ACV OUTPATIENT REHAB

PATIENT INTAKE AND CONSENT FORM

Patient Name _____ **Today's Date**_____

Address_____

City _____ **State** _____ **Zip** _____

Home Phone _____ **Work/Cell Phone** _____

DOB _____ **Age** _____ **Sex** □ **Male** □ **Female** **SS#**_____ **Marital Status:** □ **S** □ **M** □ **D** □ **W**

Referring Physician _____

Primary Insurance _____ **Secondary Insurance**_____

PLEASE PROVIDE INSURANCE CARD(S)

ARE YOU RECEIVING ANY HOME HEALTH SERVICES? □ **YES** **(IF YES STOP HERE & NOTIFY THERAPY STAFF)** □ **NO**

AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to this department AND also authorize release of any medical records necessary to facilitate my treatment to process medical claims. I understand that in the event my insurance company or financially responsible party do not cover the services I receive, I will be financially responsible for payment.

COPAY _____ **DEDUCTIBLE** _____ **Initials** _____

CONSENT TO TREATMENT: I consent to rehabilitation and related services at this department. In doing so, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching, and/or direct contact to a sensitive nature. **Initials** _____

LIABILITY: I know and agree that this department is not responsible for loss or damage to personal valuables. **Initials** _____

WAIVER AND RELEASE OF MEDICAL RECORDS: I hereby release, discharge and acquit this department, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services, including but not limited to ambulance service, Emergency Medical Technician, physician or urgent care services. **Initials** _____

NOTICE OF PRIVACY: I acknowledge receipt of Notice of Privacy Practices. **Initials** _____

TREATMENT OF MINORS: I as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so. **Initials** _____

I CERTIFY THAT ALL OF THE INFORMATION PROVIDED HERIN IS TRUE AND CORRECT.

PATIENT/GUARDIAN SIGNATURE _____