Initial Client Paperwork

Name_____ Date of Birth____/_____/_____ Sex: M F

Home Address _____ City _____State_____ Zip _____

Email: _____ Home Telephone #: (____)_____Cell Phone # (____)_____

Emergency Contact Name: _____ Relation:_____

Email: _____ Home Telephone #: (____)_____Cell Phone # (____)_____

Primary Insurance:_____ Phone # _____

Name On Card: _____; Id #:_____; Group #_____ Payor Id _____

Secondary Insurance: _____ Phone # _____

Name On Card: _____; Id #:_____; Group #_____ Payor Id _____

Referring Provider and Specialty: _____ Phone #_____

Fax #_____ Address: _____

Dates of Hospitalization in Past Year: _____

Dates of Home Health, Under Medicare Part A In Past Year: _____

Prior Therapy Received in Past Year: _____

Current Medications:

Medical History

1. High blood pressure
2. Diabetes
3. Cancer
4. Heart disease/ heart attack
5. Chest discomfort
6. Heart murmur/ valve disease
7. Pacemaker
8. Shortness of breath
9. Swollen ankles
10. Palpitations
11. Lightheadedness / Dizziness
12. Rheumatic fever
13. Asthma
14. Persistent swollen glands
15. Hearing problems
16. Bone fractures
17. Depression
18. Total Joint Replacement
19. Back Injury/Surgery
20. History of fall. How many episodes did you have in past 12 month____?
21. Bronchitis
22. Pneumonia
23. Persistent cough
24. Tuberculosis
25. Hay fever
26. Sinusitis
27. Abdominal discomfort
28. Indigestion/heartburn
29. Nausea
30. Vomiting
31. Diarrhea
32. Incontinence
33. Blood in stool
34. Constipation
35. Vision problems
36. Latex Allergy
37. Other:
38.

Release of Information: I hereby authorize the release of any information by telephone, email/fax, or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by **Root to Rise Therapy LLC LLC** to the physician who referred me for therapy, to any organization responsible for payment of my account to_____

_____

I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Notice of Privacy Practices: I acknowledge receipt of the Notice of Privacy Practices from **Root to Rise Therapy LLC LLC**. I understand that the Notice of Privacy Practices provides information about how **Root to Rise Therapy LLC LLC** may use and disclose my protected health information. I have reviewed it and understand that the Notice of Privacy Practices is subject to change. If the Notice is changed, I may request a revised copy.

Assignment of Insurance Benefits: I hereby authorize that the payment of authorized benefits be made directly to **Root to Rise Therapy LLC LLC** of any services that are reimbursable by Medicare or another insurance if applicable.

Consent for Treatment: I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of **Root to Rise Therapy LLC LLC.**

Guarantee of Account: I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by Insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon invoice. I understand that the client responsibility portion of my bill shall be due and payable at time of invoice. I understand that I am personally responsible for full payment of all charges including Insurance denials, deductibles and copayment and coinsurance fees. I understand that I will be provided with an invoice for services not covered.

Medicare: I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance. I understand that I cannot receive Medicare Part B services in the home if I am currently on Home Health under Medicare Part A and or on Hospice Care. I understand that services must be skilled and medically necessary to be covered by Medicare Part B. I understand Medicare will pay for 80% of the allowed amount, and I am responsible for the remaining 20% if I do not have a secondary insurance.

Cancellation/No Show Policy: I understand that I will be charged a missed visit fee of $50 if I cancel less than 24 hours from my visit. This amount is my responsibility. I understand if I cancel more than 2x I will be placed on a same day scheduling list.

Estimate of Insurance Payment/Expense: Based on the insurance information provided to Root to Rise Therapy LLC, the following is the best estimate of payment/expense.

Insurance Deductible Remaining: _____ Coinsurance: _____ Copay: _____

Estimated cost of one hour therapy session: _____

*Evaluation sessions are higher than treatment sessions.

I, _____, by signing this document, acknowledge my consent to the above.

Signature: _____ Date: _____

Staff Signature: _____ Date: _____

Verbally discussed with _____ (caregiver) on _____ (date). This party agrees of rights/responsibilities/consent to treat and agrees to return signed paperwork as soon as possible.