Patient Express Registration

Todays Date:

1. Patient Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name _____ First Name _____ Age _____ ❑ Male ❑ Female

Street Address _____ City _____ State _____ ZIP _____

(_____) Home Phone _____ (_____) Cellular _____ ● Email Address (Required in order to watch "New Patient Video") _____

Occupation _____ Employer Name _____ (_____) Phone # _____

Emergency Contact Person _____ (_____) Phone # _____ If Patient is a MINOR: Parent/Guardian Name and Signature Here _____

Social Security #_____ Date of Birth_____/_____/_____ ❑ Single ❑ Married

Work Status: ❑ Currently Employed: ❑ Retired ❑ Disabled (__Total or __Temporary) ❑ Student (__P/T __F/T)

2. My Condition Info

ALL INFO REQUIRED

My injury/ailment is related to . . .

❑ AUTO/PERSONAL INJURY: Date of accident:_____/_____/_____

❑ WORK INJURY: Complete all information below.

Date of injury:_____/_____/_____

Your company HR person name_____

Insurance adjustor name_____

Insurance adjustor PH#_____

❑ NO INJURY: What do you think may have caused it?

I have already had . . .

❑ SURGERY: When and what type?

❑ PHYSICAL THERAPY BEFORE: When and where?

❑ HOME HEALTH Care: Are you still receiving it? __YES __NO

❑ OTHER care: What?

3. Payment Info

(check only one box)

I am paying TODAY by . . .

❑ **INSURANCE** and would like to . . .

__ Have you deal directly with them. I will assign my benefits to you by completing the **"Assignment of Benefits Form"** (Fees may apply in some cases).

❑ **WORKERS COMP** . . .

You must have all info provided under "My Condition...".

❑ **CASH, CHECK, CREDIT** and would like a . . .

__ Up to 25% discount by paying at the time of service.

__ Payment plan and apply for "Financial Hardship" You must qualify for this.

❑ I have an **ATTORNEY** and would like to . . .

_ Pay up front. I'll get reimbursed after my case settles.

4. Referral Info

How did you hear about us?

❑ Friend or Family: ❑ Brochure: Give details:

❑ Internet: ❑ Insurance/Directory:

❑ Advertisement: ❑ Other:

❑ Physician/Dentist/Chiropractor/Nurse: Give details below.

Referring Physician/Person's Name _____

City _____ State _____

Phone # _____

❑ I have read and agree to all the policies on the back of this form. Signature_____

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing on the other side of this form (bottom).

Initial All Boxes

☐ **Late Policy "10-minutes"**
Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

☐ **24-Hour Advance Notice Fee**
If you wish to change or cancel an appointment we require a minimum ***24-hour advance notice***. Anything less will result in a ***$25 fee*** charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere ***$25 fee***. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. Please be courteous and responsible. Thank you.

☐ **Copays are due upon arrival**
If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an "Extension Request" form. This is a "promise-to-pay" form and carries a minimal fee that allows you to keep your appointment.

☐ **No-shows are bad**
If you fail to show for an appointment without notice all future appointments will be removed and a ***$25 fee*** assessed to your account. You may re-schedule appointments again on a "first come, first serve basis".

☐ **Cell phones must be shut OFF or silent.**
We realize emergencies may arise and therefore allow you to carry your cell phone during your session, however, please be courteous and set to silent mode or turn off. Thank you.

☐ **Children requiring supervision are NOT allowed to attend sessions with you.**
Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

☐ **Financial Hardship**
If you are experiencing financial difficulties and are unable to afford the cost of our services we have a "Financial Hardship Form" which may be filled-out. If you quality for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

☐ **Important Notice from the Federal Government:**
"It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as "professional courtesy" and "TWIP's - Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General, 202 619-0089."

We look forward to building a successful relationship with you that lasts a lifetime!

Assignment of My Benefits

IMPORTANT: All information must be **completed** or we will NOT be able to do the courtesy of dealing directly with your insurance.

1. Benefit Info

For the services you are seeking: *If you don't know this information, call the "800" number on your insurance card. The front desk person may be able assist you.*

What is your plan deductible? $ _____ Co-Insurance? $ _____ Co-Pays? $ _____

Any Plan Maximums/OOP? $ _____ Visit Max per year? _____ Visits already used this yr? _____

2. Policy Info

☐ Text Message Reminders *Are you currently receiving home health services?* _____

Patient Name:_____ID #_____DOB_____

Insurance Policy 1 Name/Number/Group # (if applicable) _____

***IS PATIENT INSURED THROUGH SOMEONE ELSE'S POLICY?** Give their info here: (otherwise, skip this portion)

- Policyholder Name_____DOB_____SSN_____
- Address (if different than Patient)_____
- Relationship to Patient: Spouse Parent Other: _____
- Employer _____ Ph#_____ Claim #_____
- Employer Address _____

Insurance Policy 2 Name/Number/Group # (if applicable)_____

I hereby instruct and direct _____ insurance company to **pay by check made out to the "Healthcare Provider" to the right and mailed to** the address on the right (not mine). If my/this current policy prohibits direct payment to doctor/therapist, I hereby also instruct and direct you to make out the check to me and mail it to the above address for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered.

Healthcare Provider info:

Zoom Rehabilitation, Inc.
1101 E Airline Rd
Victoria TX 77901

This is a direct assignment of my rights and benefits under this policy.

This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

(Check each box and sign at the bottom)

- ☐ A photocopy of this Assignment shall be considered as effective and valid as the original.
- ☐ I authorize the release of any medical or other information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment of benefits.
- ☐ I authorize the use of this signature on all insurance submissions.
- ☐ I authorize the "Healthcare Provider" named above to deposit checks made in my name.
- ☐ I authorize the "Healthcare Provider" named above to initiate a complaint to the Insurance Commissioner for any reason on my behalf.
- ☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Dated this_____day of_____, 20_____.

Signature of Policyholder _____ Witness _____ Signature of Claimant, if other than Policyholder _____

Zoom Rehabilitation, Inc.

Statement of Privacy Notice AND
Informed Consent and Policies Agreement

THIS NOTICE DECSCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are:

1) Does your condition interfere with the quality of your life?
2) Does your condition interfere with your ability to perform work or daily activities?
3) Are you motivated and able to participate in your treatment program and follow home and self-care instruction?
4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc.?
5) Are there specific goals set that are measurable and track-able?

If the above criteria are not met, you are welcome to participate in our elective services such as 830laser, massage, myofascial treatments, fitness/exercise training, Posture Program, etc. payable out-of-pocket by cash, check or credit card.

Cancel/No-show/Late

Please refer to the Express Registration Form.

Authorization for Release of Records

Assignment of Benefits (for insurance patients)

Please refer to the Assignment of Benefits form.

Results

The purpose of physical/occupational therapy is to maximize your body's own healing potential through natural means and promote your ability to perform daily, work, and leisure and sports activities through increased strength, flexibility, agility, and movement strategies. It is not possible to predict the results or outcomes of treatment. Sometimes benefits are realized immediately and sometimes it's more gradual over time.

Insurance Patients

It is your responsibility to know your benefit and insurance coverage for physical therapy services, including any maximums or exclusions. You are responsible for all charges whether paid by insurance or not. Any balances that exceed 30 days may incur fees and collection costs.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the Therapy Cap (unless your diagnosis is exempt from the Cap).

Minors and Parents

If patient is a minor (under 18 years of age), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

Informed Consent

By signing below, the patient gives the therapist permission to the evaluation and treatment. It is your right to accept or refuse any treatment offered. There are no guarantees made as to the results that may be obtained from our treatment(s). If you have any questions about your care, be sure to ask the therapist.
It is up to patient/caretaker to inform the therapist/staff about any health problems or allergies patient may have. Patient/caretaker must also tell the therapist/staff about drugs or medications being taken as well as any medical conditions and/or surgeries.

Please discuss any questions or problems with the therapist before signing this statement of understanding and consent for care.

Patient Declaration

The therapist has explained to me the type of treatments ideal for my condition and the benefits of therapy, along with the risk of NOT receiving treatment. I have been given an opportunity to ask questions, and all my questions have been answered to my satisfaction. I confirm that I have read and fully understand this consent and policies form.

Informed Consent

- We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.
- We may disclose your health information to your insurance provider for the purpose of payment or health care operations.
- We may disclose your health information as necessary to comply
- with State Workers' Compensation Laws.
- We *may* disclose your health information to notify or assist in notifying a family member, or another person responsible for your care about your medical condition or in the event of an emergency orof your death.
- As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.
- **We** may disclose your health information in the course of any administrative or judicial proceeding.
- We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.
- We may disclose your health information to coroners or medicalexaminers.
- We may disclose your health information to organizations involved in procuring, banking, or transplanting organs and tissues.
- We may disclose your health information to researchers conducting research that has been approved by an Institutional Review Board
- It may be necessary to disclose your health Information lo appropriate persons in order to prevent or lessen a serious and imminent threat to
- the health or safety of a particular person or to the general public.
- We *may* disclose your health information for military, national security, prisoner and government benefits purposes.
- We may leave a message on an automated answering device or person answering the phone for the purposes of scheduling appointments. No personal health information will be disclosed during this recording or message other than the date and time of your scheduled appointment along with a request to call our office if you need to cancel or reschedule your appointment."
- We may contact *you* by phone, mail, or email. "It is our practice to participate in charitable and marketing events to raise awareness, food donations, gifts, money, etc. During these times, we may send you a letter, post card, invitation or call your home to invite you to participate in the charitable activity.
- In the event that we are sold **or** merged with another organization, your health information/record will become the property of the new owner.
- You have the right to request restrictions on certain uses and disclosures of *your* health information. Please be advised, however, that we are not required to agree to the restriction that you requested.
- You have the right to have *your* health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that we amend your protected health information. Please be advised, however, that we are not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.
- You have a right to receive an accounting of disclosures of your protected health information made by us.
- You have a right to a paper copy of this Notice of PrivacyPractices at
- any lime upon request.
- We reserve the right to amend this Notice of Privacy Practices at any time in the future and will make the new provisions effective for all information that it maintains. Until such an amendment is made, we are required by law to comply with this Notice.
- We are required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have questions or complaints about any part of this notice or how we have handled your health information or if you want more information about your privacy rights, please contact us by calling this office at **(361) 237-1670.** If our Privacy Officer is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days.

If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights
200 Independence Avenue, S.W.Room 509F HHH Building
Washington, DC 20201

By *way* of *my* signature, I provide the company above with *my* authorization and consent to use and disclose *my* protected health care information for the purposes of treatment, payment and health care operations as described in this Privacy Notice as well as the understanding of the foregoing explanation of rehabilitation/therapy care that will be provided to me. I herby consent for treatments rendered to me.

Patient's Name (print)

Patient's Signature Date

Authorized Facility Signature Date

ZOOM Rehabilitation, Inc.
The Right Path to Better Health

DESIGNATION OF INDIVIDUALS INVOLVED IN MY PAYMENT AND TREATMENT DECISIONS

NAME	*Last*	*First*	*MI*
DATE OF BIRTH		SOCIAL SECURITY #	
		MEDICAL RECORD # / ID	

In order to comply with the HIPAA Privacy Laws, **Zoom Rehabilitation, Inc** may provide limited information about you to individuals who may be involved in your treatment or payment decisions.

In order to assure your privacy while still making information available to those you want to be involved in your care and payment decisions, **Zoom Rehabilitation, Inc.** requests that you list on this form those people you authorize to receive your health information. These persons may include:

- Family members or others who accompany you to appointments
- Family members or others who call us about your care or payment issues

Please provide us with complete information about these individuals below. You may use multiple forms if needed.

NAME AND ADDRESS OF THE INDIVIDUAL(S) / ENTITY(S) WHO RECEIVED THE INFORMATION:

Name: _____

Address: _____
Street City State Zip

Phone: (____) _____ Fax: (____) _____

Relationship: _____ Involved in: ❒ Treatment ❒ Payment ❒ Both

Name: _____

Address: _____
Street City State Zip

Phone: (____) _____ Fax: (____) _____

Relationship: _____ Involved in: ❒ Treatment ❒ Payment ❒ Both

Name: _____

Address: _____
Street City State Zip

Phone: (____) _____ Fax: (____) _____

Relationship: _____ Involved in: ❒ Treatment ❒ Payment ❒ Both

This information will be presumed valid and the Clinic may rely on it until you have notified us in writing of any changes to this form.
SUBMIT ANY CHANGES TO THIS FORM TO THE PRIVACY OFFICER AT: 361-415-2296(fax) or mail to 9606 Zac Lentz Pkwy Victoria TX 77904

SIGNATURE: **TODAY'S DATE:**

PRINTED NAME: _____

RELATIONSHIP: ❒ Client/Patient ❒ Parent ❒ Guardian ❒ Representative ❒ Conservator ❒ Other _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

PRE-EXAM FORM: In order to evaluate your condition fully, please be as accurate as possible. Thank you.

PATIENT NAME: _____ AGE: ___ DOB: ___/____/_____ ❑ Female ❑ Male

OCCUPATION: _____ ARE YOU WORKING NOW? ❑ Yes ❑ No

1.	Where is your pain/problem?		
2.	What caused your pain/problem?		
3.	Approximately when did it start?		
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe?) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that you'll get better? (circle one)	Not at All Mildly Optimistic Fairly Very Optimistic Extremely	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week will you commit to getting better?		
10.	What are you expecting from therapy?		
11.	On the scale, circle your worst pain level in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1. . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List any medications you are taking:		
13.	List all past surgeries with dates:		
14.	List all medical conditions you have (or were told you have):		

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation program and that my approval into their program is not guaranteed.

Patient Signature (or guardian): _____ Date: _____

Non-Covered Products or Services

Under your health plan, you are financially responsible for co-payments, co-insurance and deductibles for covered services, as well as those services that exceed benefit limits. You are also financially responsible for all non-covered services as defined by your health plan contract. For example, this may include items such as supplies, vitamins, or durable medical equipment. The services or products listed below are not covered according to your health plan. Your acknowledgement below indicates that you have been advised of this information and that you agree to pay for the listed services or products. **You are not required to purchase anything however, the products listed below are not covered by your insurance plan.** The products or services listed are included under the **Non-Covered Services** statement and *may or may not* be an item that your Physical Therapist determines to be helpful in your recovery for your current diagnosis. It is common for 1 or 2 of the items listed below to be used during our usual Physical Therapy programs. It is recommended that during home exercises and self-treatments that you simulate the same movements as in our clinic as close as possible.

NON-COVERED ITEMS

Theraband/Theratubing	**$5**
TENS unit with pads	**$90**
Electrodes	**$5**
Shoulder Pulley	**$17**
TherBand Foot Roller	**$20**
Gait Belt	**$15**
Moist Heating Pad	**$30**
Gel Ice Pack – Cervical	**$20**
Gel Ice Pack – Oversized (11x14)	**$25**
Subzero-Roller	**$10**
Subzero- 20oz	**$30**
Sombra- 2oz	**$12**
4oz.	**$15**
8oz.	**$25**
Spider Tech Tape	**$15**
Exercise Programs	**FREE**
Balloons	**FREE**

I HAVE READ AND UNDERSTOOD THAT CERTAIN ITEMS ARE NOT COVERED UNDER INSURANCE AND MAY BE PURCHASED IF SUGGESTED BY THE PHYSICAL THERAPIST AT THE COST ABOVE. I ACKNOWLEDGE THAT I HAVE BEEN TOLD IN ADVANCE BY MY PROVIDER THAT THE SERVICES/PRODUCTS LISTED ABOVE ARE NOT COVERED BY MY HEALTH PLAN. I AGREE TO PAY FOR THESE NON-COVERED SERVICES SHOULD I CHOOSE TO PURCHASE THEM.

SIGNATURE _____ DATE _____