

If you have Medicaid for insurance,
please DO NOT USE THIS FORM.
Choose the Medicaid version.



Date: _____

(All Others)

PATIENT INFORMATION

Client's Name: _____
Address: _____
Address 2: _____
City, State, Zip: _____

DOB: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____

Gender: (circle one) Male Female Or _____

Optional - Pronoun: (circle one) He She They or _____

Are you receiving care for injuries from a **Motor Vehicle Accident**? No
 Yes – Date of Accident is ___/___/___ and what STATE did the accident occur in? _____

I have given Access Rehab Centers information regarding my Auto Insurance.
I, do not have medical insurance do not wish to give Access Rehab this information.
I understand that my auto/workers comp. insurance may not pay for my services, in which case I will be responsible to pay for these services. I understand that my medical insurance carrier may have prior authorization or timely filing requirements and by not providing this information in advance, Access Rehab Centers will be unable to fulfill these requirements. I am instructing Access Rehab Centers to bill my: Auto Insurance Own account-I am responsible for paying.

Do you carry **MED PAY** on your Automotive Insurance Policy? No
 Yes – Auto Carrier Name & Phone: _____
Attorney Name & Phone: _____

Are you receiving care for injuries relating to a **Workers Compensation Case**? No
 Yes – Date of Injury is ___/___/___ and Claim Number _____

I have given Access Rehab Centers information regarding my Workers Comp Insurance.
I, do not have medical insurance do not wish to give Access Rehab this information.
I understand that my workers compensation insurance may not pay for my services, in which case I will be responsible to pay for these services. I understand that my medical insurance carrier may have prior authorization or timely filing requirements and by not providing this information in advance, Access Rehab Centers will be unable to fulfill these requirements. I am instructing Access Rehab Centers to bill my: Workers Comp carrier Own account-I am responsible for paying.

Are you receiving care for injuries relating to a **Liability Claim**? No
(NOT Motor Vehicle or Workers Comp)?
 Yes – Date of Injury is ___/___/___ and
Attorney Name & Phone: _____

Are you receiving **Home Care**? No
 Yes – Agency Name & Phone: _____

Do you have **Medical Insurance?** Yes (*skip to next question*)
 No, I **do not have medical insurance**, have exhausted my benefits, my insurance does not cover my services at Access Rehab or I do not wish to use my insurance. In the case of a high deductible plan, I understand that by not billing my insurance, charges will not be applied to my deductible. If insurance is billed and service is denied, I will pay the rates established by the insurance company.

My services are not related to any type of accident and there is no attorney involved. Discounted fees do not apply to charges that are being billed to an attorney.

Do you want to **Self-Pay?** No
 I agree to pay at each visit: \$95 for an evaluation; \$75 for each therapy session; \$55 for each Group therapy session.
 I agree to be billed: \$100 for an evaluation; \$80 for each therapy session; \$60 for each Group therapy session.

Do you have a **Letter of Protection?** No (*skip to next question*)
 Yes, I have provided Access Rehab Centers with a Letter of Protection from my attorney to replace any other third party carrier. I do NOT have:
 Medical Insurance Workers Comp Insurance
 Auto Insurance I prefer not to use any Insurance

Payment will be made by my attorney when my case is settled. If I withdraw my case or if it is not successful, I will be responsible for payment for my services at Access Rehab Centers. I acknowledge that prior authorization or timely filing limits will not be fulfilled at that time.

INSURANCE INFORMATION

Guarantor: _____

PLEASE - verify the information below with your insurance carrier. We are Not responsible for any incorrect information your carrier has relayed to us.

Relationship: _____

Primary Insurance Plan Benefits for: _____

We have contacted your Primary Insurance Carrier and at this time they have indicated the following:

Deductible: \$ _____
I will pay \$ _____ per visit towards my deductible.
Co-pay: \$ _____ **(payable at each visit)**
Coinsurance: _____ %
Total Treatment Days Allowed per Calendar Year: _____

Secondary Insurance Plan Benefits for: _____

We have contacted your Secondary Insurance Carrier and at this time they have indicated the following: Deductible: \$ _____

I will pay \$ _____ per visit towards my deductible.
Co-pay: \$ _____ **(payable at each visit)**
Coinsurance: _____ %
Total Treatment Days Allowed per Calendar Year: _____

I have reviewed the above information and verify that it is correct.

Also, any Balance will be Billed or Refunded to me. _____ (Patient's Signature)

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY ...

CANCELLATION / ATTENDANCE POLICY

Should you need to cancel or re-schedule your appointment, please contact us at least 24-hours prior to your scheduled appointment. Missed appointments or cancellations with less than 24-hour notice will result in a \$25.00 charge. If you miss two (2) consecutive appointments, or a total of three (3) appointments in total, your name will be taken off the schedule and your physician will be informed. If you are late for an appointment, your therapist will see you as the schedule permits.

I have read and understand the Cancellation/Attendance Policy _____(Patient's Initials)

PATIENT AGREEMENT AND INSURANCE BENEFITS

PERMISSION FOR GENERAL CARE: I hereby consent to diagnostic and treatment procedures that may be performed on me during my visit at Access Rehab Centers. These procedures are provided under the direction of my referring physician and other physicians involved in my care. I understand that Access Rehab Centers will occasionally accept students of therapy professions and that these students may be involved in observing or rendering services under the direction of a licensed therapist.

AUTHORIZATION TO PAY BENEFITS: I hereby assign benefits to include major medical, private insurance or any other plan to Access Rehab Centers. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of Access Rehab Centers. I HAVE PROVIDED Access Rehab Centers with my insurance information, and I understand that the benefits quoted to them may include benefits already used by me. I am responsible for being aware of the benefit limitations of my insurance. PLEASE NOTE: BENEFITS, IF VERBALLY QUOTED BY INSURANCE COMPANIES, ARE NOT CONSIDERED A GUARANTEE OF PAYMENT.

FINANCIAL AGREEMENT: In consideration of the services rendered by Access Rehab Centers at my request and directions, I agree to pay in full, within thirty (30) days of the date of billing, any portion of the bill that is deemed to be my responsibility. If it is necessary for Access Rehab Centers to engage in Attorney or Collection Agency to collect the balance due, I agree to pay lawful and reasonable attorneys collection fees and court costs. In addition, I authorize the release of medical records to the collection agency, collection attorney and/or their agents for collection purposes.

PAYMENT REQUEST FOR MEDICARE/MEDICAID: I certify that the information given by me in applying for payment under TVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Medicare/Medicaid Program, its intermediaries, or professional review organization, any information needed for this or a related Medicare/Medicaid claim. I authorize payment of benefits be made on my behalf.

PROTECTED HEALTH INFORMATION: I consent to the user or disclosure of my protected health information by Access Rehab Centers to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Access Rehab Centers may include HIV/AIDS related information, psychiatric and other behavioral health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which require that I provide specific authorization. I understand that information regarding how Access Rehab Centers will use and disclose my information may be found in Access Rehab Centers' Notice of Privacy Practices. I understand that consent is effective for as long as Access Rehab Centers maintains my protected health information.

CONSENT FORM FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The undersigned patient, consent to have Access Rehab Centers use and disclose my protected health information, including, if applicable, drug/alcohol abuse, HIV and psychiatric information for the purposes of my treatment, healthcare operations and payment by the payer(s) of my health care benefit.

In addition, I consent for Access Rehab Centers to disclose my protected health information to the following for the following:

- Primary Care or referring Physician for follow-up care.
- To other providers for coordination of care.
- To other providers for referral and discharge planning.

I have been provided with Access Rehab Center's Notice of Privacy Practices and understand that I have the right to review this notice before signing this consent. I understand that Access Rehab Centers reserves the right to change its privacy practices, described in its Notice, and that if I wish to receive notification of any changes to the Notice, I may contact Access Rehab Centers' Patient Service Representative at the clinic where I receive care or go to Access Rehab Center's web site at www.accessrehabcenters.com.

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, Access Rehab Centers may provide me with treatment; however, I will be responsible for charges incurred at the time of service. I understand that treatment required by law, such as emergency care will be provided to me whether or not I sign this consent.

Unless I object, Access Rehab Centers may disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

I have the right to request that Access Rehab Centers restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment and/or conducting health care operations. Access Rehab Centers is not required to agree to any restriction I request. If Access Rehab Centers does decide to agree to my request, Access Rehab Centers must honor the restriction placed on the use and/or disclosure of my health information. I also understand that I have the right to request confidential communications by alternate means or locations. However, Access Rehab Centers may deny the request if it determines that it would be administratively difficult to comply with my request.

I understand that with respect to drug/alcohol abuse, HIV and psychiatric information, this Consent will expire 365 days after the date appearing below or 365 days after my final treatment, whichever is later. I also understand that I have the right to revoke this consent by notifying Access Rehab Center's Patient Service Representative at the clinic where I receive care in writing. I understand that if I revoke my consent, there will be no effect on uses and disclosures already made in reliance on my prior consent.

HIV RELATED INFORMATION: In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION: In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

DATE: _____

PATIENT / GUARDIAN AGREEMENT

- I authorize release of information requested by my insurance plan for payment.
- I understand that I am financially responsible for any balance due.
- I have had the opportunity to have my questions answered regarding Access Rehab Centers' privacy practices.
- I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.
- I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Legal Guardian

Date

When completed and signed, please return this paperwork to the receptionist. Thank you.

Date: _____

Appointment Reminder Consent

for

Client Name: _____

Complete this form and sign below to acknowledge and give permission for Access Rehab Centers to provide automatic Appointment Reminders for the above-mentioned client, via:

Email to: _____

Text Message to Cell Phone # _____

Note: We cannot set your account up to send email text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders.

- | | | |
|---|--|---|
| <input type="checkbox"/> ALLTel | <input type="checkbox"/> G C I | <input type="checkbox"/> Sprint PCS |
| <input type="checkbox"/> AT&T | <input type="checkbox"/> Illinois Cellular | <input type="checkbox"/> T Mobile |
| <input type="checkbox"/> Bluegrass Cell | <input type="checkbox"/> Metrocall | <input type="checkbox"/> US Cellular |
| <input type="checkbox"/> Boost Mobile | <input type="checkbox"/> MetroPCS | <input type="checkbox"/> Verizon |
| <input type="checkbox"/> C Spine | <input type="checkbox"/> Nextel | <input type="checkbox"/> Virgin Mobil |
| <input type="checkbox"/> C Spine Wireless | <input type="checkbox"/> Pioneer Cellular | <input type="checkbox"/> Xfinity |
| <input type="checkbox"/> Cell Com | <input type="checkbox"/> Qwest | <input type="checkbox"/> Xfinity Wireless |
| <input type="checkbox"/> Cingular | <input type="checkbox"/> Silverstar | |
| <input type="checkbox"/> Cricket Wireless | <input type="checkbox"/> Simple Mobile | <input type="checkbox"/> _____ |

By signing below, I understand that normal text messaging rates may apply, and I am responsible for these related charges.

I will contact Access Rehab Centers if any above information should change.

Signature of Patient or Guardian

Date

NOTE:

If you wish to stop the current Phone Call Reminders, please listen to the next message you receive and choose the "OPT OUT" option.

For use by Access Rehab Centers: Received by: _____ Entered On: _____