GENESIS PHYSICAL THERAPY AND REHAB

Rev 06/17

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 currently attend? _____

Mailing Address: _____
City State Zip

Physical Address (if different from Mailing): _____
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

RELEASE OF MEDICAL TREATMENT: The undersigned authorizes Genesis Physical Therapy to release the Patient's health information as needed to process insurance claims. The undersigned understands Genesis Physical Therapy participates in various insurance programs with insurance carriers and may be required to submit the Patient's health information to the Patient's insurance carrier.

PAY BENEFIT CLAIMS: The undersigned assigns payment directly to Genesis Physical Therapy for all insurance and similar benefits otherwise payable to the Patient by virtue of medical treatment provided by Genesis Physical Therapy, but not to exceed regular charges for medical treatment. The undersigned understands the Patient is financially responsible for charges not covered by insurance and agrees that the Patient shall be responsible for all charges incurred, regardless of the status of medical insurance or similar benefits.

CONSENT FOR TREATMENT: The undersigned authorizes and consents Genesis Physical Therapy to furnish medical treatment that the Therapist and/or Physician consider necessary and proper in the treatment of the Patient. In doing so, I understand 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.

PAYMENT TERMS: The undersigned understands that payment in full is due on the date of treatment for all services provided and the undersigned agrees to pay all charges for the Patient. Genesis Physical Therapy does not issue refunds or invoices for debits/credits less than $5.00. After 90 days, balances under $5.00 will be written off and credits under $5.00 will be retained by Genesis Physical Therapy. I acknowledge a $30 fee will be added to my account for returned checks. I understand that if I fail to pay the balance in full within (30) days after the last date of service, a late fee will be added that is the GREATER of five dollars ($5.00) or four percent (4%) of the unpaid balance. I understand that if I fail to pay the balance in full within (30) days after the last date of service, this account can be referred to a collection agency. If I fail to pay any balance in full and am referred to a collection agency or attorney, I agree to pay any cost of collections, attorney fees, and cost of court.

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

CANCELLATION / NO SHOW 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 24 hours in advance can result in a $35.00 fee. This policy also applies to not showing up for your current and any future scheduled appointments.

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. 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 Work Comp Adjuster, 3) Contact your Physician to explain any missed appointments. It is our policy to contact your Physician, Employer, and/or Work Comp Adjuster with explanations of any and all missed appointments.

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.

RELEASE OF INFORMATION: Unless otherwise authorized by this document or by law, Genesis Physical Therapy will only release the Patient's health information to the undersigned. The undersigned may specify below to whom the Patient's health information may be released. This information would include but not limited to medical information, billing, and other protected health information.

_____ _____
Name Relationship Name Relationship

Patient / Patient's Representative Name: (PRINT) _____

Signature: X _____ **Date:** X _____