REGISTRATION
(PLEASE PRINT)

Whitewater Valley Rehabilitation
Physical & Occupational Therapy
750 Chester Blvd. - Richmond, IN 47374 (765) 939-0820
2102 N. Park Rd. - Connersville, IN 47331 (765) 825-8099

Date ______________ Home Phone (____) ______________ Cell Phone (____) ______________

PATIENT INFORMATION

Name ______________ Last Name First Name Middle Initial SS/HIC/Patient ID # ______________

Address ______________ E-mail ______________

City ______________ State ______ Zip ______

Sex ☐ M ☐ F Age ______ Birthdate ______________ ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐ Single ☐ Partnered for ______ years ☐ Minor

Patient Employer/School ______________ Occupation ______________

Employer/School Address ______________ Employer/School Phone (____) ______________

Whom may we thank for referring you? ______________

In case of emergency who should be notified? ______________ Phone (____) ______________

PRIMARY INSURANCE

Person Responsible for Account ______________ Last Name First Name Middle Initial

Relation to Patient ______________ Birthdate ______________ Soc. Sec. # ______________

Address (If different from patient's) ______________ Phone (____) ______________

City ______________ State ______ Zip ______

Person Responsible Employed by ______________ Occupation ______________

Business Address ______________ Business Phone (____) ______________

Insurance Company ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name ______________ Birthdate ______________ Relation to Patient ______________

Address (If different from patient's) ______________ Phone (____) ______________

City ______________ State ______ Zip ______

Subscriber Employed by ______________ Business Phone (____) ______________

Insurance Company ______________ Soc. Sec. # ______________

Contract # ______________ Group # ______________ Subscriber # ______________

Names of other dependents covered under this plan ______________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________ (Name of Insurance Company(ies)) and assign directly to Dr. ______________ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

______________ Signature of Patient, Parent, Guardian or Personal Representative ______________ Date

______________ Please print name of Patient, Parent, Guardian or Personal Representative ______________ Relationship to Patient

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Authorization for Release of Information: I understand that Whitewater Rehabilitation will release any medical information acquired Information in the course of my evaluation and treatment to any referring physician's or any workman's compensation case managers. This facility makes every attempt to maintain your confidentiality and will not forward any information without a signed release.

Liability Acknowledgement: This is to verify you have been made aware that physical or occupational therapy techniques and exercises may cause an inflammatory response to joints, muscles and surrounding tissues which you may not be directly treated for. It is normal to experience an increase in pain, discomfort or even soreness with exercise and therapy techniques due to inflammation from your current injury or surgery. You may also experience these symptoms even in body parts not being directly treated secondary to de-conditioning, lack of use prior to injuries or surgeries or inflammatory conditions with which you have been diagnosed. In the event that severe increased in pain arises in any body part, you are responsible for relaying this information and the manner in which it happened (i.e. work, home, recreation) to your therapist so your treatment program can be modified. We are not responsible for injuries occurring due to negligence of the patient or improper use of exercise equipment. Our goal is to make your rehabilitation at our facility a pleasurable experience, and with your help we will be able to accomplish that.

Medicare/Medicaid: As an outpatient physical, occupational and rehabilitation center, Whitewater Valley Rehabilitation is Medicare and Medicaid approved. We will bill Medicare and any secondary insurance you may have, you will not receive a bill from us until we get payment from either Medicare or your secondary insurance. You may responsible for any co-pays, co-insurance or deductible that your insurance does not pay. You also may be responsible for payment if Medicare denies any therapy services that you have received. As of January 1st,2019 PHYSICAL AND OCCUPATIONAL THERAPY HAVE A LIMIT OF $2040.00 EACH. You will be responsible for any balance over this limit. Also, if you have had or are currently having home healthcare please list the name of the facility____________________________________-. There are some exceptions to Medicare rules.

Payments: **Copays are due at the time services are rendered unless arrangements have been made with the Business office.**

Insurance: This is a contract you and your insurance company. We will bill your insurance as a courtesy to you, it is up to you to know your policy and what they pay and who is in your network. If they require a referral that is also up to you to obtain. Anything that is not covered by your insurance you may be billed.

Returned Checks: There is a $25.00 fee for any returned checks by the bank.

No Shows/Reschedules: If you no show 3 times we will consider you discharged and will not schedule you again. If you reschedule 3 times and do not keep the appointment(s) we will also consider you discharged.

Personal Injury: If you are being treated as a part of a personal injury lawsuit or claim, we will not bill your personal health insurance, other financial arrangements can be discussed. Payment of the bill will remain the patient's responsibility. We can not bill your attorney for your charges incurred due to a personal injury case.

AUTHORIZATION FOR PAYMENT: I hereby authorize and request my insurance company to pay whitewater valley rehabilitation the amount due on my claim for services provided to me. I understand that I am responsible for any amount not covered by my insurance carrier. in consideration of the services provided to me, I hereby guarantee payments in full of my account in accordance with the financial agreements made. I agree that in the event of default in payments reasonable costs of collection fees, equal to fifty (50%) of the delinquent balance and attorney fees may be added to the amount due on the account.

once you have signed this agreement, you agree to all the terms and conditions contained, the agreement will be in full force and effect.

Signature____ Date________________________________

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ____
(PRINT NAME PLEASE)

Signature: ____ Date: ______________

Witness: ____ Date: ______________

3/4/19

ADDENDUM TO OUR INSURANCE FILING

Effective immediately: If you have had a change in your insurance and you fail to inform us of this change, you will be financially responsible for all the bills **IF** your policy requires a prior authorization. Most insurance companies will **not** let us get what is called a **RETRO PRIOR AUTHORIZATION**, so in that case, it is your responsibility to make sure we have the correct information on file. Please help us comply with your insurance company's policy.

Thank you!

Signature ____

Date ____