ZARETT | REHAB | FITNESS

Patient Information

Referred By: _____
Referring Physician: _____

Appointment
Date: _____
Time: _____

Patient Name: _____
Last First Middle Int.

Date of Birth: _____ SS#: _____

Street Address: _____

City/State/Zip: _____

Phone Numbers: Home: _____ Work: _____

Cell: _____ Email: _____

Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____

Type (Circle): Insurance Fitness Work/Comp Personal Injury Auto D/A: _____

Primary Insurance: _____ Phone: _____

ID/Claim #: _____ Group #: _____

Policy Holder Name: _____ DOB (if other than patient): _____

Secondary Insurance: _____ Phone: _____

ID/Claim #: _____ Group #: _____

Policy Holder Name: _____ DOB (if other than patient): _____

Notes: _____

_____

_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby assign to Zarett Rehab & Fitness all payments made by any insurance company for physical therapy services rendered to myself or my dependents. I further hereby assign to Zarett Rehab & Fitness all payments for said physical therapy services are sent promptly and directly to Zarett Rehab. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature Date

520 South 19th St. Philadelphia, PA 19146
P. 215.731.1449 F. 215.731.1345 WWW.ZARETTREHAB.COM

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Medical History Intake Sheet

Name _____

Date _____

Please check if you have had any of the following:

__High blood pressure	__Heart murmur	__Atrial fibrillation
__Heart disease	__Heart attack	__Circulatory problems
__Migraine headaches	__Neurological problems	__Cancer
__Lung disease	__Broken bones	__Metal implants
__Osteoporosis	__GI problems	__Stroke
__Epilepsy/seizures	__Kidney disease	__Bowel/bladder changes
__Liver disease	__Asthma	__Other

__Diabetes (__Type 1 or __Type 2)

Do you have a pacemaker? ____

Females: Are you pregnant? ___ If so, how many months? _____

Please list relevant surgeries you have had _____

List any medications you are currently taking _____

Do you know of any medications to which you are allergic? _____

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Patient Injury Information

Patient Name_____ Date of Birth_____

Area of Concern_____

Is this due to accident or injury?_____

Work related injury_____

Auto related injury_____

Sports related injury_____

Other cause of injury_____

Describe how symptoms first occurred (please be specific)

_____

_____

Date of injury_____

Have you ever been treated for the same injury in the past?

_____

If yes, when, where and under which insurance coverage?

_____

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Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Zarett Rehab & Fitness's Notice of Privacy Practices with an effective date of May 1, 2003.

Name of Patient _____

Address of Patient _____

Signature of Patient _____ Date_____

Name of Witness _____

Signature of Witness_____ Date_____

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Authorization/Release of Medical Information

I, hereby authorize the release of any medical information to determine and process insurance benefits payable for services rendered to me and for which claims are submitted for payment to my insurer.

_____ _____

Signature Date

Assignment of Insurance Benefits

I request payment of medical insurance benefits to which I may be entitled (including Medicare or Medicaid) to be made on my behalf to Zarett Rehab & Fitness, to which I hereby assign my rights to payment. This assignment shall remain in effect until revoked by me.

_____ _____

Signature Date

Please review our financial policies in our patient information notice (attached).

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Providing Your Credit Card Information

If you choose to pay with a credit card, we ask that you provide your credit card information for us to keep on file. We will provide you with the receipt after your credit card has been charged.

Your credit card will be charged if:

- A payment is missed at the time of service.
- A payment needs to be made towards your deductible (if applicable).
- A co-insurance payment needs to be made (if applicable).

_____ Yes, I will provide my credit card information.
****Please fill out all information below.**

_____ No, I will not provide my credit card information.

Name of Patient: _____

Name on Card: _____

Credit Card #: _____

Expiration Date: _____

Please Circle: VISA MASTERCARD DISCOVER

Billing Address: _____

_____

_____

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Medicare Reimbursement

Medicare policies allow coverage for outpatient physical therapy up to a limit of $1860. This amount can change by law over time. Medicare pays 80% of amounts up to $1860. Your secondary insurance may cover the 20% which remains. If you have used $1860 of Medicare outpatient physical therapy (which we estimate to equal about 12 visits, but depends on the specific services you receive), you no longer have Medicare coverage and you must pay cash for any additional therapy. We will let you know when your Medicare coverage has been exhausted. In some instances, secondary insurance may continue after Medicare benefits are exhausted.

I have read and understand the Medicare Reimbursement Policy for outpatient physical therapy.

Patient signature_____

Date_____

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Patient Policies and Information

Welcome to Zarett Rehab & Fitness. We strive to provide a professional, caring level of service to our patients. In order to get the most out of your treatment with us, it will be helpful for you to understand our approach to treatment and our policies, including our financial policies.

1. Zarett Rehab and Fitness offers a highly trained staff to deliver a program of treatment which is personalized to your specific needs. The staff and our methods are very standardized so you can be assured of excellent treatment from every person who works with you. Because of our standardization of techniques, any of our staff is able to provide your personal program of treatment. You may be supervised or treated by different people during one session or at different sessions.

2. We schedule appointments based on the availability of staff to work with the multiple patients who may be in the gym or in treatment at any one time. Because people complete their specific treatments at varying rates, when you return to the second floor for manual therapy or other physical therapy, you may have to wait a few minutes for us to be available to provide what you need on that day. We suggest you allow at least 90 minutes for each session.

3. Because we schedule so as to accommodate people in an efficient manner, it is important that you arrive on time to be available for your scheduled slot. If you have to miss an appointment you must cancel no later than twelve hours in advance. You may call Monday-Friday until 7:00PM and Saturdays until 1PM. Failure to cancel at least twelve hours in advance, no matter the reason, will result in a charge. (See below in Financial Policies).

4. We pride ourselves on the quality of the professional services we provide. We encourage good interpersonal relationships between all our patients and all our staff. That said, we have a strict policy against social interactions between staff and patients outside of the facility.

5. We encourage you to ask any questions you may have about your treatment or how you feel in treatment at any time to any staff member. We value knowing how you feel at any time.

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Financial Policies

You have the financial responsibility to pay for all services rendered by Zarett Rehab & Fitness. We accept insurance payment on your behalf for physical therapy services. However, this acceptance does not eliminate all financial responsibility to us.

1. We accept most insurances. We make a good faith effort to verify coverage. However, it is your responsibility to be knowledgeable about your insurance coverage, which can vary widely.

   a. Deductibles. Many insurance programs have a deductible, a specified amount of money you must pay in cash for your treatment, before your insurance benefits become available. We are not permitted to waive deductibles. You must pay them upfront until the specific amount your insurance program requires has been paid.

   b. Co-Pay/ Co-Insurance. Many insurance programs impose some type of cost for patients to use their coverage. These fees go on throughout the benefit coverage period, even after the deductible has been satisfied. The cost sharing may be a fixed amount (e.g., $20 per visit – often called a "co-pay") or it might be a percentage of the fee schedule amount (e.g., 20% of $110 – often called "co-insurance"). We have no control over your insurance coverage and we are obligated to collect all co-pays and co-insurances as established by your insurer.

   c. Exhaustion of Benefits. Many insurers limit the number of treatments you may get with insurance coverage. If you exhaust your benefits, you must pay cash for any additional treatments.

2. Physician Authorization. Insurance coverage requires a physician prescription every 30 days. Without the prescription, your treatment is not covered and you must pay out of pocket if you proceed with treatment. It is your responsibility to make sure your physician's prescription is current when you present for treatment. Treatment without a physician prescription requires cash payment.

3. Appointments Canceled Too Late. Our facility is designed to deliver personal, efficient treatment. We reserve time for you. If you do not notify us 12 hours in advance you will have to pay a fee for the missed appointment. For physical therapy, where more than one member of the staff may be working with you, the charge is $60 for an appointment canceled too late. For fitness appointments and appointments that are longer than an hour, the charge may be higher. For nutrition, massage and acupuncture where the service is one-on-one, if you cancel too late, you must pay the full amount of the service you reserved.

Failure to pay for services rendered which require us to charge late fees for payment, attorney's fees or collection charges are your responsibility.

IF YOU HAVE ANY QUESTIONS ABOUT THESE POLICIES OR ANYTHING ELSE, PLEASE DO NOT HESITATE TO ASK AT THE DESK.

* * * * *

By my signature below I indicate I have read and agree to the patient policies.

_____ _____

Signature Date