TOP Rehab Services, Inc.

PATIENT INFORMATION

PATIENT NAME: LAST	FIRST	MIDDLE	SOCIAL SECURITY NUMBER

AGE	DATE OF BIRTH	HOME PHONE NUMBER	SEX ☐ M ☐ F	MARITAL STATUS ☐ S ☐ M ☐ W ☐ D ☐ SEP

PATIENT'S ADDRESS	CITY	STATE	ZIP CODE

REFERRING PHYSICIAN	ADDRESS	CITY	STATE	ZIP CODE

PATIENT'S EMPLOYER	PHONE NUMBER	JOB OR POSITION HELD:

MAILING ADDRESS	CITY	STATE	ZIP CODE

SPOUSE (PARENT, IF A MINOR)	SPOUSE'S EMPLOYER (PARENT'S, IF A MINOR)	BUSINESS PHONE

JOB OR POSITION HELD	MAILING ADDRESS	CITY	STATE	ZIP CODE

NEXT OF KIN OUTSIDE OF HOUSEHOLD: NAME	PHONE NUMBER

TYPE OF INJURY: ☐ Work ☐Athletics ☐Other Auto Accident (choose one): ☐Liability ☐ No Fault	DATE OF INJURY

IS THERE AN ATTORNEY INVOLVED? ☐ Yes ☐ No	ATTORNEY'S NAME	ATTORNEY'S PHONE NUMBER

ATTORNEY'S ADDRESS

NOTICE TO ALL PATIENTS: **Anyone using the LOCKER ROOM for any reason needs to bring a personal lock for the locker being used. We advise you to leave valuables at home or to lock them in your automobile. TOP REHAB WILL NOT BE RESPONSIBLE FOR LOST OR STOLEN ITEMS.**

AUTHORIZATION TO RELEASE INFORMATION: **I do hereby authorize TOP REHAB SERVICES, INC., to release any information acquired in the course of my treatment to my insurance company, to other doctors, and to my attorney (if one has been retained).**

The information I have filled out is true and accurate to the best of my knowledge. I have read and understand the above referenced information.

Patient Signature	Date	Reviewed By	Date

TOP Rehab Services, Inc.

SCHEDULING APPOINTMENTS

TOP Rehab Services, Inc., hours of operation are Monday-Friday 7:00 AM–6:00 PM. Please feel free to contact our office staff during regular business hours to schedule, re-schedule, or cancel an appointment. You may feel free to leave a message on our voice mail system if you reach us after hours. If an emergency arises after regular business hours, we recommend that you contact your physician.

Cancellations need to be made 24 hours in advance. If you do not show for an appointment or if you do not call within 24 hours to cancel/reschedule, you will be billed for an office visit ($25.00) that will not be covered by your insurance company.

It is our policy to give appointments after 3:00 PM to patients who work or attend school, so please help us accommodate them. Every effort will be made to honor your appointment time, however if a delay occurs, your cooperation and understanding will be greatly appreciated.

BILLING & INSURANCE

We appreciate your confidence in choosing TOP Rehab Services, Inc. Please take a moment to review our financial policy. TOP Rehab will be glad to file your medical insurance as a courtesy. You will be asked to pay on your account for any co-payment, co-insurance, or deductible once per week for the previous weeks charges. The business office will explain what your insurance company quoted as your benefits in an interview before your initial evaluation.

Payments may be made by cash, check, MasterCard, VISA, or Discover Card. If you are unable to pay weekly, the situation may be discussed with the business office staff to work out mutually agreeable payment arrangements. It is the policy of this practice to apply a $25 service charge for all returned checks.

You will receive your first statement after you have been discharged from therapy and your account has been audited for accuracy. You will be required to pay any balance due within 30 days from the date of the statement. We only send three bills. Thereafter, no further bills will be sent and the account will be turned over to a collection service without prior warning.

If you do not understand the reason you owe a balance, please do not hesitate to contact our office. The staff will be glad to explain the balance to you and answer any questions you may have.

I hereby authorize my insurance company to pay benefits directly to TOP Rehab Services, Inc.

I have read and understand my financial responsibility.

Patient Signature	Date	Reviewed By	Date

TOP Rehab Services, Inc.

PATIENT CONSENT TO TREATMENT FORM

Patients are admitted to this Facility and are rendered services without distinction, regardless of race, color, creed, sex, age, marital status, ancestry, physical handicap, national origin, or source of payment of his/her care. This Facility complies fully with:

1. Title VI of the Civil Rights Act of 1964.
2. Section 504 of the Rehabilitation Act of 1973.
3. The Age Discrimination Act of 1975.

I understand the Admission Policy of TOP Rehab Services, Inc., and hereby give my consent to have a physical, speech, and/or occupational therapy evaluation and treatment as prescribed by my physician.

PATIENT RULES AND REGULATIONS

TOP Rehab Services, Inc., reserves the right to refuse treatment to any patient that we feel is under the influence of any substance which might impair the patient's sensory, motor, and/or neurological responses. TOP Rehab Services, Inc., also reserves the right to discontinue treatment on any patient who sexually harasses any employee of TOP Rehab Services, Inc. Patient's physician will be apprised immediately of any such situation.

I have read and understand the above Patient Rules and Regulations and consent to treatment form.

_____	_____	_____	_____
Patient Signature	Date	Reviewed By	Date

ADVANCED BENEFICIARY NOTICE

TOP Rehab will gladly file your outpatient therapy charges.

The beneficiary has the right to request the provider to file a claim for an insurance coverage decision. In the event that your insurance will not pay for certain procedures or supplies provided by your therapist and/or if any non-covered charges occur because you have exhausted your day/dollar visit limit, you will be notified as soon as insurance company notifies this facility by way of remittance advice. Upon TOP Rehab Services' receiving this notification, you may then opt to discontinue the particular non–covered procedure(s)/supplies or may continue to have the procedure(s)/supplies by paying for procedure(s)/supplies at the time of service.

_____ procedure/supply is non-covered by insurance company. I agree to pay $_____ for this procedure/supply.

I have read and understand the policy for non-covered procedures/supplies.

_____	_____	_____	_____
Patient Signature	Date	Reviewed By	Date

TOP Rehab Services, Inc.

ALTERNATIVE COMMUNICATIONS REQUEST

I, _____, request that TOP Rehab Services, Inc., communicate my protected health information with me by the alternative means or at the alternative locations indicated below:

☐ **Telephone(s)**: _____
  ☐ Do leave a message if I do not answer.
  ☐ Do NOT leave a message if I do not answer.
☐ **Pager:** _____
☐ **Mailing Address:** _____
  _____

☐ **Alternative Contacts**:
  Name: _____ Address: _____
  Name: _____ Address: _____
  Name: _____ Address: _____

Patient or Personal Representative Signature: **Date:**

_____ _____

_____ _____
Printed Name of Patient or Personal Representative *Personal Representative's Relation to Patient*

ABOVE – Patient or Personal Representative Use Only

BELOW – Provider Use Only

Status of Request: ☐ Approved ☐ Denied

_____ _____
Company Representative Signature Date

PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____, acknowledge that I have received a copy of the Privacy Notice for **TOP Rehab Services, Inc.**

Privacy Notice Revision Date: April 14, 2003

Patient or Personal Representative Signature: **Date:**

_____ _____

_____ _____
Printed Name of Patient or Personal Representative *Personal Representative's Relation to Patient*

ABOVE – Patient or Personal Representative Use Only

BELOW – Provider Use Only

Documentation of Good Faith Effort

The patient identified above was provided with a copy of the Provider's Privacy Notice on this date. A good faith effort has been made to obtain a written acknowledgement of the patient's receipt of the Privacy Notice. However, acknowledgement has not been obtained because:

☐ Patient refused to sign the Privacy Notice Acknowledgement.
☐ Patient was unable to sign because:
☐ There was a medical emergency. Provider will attempt to obtain acknowledgement as soon as practical.
☐ Other reason: _____
_____

_____ _____
Company Representative Signature Date

NAME: _____
AGE: _____
WORK STATUS: □ Full-time □ Part-Time □ Student □ Retired □ Disabled

PATIENT HISTORY

Current Symptoms: _____

Symptom Start Date/Symptoms at onset: _____

How were you injured? Or, was your pain onset for no apparent reason? _____

Past Medical History: (And date if applicable)

□ CVA/stroke
□ Heart Disease/Attack
□ Head Injury
□ Whiplash/car wreck
□ Arthritis
□ Tumor/Cancer
□ Allergies
□ Depression
□ Panic Attacks
□ Diabetes
□ Fractures (with location)
□ Falls
□ Car Wrecks
□ Hypertension/High Blood Pressure
□ Autoimmune Disease
____ AIDS ____ HIV ____ Hepatitis
□ Other:

Surgeries with dates: _____

Tests performed and when:
□ MRI □ X-rays □ CT Scan □ EKG/EEG □ EMG

Medications: Please List: _____

Allergies to medications/latex: _____

What are your hobbies or things that you would like to return to doing that you cannot do now because of this problem? _____

What are your goals for therapy? _____

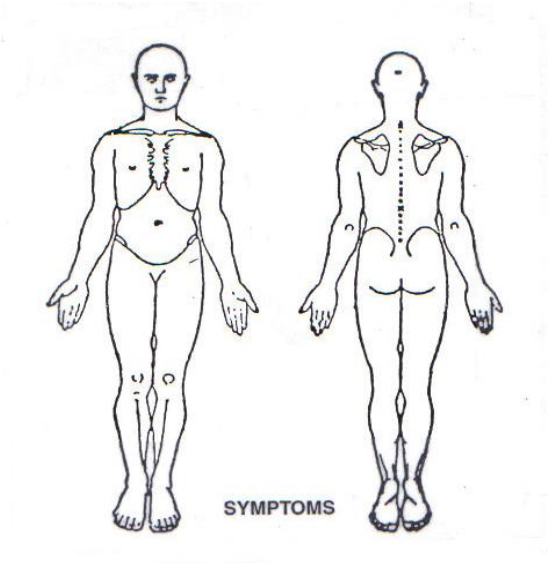
Have you had home health therapy in the past 30 days? _____YES _____ NO
If yes, what company was used, and when were you discharged? _____

Rate your current pain on a scale of 0-10 with 1 being minimal pain and 10 being ready to go to the emergency room.

0 10
No pain Max pain

Do you have numbness or tingling, if so, where? _____

Please draw your pain on the body diagram below, using x's to mark the pain location.



NO SHOW / CANCELLATION POLICY ……EFFECTIVE January 2020

Success in rehab depends upon keeping the prescribed number and frequency of visits: consistent attendance results in the most expedient and best outcome. Just as it is important to finish a course of antibiotics for effective treatment, so too is it imperative to finish a full course of rehab treatments. Having pain or other symptoms from rehab could be a normal occurrence in your care, or it could signal something else: this is critical for the PT/OT/ST to assess, and you should not cancel because of symptoms. Likewise, if you become symptom-free and don't feel the need for further therapy, a visit allows the clinician to assess the proper time to discharge. Please do not self-discharge.

Additionally, keeping your scheduled appointment shows respect for your clinician's schedule. Clinicians have appointments scheduled back-to-back, and often there is a waiting list of patients who were unable to fit in. If you do not show, or you cancel an appointment too late, this is a whole hour of wasted time for the clinician and a lost opportunity for another patient to be seen.

Therefore, in an effort to keep your care on track, maintain productive schedules at TOP Rehab Services, and give all patients an opportunity to be seen, TOP Rehab requires 24-hour notice for the cancellation of all scheduled appointments.

There is a $25 fee for a cancellation without proper notice and a $50 fee for a "no show" (i.e., not showing up for an appointment without any communication). THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE CARRIER. It is your responsibility and applies to ALL patients.

After two missed appointments or three cancelled appointments, you may either be discharged from therapy or restricted to day-of-only appointment scheduling.

We understand that extenuating circumstances sometimes occur, which is why we have implemented a "one-strike" policy: we will allow for one cancellation before charging a fee.

I understand TOP Rehab's Cancellation/No Show Policy and my responsibility to plan appointments accordingly. I will notify TOP Rehab if I have difficulty fulfilling my scheduled appointments.

I consent to the above, as indicated by my signature below:

Print Name / Signature (Parent/Guardian if under 18) Date

_____ _____

Witness Name / Witness Signature Date

_____ _____

PLEASE SIGN UP FOR APPOINTMENT REMINDERS

As a courtesy to our patients, we offer an appointment reminder system. You can receive a reminder by one of the following: email, phone call, or text.

Please choose the best way for you to receive your reminder:

_____Phone call to number :_____

_____Text to number : _____

_____Email to :_____