardian Signature **Date**

Red River Rehab

Health Insurance Portability & Accountability Act
Joint Notices of Privacy Practices

I understand that under the Health and Accountability Act of 1996 (commonly referred to as "HIPPA"), I have certain rights to privacy regarding my protected health information.

I have been informed about the Red River Rehab Health Care Arrangement as well as the "Joint Notice of Privacy Practices" which contains a detailed description of the uses and disclosures of my health information. I have been given the right to review the "Joint Notice of Privacy Practices" prior to signing this Consent Form.

I understand that Red River Rehab has a right to change its "Joint Notice of Privacy Practices" from time to time and that I may contact Red River Rehab to obtain a current copy of the "Joint Notice of Privacy Practices" at the following address: 1646 Military Highway, Pineville LA 71360.

I understand that I must request in writing that Red River Rehab restrict how my health information is used or disclosed to carry out the treatment, payment, or health care operations. I also understand that Red River Rehab is not required to agree to my requested restrictions, but if they do agree, Red River Rehab is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Red River Rehab has previously taken action relying on this consent.

_____ _____

Patient/Guardian Signature **Date**

_____

Printed Patient's Name

_____

Printed Guardian's Name