GENESIS PHYSICAL THERAPY AND REHAB
PATIENT INTAKE AND CONSENT FORM

Name: _____ **Gender:** ○Male ○Female
First Middle Last

Date of Birth: _____ **Marital Status:** ○Single ○Married ○Other **Employer:** _____

If a minor, what school do you attend? _____

Mailing Address: _____
City State Zip

Primary Insurance: _____ Subscriber ID _____ Subscriber DOB _____

Secondary Insurance: _____ Subscriber ID _____ Subscriber DOB _____

Home Phone (___) _____ **Cell Phone** (___) _____ **Work Phone** (___) _____

Email (required): _____ **Social Security#:** _____

Emergency Contact: _____ **Phone #:** _____

Are you currently receiving Home Health or Hospice services? ○Yes ○No **Do you currently have…**○**MediCARE** ○ **MediCAID**

Responsible party (if different from patient): _____
Name Address

Consents and Authorizations

Consent for Treatment: The undersigned patient or patient's representative authorizes the therapist(s) on duty at Genesis Physical Therapy to furnish medical treatment by those means he/she considers necessary and proper in the treatment of the patient identified while a patient of Genesis Physical Therapy. In doing so, I understand, acknowledge, and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature, including but not limited to areas of my body I may consider sensitive and/or private.

Valuables: The undersigned hereby releases Genesis Physical Therapy and/or its staff from any responsibility due to loss or damage to any valuables while on the premises of Genesis Physical Therapy.

WAIVER AND RELEASE: I hereby release, discharge, and acquit this facility, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive, or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician, or urgent care services.

Authorization of Payment: I hereby assign all insurance and similar benefits directly to Genesis Physical Therapy and authorize release of any medical records necessary to process medical claims. I understand that in the event my insurance company or financial responsible party does not pay for services or products, I will be financially responsible.

Payment Terms: I understand that payment in full is due on the date of treatment for all services provided and I agree to pay all charges for the patient named below. I acknowledge that a $30 fee will be added to my account for returned checks. If payment in full is delayed for any reason (such as the failure of my insurance to pay the balance in full), I agree to pay the full balance. On any balance remaining more than thirty (30) days after the last date of service, I also agree to pay a late fee that is the GREATER of five dollars ($5.00) or four percent (4%) of the unpaid balance.

Acknowledgement of Receipt of Notice of Privacy Practices: Designated Privacy Official: (601) 898-7561.I hereby acknowledge that I have received, reviewed, and understand the Genesis Physical Therapy Notice of Privacy Practices. You may request at any time to receive a copy of this notice for your records.

No Show/Cancellation Fee: In an effort to enhance each of your therapy visits, we strongly encourage regular attendance. If it is necessary to cancel your scheduled appointment, we require that you call our office at least 24 hours in advance. Failure to notify our office will result in a $35.00 fee. This policy also applies to not showing up for your scheduled appointment.

Workers' Compensation Patients: Your physician feels that you have a need for therapy, so it is imperative that you come to all of your therapy sessions just as it is imperative that you go to work. In the event you feel you will be unable to keep your scheduled appointment, it is your responsibility to take the following steps: 1) Contact Genesis, 2) Contact your Physician, 3) Contact your employer/work comp carrier. It is our policy to contact the referring physician and employer with explanations of any and all missed appointments.

Release of Information: According to office policy, medical information will be released to the patient only. Please specify below to whom information may be release to other than yourself. This information would include but not limited to medical information, billing, and other protected health information. (Example: your spouse, son, daughter, sibling, caretaker, friend)

_____ _____
Name Relationship Name Relationship

Patient/Guardian Signature: X _____ **Date:** X _____

Witness Signature: _____