TRI-STATE REHAB SERVICES

Ashland Ironton Louisa New Boston Portsmouth Westmoreland

Returning Patient Forms

Date: ___________________________

Name: ____
(First) (M.) (Last)

Address____
(Street Address) (City) (ST) (Zip)

Date of Birth: __________________________ Social Sec #_________________________________

Home Phone #_________________________ Cell Phone # ________________________________

Email address: ____

Male______ Female______ Single_______ Married______ Divorced_______ Widowed_______

Name of an Emergency Contact (Not living in your home) ____

Emergency Contact Phone # ____

Relationship to Patient: Parent/Guardian Spouse Children Friend Other: ______________________

Referring Physician: _______________________ Next scheduled appointment with Physician:____________

What area(s) will we be treating ____

On a scale of 1-10, with 10 being the worst, rate your pain at rest.
1 2 3 4 5 6 7 8 9 10

On a scale of 1-10, with 10 being the worst, rate your pain with activity.
1 2 3 4 5 6 7 8 9 10

What activities, if any, **increase** your pain? ____

What activities, if any, **decrease** your pain? ____

Any new surgeries? Y N If yes, Body Part_______________________ Date of Surgery ________________

Please List Medications: ____

____

What has changed with your condition since last visit ____

____

Patient's Signature____ **Date:** ________________________

Witness Signature____ **Date:** ________________________

Patient Name ___________________________________

AUTHORIZATION & RELEASE

I authorize, give consent to treat and hereby assign/transfer, to Ironton Physical Therapy, Inc., dba Tri-State Rehab Services my rights, title, and interest to my medical reimbursement benefits under my insurance policy for the services rendered by Ironton Physical Therapy, Inc., dba Tri-State Rehab Services. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until I revoke said authorization by giving written notice.

I understand that I am financially responsible for all charges whether or not they are covered by insurance.
I give my permission to use my picture, and likeness on marketing material, and to receive marketing material in the future from Tri-State Rehab Services.

Patient's Signature:____ **Date:** ______________________

(Must be signed by responsible party or the parent/legal guardian of minor children.)

For Medicare Patients:

I certify that the information given by me in applying for payment under title XVII of the Social Security Act is correct. I authorize Tri-State Rehab Services to release information concerning treatment to the Health Care Financing Administration or its intermediaries/carriers which may be required for processing my Medicare claims. I authorize Ironton Physical Therapy, Inc. dba Tri-State Rehab Services to submit claims and receive payment for authorized Services to Medicare intermediaries/carriers on my behalf.

Patient's Signature: ____ **Date:** ____________________

INSURANCE INFORMATION

Primary Insurance/Policy Holder's Name: ____ Policy #: _________________________

Primary Insurance Policy Holder's Employer: ______________________________ Soc. Sec. # of insured__________________ DOB: _____________

Other Insurance/Policy Holder's Name: ____ Policy #: _________________________

Other Insurance/Policy Holder's Employer: ______________________________ Soc. Sec. # of insured__________________ DOB: ___________

Email address for Responsible Party: ____

Ironton Physical Therapy, Inc. d/b/a:

TRI-STATE REHAB SERVICES

Ashland Ironton Louisa New Boston Portsmouth Westmoreland

PATIENT ORIENTATION SHEET

PHYSICIAN APPOINTMENTS
Each time you return to your referring physician, please notify our office at least 48 hours in advance, so we can prepare a progress note regarding your physical therapy treatment.

MEDICARE PATIENTS
Your referring physician must sign a plan of care/treatment which will be set by the evaluating physical therapist to assist in achieving your functional goals. This plan of care/treatment can be for a period of up to 90 days in accordance with government mandates. This plan of care will be sent to your referring physician with the initial evaluation letter.

KEEPING APPOINTMENTS
We ask that you arrive on time and keep all scheduled appointments unless a true emergency arises.
Missed appointments have resulted in our patients being denied further worker's compensation benefits.
We reserve the right to bill you $30.00 for missed appointments without a 24-hour notice of any appointment change or reschedule.

YOUR FINANCIAL RESPONSIBILITIES
Your insurance company requires that you present your insurance card. We will call your insurance company to verify what your financial responsibilities will be for your physical therapy services. If your insurance policy does not pay 100% of your physical therapy treatments, any co-payments, co-insurance, and/or deductible amounts are due at the time of service. **If your insurance coverage changes during treatment, please let us know**, so that we may re-verify your insurance and make you aware of any changes to your physical therapy benefits. We cannot guarantee the benefits quoted by your insurance company. Insurance verifications are not a guarantee of payment by your insurance carrier.

You are responsible for any charges that your insurance deems your responsibility. It is your responsibility to know your insurance benefits. If they determine your coverage to be different at the time of claims processing, you will be billed any balance due that is deemed your responsibility. We accept cash, checks and most major credit cards.
A 1.5% monthly finance charge (18% APR) **may be applied** to accounts with any remaining patient balances over 30 days from the time the last insurance payment is received.

CONSENT TO WIRELESS TELEPHONE CALLS: If at any time you provide a wireless telephone number you consent to receiving calls or text messages which include but are not restricted to communications regarding billing and payment for items and services. You must notify Tri-State Rehab to the contrary in writing to opt out. Calls/text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing devices or other computer assisted technology, electronic mail, text messaging or any other form of electronic communication from Tri-State Rehab, its affiliates, contractors, servicers, attorneys or its agents including collection agencies.

CONSENT TO E-MAIL USAGE: If at any time you provide an email address at which you may be contacted, unless you notify Tri-State Rehab to the contrary in writing, you consent to receiving statements, bill and marketing material for services and payment receipts at that email address from Tri-State Rehab.

Patient's Signature________________________________ **Date:**____________________

Witness Signature________________________________ **Date:**____________________