



Consent for Care and Treatment

8300 Whitesburg Dr SE
Suite A
Huntsville, AL 35802
Phone: (256)270-9922
Fax: (256)270-9923
www.mandevillept.com

I, the undersigned, do hereby agree and give my consent for Mandeville Physical Therapy & Wellness to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ Date _____
Patient / Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Mandeville Physical Therapy & Wellness. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Mandeville Physical Therapy & Wellness to release all medical information and records necessary to secure payment for services rendered.

Signature _____ Date _____
Patient / Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Mandeville Physical Therapy & Wellness, you must promptly remit such payment directly to Mandeville Physical Therapy & Wellness.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ Date _____
Patient / Guardian



Confidential Medical Information

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Please state current problem(s): _____

Are you currently being treated by:

- | | | | |
|--------------------------|----------------|------------------------------|----------------|
| Another Therapist | ___ Yes ___ No | Or within the last 12 months | ___ Yes ___ No |
| Chiropractor / Osteopath | ___ Yes ___ No | Or within the last 12 months | ___ Yes ___ No |
| Home Health Agency | ___ Yes ___ No | Or within the last 12 months | ___ Yes ___ No |

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the following:

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other Illnesses |

specify:

specify:

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____



Confidential Patient Information

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Name _____ DOB _____ Age _____
Address _____ Apt _____ Phone _____
City _____ State _____ Zip _____ Gender Male Female
Permanent Address _____ Phone _____
City _____ State _____ Zip _____ E-Mail _____
Social Security # _____ D/L # _____ State _____
 Single Married Widowed Divorced Separated

If a minor, parent / guardian name _____
Social Security # _____ DOB _____

Employer _____ Phone _____
Address _____ Ext or Dept _____
City _____ State _____ Zip _____ Hours _____
Occupation _____ Supervisor _____

Spouse _____ DOB _____ Age _____
Social Security # _____ Phone _____
Employer _____ Work _____
Address _____
City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____
Address _____ Phone _____
City _____ State _____ Zip _____

Referring Physician _____ Next Visit _____
Primary Care Physician _____ Next Visit _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____



Patient Privacy Policy & Procedure Statement

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Dear Patient:

Mandeville Physical Therapy & Wellness maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 256-270-9922.

Mandeville Physical Therapy & Wellness reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature _____
Patient / Guardian

Date _____

ATTENTION!!!!

Mandeville Physical Therapy & Wellness, Inc. is excited you picked us to assist in your rehab goals. In order for your rehab to be successful a couple of things must happen:

It is imperative that you perform your home exercise program at home. Only doing your exercises here is NOT enough. Doing your "homework" will expedite your outcome and help you return to your previous level quicker.

You must make every effort to keep ALL scheduled appointments. There will be a \$75 charge for missed visits. Failure to pay for any charges will result in the patient being sent to collections. We will reschedule 1 no show visit. If you no show 2 times or cancel 3 times, Mandeville Physical Therapy & Wellness, Inc. reserves the right to remove you from the schedule and notify your physician of your non-compliance. A cancelled visit is defined as an appointment that is cancelled with less than 24 hours notice or a visit that is cancelled with more than 24 hours notice but never rescheduled. (Emergencies and unforeseen circumstances are taken into consideration).

Patient Responsibility: Payment (deductibles, copays and coinsurance) in lieu of secondary insurance, is due upon services rendered. Arrangements may be made, but all payments must be received **within 3 months from discharge** or the patient will be sent to collections with additional expenses incurred by the patient.

Your rehab is our number one focus. Mandeville Physical Therapy & Wellness, Inc. is only successful if you are happy with your outcome and tell others about us

Again, we are excited that you have chosen our facility for your rehab goals. We will make EVERY effort for you to have success.

By signing below, you agree to comply with the above.

Signature

Date