



WELCOME TO REHAB ASSOCIATES – NEWARK 25 Years of Service to Our Community

We are looking forward to meeting you on _____ at _____.
Our goal in therapy is to maximize your abilities, and to improve your quality of life. On your first visit a complete evaluation and plan of care will be designed to meet your specific goals.

Please complete this initial paperwork and bring it to your appointment. If you would like for us to bill your insurance company, please bring your insurance card(s) and the physician's prescription with you to your first appointment. We are located at 159 West Main Street, Newark, Ohio.

Your first appointment will take approximately 1 hour. If you become aware that you will not be able to keep this appointment please give us a call as soon as possible and we will gladly reschedule your appointment. Our phone number is (740) 345-2837. You will be scheduled for your follow-up therapy sessions based upon the physician's prescription and the evaluation findings from your first therapy visit. Established therapy goals will help us monitor your progress and modify your exercises as your condition improves. Active participation in your therapy program is very important. We are partners in the goal of improving your health. Your input in developing goals that are meaningful to you is a big part in the success of your therapy program.

We have found the following information helpful to new patients:

1. Wear loose fitting clothing and tennis shoes.
2. Plan on completing the full number of treatments prescribed by your physician and therapist.
3. Your home program is an essential part of your treatment and should be followed as prescribed by your physician and therapist.
4. If you have any questions or concerns about your program please talk with your therapist.
5. You must be supervised on all equipment in the gym area. Please wait for an employee to assist you with all equipment.

I have fully read and agree to the above therapy patient guidelines.

Signature _____ Date _____

We would like to take this opportunity to ask you two questions. Please turn this sheet over



WELCOME TO REHAB ASSOCIATES – NEWARK
25 Years of Service to Our Community

1. How did you **FIRST** find out about Rehab Associates – Newark?

- I have been here before
- My Physician
- My Employer
- My Insurance Company
- Friends/Family Members Name _____
- Yellow Pages/Phone Book
- Brochure/Advertisements
- Internet
- Other _____

2. Why did you choose to come here for therapy services? (Please choose no more than two)

- I have been here before
- No waiting period to start
- Friend/Family Recommendation
- Convenient location for work/home
- Physician Recommendation
- Insurance coverage accepted
- Convenient hours in AM/PM (circle one)
- Other _____

Patient _____ Date _____

Physician _____

YOUR E-MAIL ADDRESS _____

REHAB ASSOCIATES - NEWARK PATIENT INFORMATION SHEET

ARE YOU RECEIVING ANY IN HOME SERVICES ? YES OR NO

IN THE LAST 3 MONTHS HAVE YOU RECEIVED IN HOME SERVICES? YES OR NO

PATIENT INFORMATION:

DATE OF INJURY:

LAST NAME		FIRST NAME	MI
XXXXXXXXXXXXXXXXXXXX		BIRTH DATE	
STREET ADDRESS			
CITY		STATE	ZIP
HOME PHONE#		CELL #	
SEX MALE	FEMALE	MARITAL STATUS	M S W D
SPOUSE OR NEAREST RELATIVE		PHONE	
SOCIAL SECURITY NUMBER		BIRTH DATE	
STREET ADDRESS		CITY	STATE ZIP
YOUR EMPLOYER		JOB TITLE	WORK PHONE
STREET ADDRESS		CITY	STATE ZIP
SPOUSES EMPLOYER		JOB TITLE	WORK PHONE
STREET ADDRESS		CITY	STATE ZIP

YOUR E-MAIL ADDRESS _____

PHYSICIAN INFORMATION:

NPI

REFERRING PHYSICIAN		PHONE	
STREET ADDRESS		CITY	STATE ZIP
FAMILY PHYSICIAN		PHONE	SEND REPORT Y or N
STREET ADDRESS		CITY	STATE ZIP
OB/GYN		PHONE	SEND REPORT Y or N
STREET ADDRESS		CITY	STATE ZIP

INSURANCE INFORMATION:

SEE COPY OF CARD

PRIMARY PAYER	HEALTH INSURANCE _____	AUTO INSURANCE _____	WORKER'S COMP _____	SELF _____
	ATTORNEY _____	MEDICAID _____	MEDICARE _____	OTHER _____
INSURANCE NAME				
SUBSCRIBER NAME AND RELATION				
SUBSCRIBER NUMBER		GROUP NUMBER		
SECONDARY PAYER				
SUBSCRIBER NAME AND RELATION				
SUBSCRIBER NUMBER		GROUP NUMBER		
WORKERS COMP NUMBER		SELF INSURED COMPANY? Y N		CLAIM FILED?
EMPLOYER AT TIME OF INJURY		DATE OF INJURY	PHONE	
STREET ADDRESS		CITY	STATE	ZIP

ADMISSION AGREEMENT

CONSENT TO CARE AND TREATMENT: I consent to be admitted to the Rehab Associates - Newark (RA) and understand that any care and examinations will be provided by RA which may include therapists, therapist assistants, or technicians. I consent to the administration by RA of all services and treatments determined necessary for me.

ACKNOWLEDGEMENT OF INFORMED CONSENT: I acknowledge it is my responsibility to comply with instructions and home treatment programs after my initial evaluation, and to inform my therapist of any change in my condition or contraindications to the plan of care. If I refuse treatment that is suggested to me, I will not hold RA or any individual responsible for any of the consequences.

RELEASE OF INFORMATION: I consent to the release of information to my physician, referring agency, and/or members of the multidisciplinary team of RA, including any medical information necessary to bill my account to my insurance company, their authorized representatives, Medicare, a Welfare agency, or Workers Compensation. I also consent to any physician, hospital, medical care facility to release all information on my medical history and treatment to RA.

ASSIGNMENT OF INSURANCE BENEFITS: I assign and authorize payment of any insurance benefits directly to RA except that payment will not exceed the balance due on my account. I understand my signature requests that this payment be made directly to RA. **I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT COVERED BY THIS AUTHORIZATION.**

CANCELLATION/NO-SHOW POLICY: I understand I am responsible for the following cancellation/no-show charges regarding scheduled therapy appointments. 1) I must cancel my scheduled appointments **AT LEAST** the day previous. 2) A \$20.00 fee may be charged for the same day cancellations that can not be rescheduled for another time that same day. 3) A \$20.00 fee may also be charged if I fail to show for a scheduled appointment without a cancellation call. This policy may vary for therapy services provided at satellite clinics. Please refer to specific satellite clinic policies for variations.

POLICY OF FINANCIAL ARRANGEMENTS AND MEDICAL INSURANCE: We are committed to providing you with the best possible care. If you have medical insurance, we will help you receive your maximum benefit allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy. **FULL PAYMENT OR PERCENTAGE OF PAYMENT IS DUE WEEKLY UNLESS OTHER PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF.** Any such request must be accompanied by a completed Patient Information Sheet and your insurance cards. We will make a copy of your card(s) to keep in file. We will gladly discuss your proposed treatment and answer any questions related to your insurance. You must realize, however: 1) **OUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY.** 2) Our fees are generally considered to fall within the acceptable range by most companies, and therefore, are covered up to the maximum allowance determined by each carrier. 3) Not all services are a covered benefit in all contracts. Some insurance companies select certain services they will not cover. **THE FINAL BILL WILL THEN BE THE PATIENT'S RESPONSIBILITY.** We must emphasize that as a medical provider, our relationship with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date of services are rendered. Services are payable within 30 days from the date of the RA billing statement. A 2% per month finance charge shall be applied to any past due balances. There shall be a \$20.00 fee charged for each/every returned check. We realize that temporary financial problems may affect timely payment of your account. Please notify us of any such financial problems.

I have fully read and agree to the above Admission Agreement and consent to any professional services provided by Rehab Associates-Newark. I understand that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered. I certify the information given is true and correct to the best of my knowledge. I will notify you of any changes in the information provided on the Patient Information Sheet.

I hereby authorize photocopies of this form to be valid as the original.

Date: _____

(Patient Signature)

PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

_____ being parent/legal guardian (circle one) of _____ hereby do give RA
(print your name) (print patient's name)

permission to evaluate and treat his/her in accordance with his/her physician's prescription.

to: _____ Signed: _____ Witness: _____

ACKNOWLEDGMENT OF RECEIPT

I, _____, acknowledge that I have received the Notice of Privacy Practices issued by Rehab Associates.

I, _____, authorize Rehab Associates to discuss my health information with the following persons:

- Spouse _____
- Children _____
- Parent _____
- Other _____

Date

Signature of Patient

11. Medical/Surgical History:

a. Please check if you have ever had:

- | | | |
|--|---|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> diabetes/high blood sugar | <input type="checkbox"/> cancer |
| <input type="checkbox"/> broken bones/fracture | <input type="checkbox"/> low blood sugar/hypoglycemia | <input type="checkbox"/> infectious disease |
| <input type="checkbox"/> osteoporosis | <input type="checkbox"/> head injury | <input type="checkbox"/> kidney problems |
| <input type="checkbox"/> blood disorders | <input type="checkbox"/> multiple sclerosis | <input type="checkbox"/> incontinence |
| <input type="checkbox"/> circulation/vascular problems | <input type="checkbox"/> muscular dystrophy | <input type="checkbox"/> pelvic pain |
| <input type="checkbox"/> heart problems | <input type="checkbox"/> Parkinson disease | <input type="checkbox"/> repeated infections |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> seizures/epilepsy | <input type="checkbox"/> ulcers/ stomach problems |
| <input type="checkbox"/> lung problems | <input type="checkbox"/> allergies _____ | <input type="checkbox"/> skin diseases |
| <input type="checkbox"/> stroke | <input type="checkbox"/> developmental or growth problems | <input type="checkbox"/> depression |
| <input type="checkbox"/> thyroid problem | | |
| <input type="checkbox"/> orthopedic surgeries _____ | | |
| <input type="checkbox"/> joint pain _____ | | |
| <input type="checkbox"/> other _____ | | |

For men only: Have you been diagnosed with prostate disease? yes no

For women only: Pregnant or think you might be pregnant? yes no

12. Medications

Do you take any medications? yes no If yes, please list: _____

13. Social/Health Habits

Currently smoke tobacco? yes _____ no
Alcohol use? yes _____ no
Prior exercise/activity level? _____

14. Height and Weight

Height _____ Feet _____ Inches Weight _____

15. Have you fallen in the last year? yes no How often? _____

Patient Signature **Date**

Therapist Signature **License #** **Date**