EXCEL REHABILITATION

Patient Registration and Authorization Form

Please Print

Patient Information

Patient's Name (Last, First, MI) Patient's Home Phone Number ( )

Address Patient's Work Phone Number ( )

City State Date of Birth SS#

Zip Sex Age Patient's Employer

Primary Care Physician _____ Phone # (___) _____

Referring Physician _____ Phone # (___) _____

Type of Injury/ Symptom _____

Date of injury or first symptom _____/_____/_____
month date year

Did injury happen on the job? (YES) (NO) Was injury a result of an Auto Accident? (YES) (NO)

If yes, when / where? _____

Please list current medical conditions (including allergies, medications and pregnancy).

_____

_____

INSURED INFORMATION (IF OTHER THAN PATIENT)

Policy Holder _____ Relationship to Patient _____

Social Security Number _____ Date of Birth _____

Employer _____ Work Phone Number _____

INSURANCE INFORMATION *(May we copy your card please?)*

Name of Insurance Company	Address	Subscriber	Policy/ ID#
1. (Primary)			
2. (Secondary)			

FINANCIAL AGREEMENT

The undersigned hereby authorizes the release of any information requested by the insurance company designated above and authorizes payment by such insurance company of medical benefits to EXCEL REHABILITATION for services rendered. The undersigned agrees to be ultimately responsible for payment of all charges for services rendered by EXCEL REHABILITATION whether or not such services are covered by insurance benefits. HMO/PPO plan participants are fully responsible for their designated co-pay and for full coverage of orthopedic appliances and custom orthotics. The undersigned agrees to reimburse EXCEL REHABILITATION for any expenses, including reasonable attorney's fees, incurred in connection with the collection of sums due for services performed hereunder.

Have you contacted your insurance company for verification of benefits? (YES) (NO)

Signature (Financially Responsible) _____ Date _____

WORKMAN'S COMPENSATION CLAIM

A claim will be submitted to your Workman's Compensation Carrier only if the information below is completed. If this information is not available, you will be billed directly until it is supplied. Failure to have claim paid within 90 days without written notification from your carrier that benefits are pending will result in billing the patient directly.

Are we to submit Workman's Compensation? (YES) (NO) Claim number _____

Carrier's Name/Address Street City State Zip

Contact Person _____ Phone Number ( ) _____

FINANCIAL POLICY FOR EXCEL REHABILITATION

Thank you for choosing us for your rehabilitation needs. We are committed to your treatment being successful and feel that an understanding of our financial policy is essential. The following is a general statement of our financial policy.

Our office submits insurance forms as a courtesy and service to our patients. We are not obligated to perform this service unless we have participating or member agreements with individual companies. If payment is not received from an insurance company with which we are not contracted within 60 days, the balance due becomes your responsibility. Please read the information below that applies to your insurance situation.

HMO'S, PPO'S, POS'S

Before returning for further treatments, it is the responsibility of the patient to contact our office to insure that authorization for subsequent appointments has been obtained. You are bound by your plan to follow their rules and guidelines for obtaining a referral from your primary care physician before being seen in this office. Obtaining a referral is your responsibility and never the responsibility of this office. It is also your responsibility to keep track of your referrals and the number of visits they authorize. We are not responsible for notifying you when you are out of authorized visits. Please also note that referrals cannot be dated retroactively, that is, after the date of the visit. It is impossible for our staff to be familiar with the requirements of all group plans as they can vary widely even within the same HMO.

COINSURANCE/COPAYMENTS

Your insurance company will determine the coinsurance amounts. Once we receive notification from the insurance company, the billing office will send you a balance due notice. If you would like to make prepayments on your coinsurance, please contact our office staff to make arrangements.

Co-payments must be made prior to each visit. Please note that if we have not received a referral, it will be assumed that you are using the out-of-network option and you will be responsible for more than the co-payment.

MISCELLANEOUS INSURANCE COMPANIES

It is your responsibility to provide us with complete insurance information during your first visit office visit. We cannot bill your insurance company unless we have complete information, including the address of the company.

A traditional insurance plan pays a percentage of your charges. You will be asked to pay your deductible and then your percentage of responsibility on a weekly basis. This formally acknowledges that the undersigned patient has been informed that Excel Rehabilitation does not participate with _____ (Insurance Company).

UCR (Usual and Customary Rates)

Our practice is committed to providing the best treatment possible for our patients and we charge competitive rates for our area. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates. We are under no legal obligation to accept what each insurance company feels is usual and customary. Our Business Office will be happy to give you an estimate of our charges, but cannot guarantee the accuracy of any estimate because treatments vary. Your physician and therapist control the actual treatment and, therefore, costs fluctuate.

SELF PAY

If you are not covered by any insurance plan, we will expect payment at the time service is rendered. If financial arrangements need to be made, please contact our Business Office at (703) 383-1616.

WORKER'S COMPENSATION

A claim will be submitted to your Worker's Compensation carrier only if the information is provided. If this information is not available, you will be billed directly until it is supplied. Please inform our front office if prior authorization is needed.

MEDICARE

Excel Rehabilitation has been approved to be a Medicare provider. You must show Part B on your Medicare card. If you have secondary insurance, please let our office know on the first visit.

Thank you for reading our financial policy. We realize that as health care changes, confusion can occur. Please let us know if you have any questions or concerns. Feel free to call our Business Office at (703) 383-1616 regarding any questions.

_____ _____

Patient's Signature Date

CANCELLATION POLICY

Dear Patients:

It is our goal to keep our fees for our services as reasonable as possible. Our fee schedule is based on efficient scheduling and is dependent upon our patients arriving for their appointments in a timely fashion.

With this in mind, if you find you are unable to keep your appointment, we request you give us at least 24 hours notice. Otherwise a $50.00 fee may be charged for the missed appointment. This $50.00 fee, which is not covered by insurance, will have to be paid at the time of your next appointment.

***Please note if you miss two consecutive appointments without prior communication to us, our office may cancel the remainder of your appointments. We will place a courtesy call informing you of such actions.**

Thank you for your cooperation.

_____ _____

Patient/Guardian Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____
(Print your name)

Have received/ reviewed the Notice of Privacy Practice from EXCEL REHABILITATION.

_____ _____
(Signature) (Date)

In, Lieu of patient signature, _____, a
(Employee of Excel Rehabilitation)
staff member of EXCEL REHABILITATION, state that, _____
(Patient name)
has been given our current Notice of Privacy Practices.

_____ _____
(Signature) (Date)