Patient's Demographic Form

Name:_____Social Security #:_____

Date of Birth:_____Home Phone:_____Cell Phone: _____

Address:_____City:_____State:_____Zip:_____

Status: Married_____ Single_____ Employed: Yes____No____ Full Time_____Part Time_____

If under 18, **Parent/s** name:_____DOB:_____SSN: _____

Employer:_____Address:_____Work Telephone:_____

PCP Name:_____ PCP Telephone:_____

Date of last visit with Primary Physician:_____(Required with Medicare Insurance)

Emergency Contact:_____ Phone: _____

May we leave medical/appointment information with your emergency contact person? Y N On your answering machine? Y N

Is there anyone else you authorize us to give appointment/medical information with? List:_____

Prescribing Physician:_____Address:_____Phone: _____

Primary Insurance:_____ ID# or Member ID:_____

Group# or Emp ID:_____Policy Holder:_____Relationship:_____

Date of Birth of policy holder:_____ Social Security# :_____

Secondary Insurance:_____ID# or Member ID:_____

Group# or Emp ID:_____Policy Holder:_____Relationship:_____

Date of Birth of policy holder:_____ Social Security# :_____

Is this injury due to: (Check if applicable) Motor Vehicle Accident Worker's Compensation Injury?

Policy #_____Date of Accident: / / Claim #_____

Adjustor:_____Phone:_____Billing Address: _____

We will bill your primary insurance if any claims are denied by your liability carrier. Initial _____

All information provided by the patient may be ***subject to outside review, when required by law, for appropriate billing purposes, or when requested by practices authorized by the patient.***

PATIENT SIGNATURE: (Parent if under 18)_____Date_____

OFFICE USE:

Insurance Information:

____Coverage Verified_____Co-pay_____Deductible:_____/Met_____Visit Limits_____Visits used to date

Authorization #_____Number of visits authorized:_____End date:_____Int: _____

All information is kept strictly confidential

_____ 1. ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Initials I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled including Medicare, private insurance, and any other health plan to iXL Rehab and Wellness Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. **I understand that I am financially responsible for all charges whether or not paid by said insurance.** I hereby authorize said assignee to release all information necessary to secure this payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS. I also understand and agree that all credit for services rendered to me is accepted by iXL Rehab, Exercise & Wellness Center. If a financial hardship exists I will bring that situation to the attention of Michael Sharr, DPT.

_____ 2. EMERGENCY CARE

Initials In the event of an emergency, I authorize iXL to transport me by ambulance to the nearest emergency facility and to contact the person below. I further authorize the release of necessary medical information to the appropriate health professionals providing care for said emergency. This information may include documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse, or HIV/AIDS related information. Person to contact in case of emergency:

_____ 3. HIPPA ACKNOWLEDGEMENT/CONSENT

Initials I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for iXL Rehab, Exercise & Wellness Center. I hereby consent to the use and disclosure of my personal health information for the purpose of treatment, payment and health care operations. I am aware that confidentiality and privacy practices will be implemented in a professional manner and according to law and regulation.

_____ 4. PHOTOGRAPHIC AUTHORIZATION AND RELEASE

Initials I hereby consent and irrevocably authorize iXL, and its designee, at the direction of my physician to take photographs of me to be put in my medical record or for use as the iXL may deem proper. Further, on my behalf, I relinquish and give iXL all right, title, and interest that I may have in the photographs and/or negatives.

_____ 5. STATEMENT TO PERMIT MEDICARE PAYMENT

Initials I certify that the information given by me in applying for payment under the TITLE XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about be to release to the Social Security Administration of its intermediaries or carries any information needed for this or a related Medicare Claim. I understand the information to be disclosed may include documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. I request that payment of authorized benefits be made by them on my behalf.

_____ 6. WORK INJURY MANAGEMENT-NON COMPENSATORY

Initials If the injuries/disabilities for which I am receiving treatment from iXL have resulted in being unable to perform my normal work duties, it may be necessary for iXL to discuss pertinent information related to my job duties with my employer or my employer's health insurance carrier. I am authorizing iXL to discuss with my employer or my employer's health insurance carrier, pertinent information related to my job duties that will enable iXL to appropriately prepare me to return to my regular job. I understand this information may include documentation on the medical record, which may include present, or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information

_____ 7. PARENTAL CONSENT

Initials I authorize iXL render treatment to my child under 18 years of age.

_____ 8. WORKERS COMPENSTATION INSURANCE WAIVER

Initials I believe that all services provided by iXL Rehab, Exercise & Wellness Center will be covered by my workers compensation insurance, If my worker's compensation carrier denies my claims, I will_____I will not____provide personal insurance at this time. Please bill the following insurance if my workers compensation claim is denied: Insurance:_____- ID_____I realize that should my workers compensation insurance deny and I do not provide alternative insurance for billing purposes, I will be personally held responsible for the balance.

_____ 9. AUTO INSURANCE WAIVER

Initials I believe that all services provided by iXL Rehab, Exercise & Wellness Center will be covered by my auto insurance, therefore I will not provide personal insurance at this time but realize that should my auto deny or exhaust, I will be held personally responsible for the balance allowed by state law.

_____10. PATIENT BILL OF RIGHTS I have received a copy of and understand the Patient Bill of Rights

Initials

Signed (Patient or Parent_____Initials_____Date_____

Witness_____Initials_____Date_____

PAYMENT POLICY & INSURANCE **FINANCIAL FORM**

At iXL Rehab, Exercise & Wellness Center, our goal is to provide the best care for our patient's best recovery. The following is our policy on handling patient claims and bills.

Group or Individual Insurance/Secondary Insurance

As a benefit to you, our office will be happy to bill your insurance. When possible, we will call to verify benefits on your insurance. **However, the benefits quoted to us by your insurance company are not a guarantee of payment. You are responsible for the difference between what your insurance pays and the total charges for your care.** If you have an insurance plan you will likely have a co-pay and deductible. Please be prepared to pay those charges and any non-covered services at the time of your visit. Please inform us of any secondary insurance you may have. **Your expected responsibility is:_____copay per visit_____annual deductible that must be satisfied. Other: _____**

"On the Job" Injury (Workers' Compensation)

If you are injured on the job, your care should be paid for under your employer's Workers' Compensation insurance. You will need to inform your employer of the accident and obtain the name and address of the carrier of their insurance, along with the claim number. If your employer does not provide us with this information, if a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are your responsibility and due immediately.

Personal Injury or Automobile Accidents

Please notify your auto insurance carrier of your visit to our office immediately. Notify our insurance department immediately if an attorney is representing you. If payment is not received or a settlement has not been made within 3 months, or if you suspend or terminate care, any fees and services are your responsibility and due immediately.

Medicare

We do accept assignment from Medicare. The check is usually sent directly to our office in payment of the services that Medicare will cover. Medicare pays 80% of the allowable fee once the deductible has been met. You are required to pay the deductible and the remaining 20% as well as any non-covered services. Our office completes and files the forms for Medicare at no charge.

Patients Without Insurance We request that your payment for services be made at the time of your visit. This policy simplifies our billing and helps keep our fees down. For your convenience, we gladly accept MasterCard, Visa, Discover, cash or check.

Underinsured/Inability To Pay

If, for some reason, you feel your co-pay, deductible or lack of insurance will create a hardship to your family, iXL wants to insure you are able to get the care you need. We do not want patients to forgo necessary treatment due to their financial situation. We offer a Financial Hardship Relief From Charges for patients who request these services. If, for any reason you feel you would need to shorten your length of care due to financial difficulties, please ask to speak with our Office Manager for assistance with this program

Missed Appointments/No Showing for Scheduled Appointments We will make every effort to accommodate your scheduling needs. In return we ask that you help us by keeping your scheduled appointments and by notifying us at least 24 hours in advance when possible if you are unable to do so. When you give us advance notice we are able to accommodate other patients. If adequate notice is not provided for an appointment (excluding emergencies) you will incur a $25 missed appointment fee.

ALL PATIENTS PLEASE READ AND SIGN THE FOLLOWING STATEMENTI authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the physician or supplier of services described in the insurance claim. I understand that some Insurance Plans may not cover the total cost of treatment. In some cases, provider service(s) may be considered medically unnecessary by the insurance company and that **I am responsible** for any **copayment, coinsurance, deductable** and **other charges** not covered by my primary or secondary insurance plan(s).

SIGNATURE:_____DATE:_____

Rehab, Exercise & Wellness Center
Personal, specialized services to help you excel every day!

Name:_____ **DOB:**_____ **Sex:** **M** **F**
Reason for visit/Diagnosis: _____
Goals:_____
Past Surgeries: _____

MEDIcation Names *Please list all Prescription, Over the counter, Herbal or supplements*	**DOSAGE**	**FREQUENCY**	**ROUTE OF ADMINISTRATION** *(ORAL, injection, etc)*

HEALTH HISTORY: Please circle any of the following that apply or for which you have been diagnosed or treated for by a health professional.

Alcohol Use(current)	**Cirrhosis**	**Hernia**	**Obesity**
Anemia/Sickle Cell	Concussion	High Blood Pressure	**Osteoarthritis**
Anxiety/Depression	Diabetes	Hyperlipidemia	Pacemaker
Arthritis	Edema (swelling of ankles)	**Joint Pain**	**Pain (3+ months)**
Asthma	Emphysema	Kidney Problems	Phlebitis
Back Strain	Fainting	**Knee Problems**	Seizures
Bronchitis, chronic	**Falls (last 12 months)**	Migraines	**Shoulder Problems**
Cancer	Fatigue	Neck Strain	Smoker (current)
Chest Pain/Cardiovascular	Gout	Neurological Condition	Stroke
Chronic Lung Disease	Head Injury	Numbness	Thyroid Problems

Other:_____

Are you currently taking any opioids? **Yes/ No** **Allergies**_____
Are you pregnant? Yes/No **Date of last pregnancy:**_____**Natural or C-Section**
Patient's Signature:_____**Date:** _____

Clinician Initials:_____**Date:**_____ **Clinician Initials:**_____**Date:**_____
Clinician Initials:_____**Date:** _____ **Clinician Initials:**_____**Date:** _____