Last Name_____ First Name_____ Initial _____ Sex: M/F
Address_____ APT_____ DOB___/___/_____ Current Age_____
City_____ State_____ Zip_____ SSN _____
Phone_____ Cell_____ Email _____
Employer:_____ Work Phone _____
Address_____ City_____ State_____ Zip_____
Are you a student? Y/N (If yes, FT or PT?) Marital Status S/M/D
Spouse/other (If patient is a minor, please provide information for parent, guardian, or responsible party)
Relationship to patient: Parent/Guardian/Spouse/Self/Other_____
Last Name_____ First Name_____ M.I. _____ D/O/B_____
Address_____ APT_____ City_____ State_____ Zip_____
Phone _____Cell_____ Work _____ Email_____

Emergency Contact Person
Name_____ Relationship_____ Phone_____

ILLNESS OR INJURY
Symptoms/Diagnosis_____Date of Onset_____
Surgery for this condition Y/N Dates_____
Was this injury from an auto accident? Y/N Was this injury from a work related injury? Y/N

Have you had any physical/occupational/speech/cardiac rehab/chiropractic treatments in the last 365 days? Y/N
If so, please circle which you have had and indicate the number of treatments _____

INSURANCE INFORMATION:
Primary Insurance Co:_____ Phone:_____
Policy Holder: Last name_____ First Name:_____ D/O/B_____
Member ID#_____ Group # _____ Relation to patient: Self/Spouse/Guardian

***If you have Medicare, do you have a home health episode open?** Y/N—please be aware that if you do have a home health episode open and you circle No, then you may be financially responsible for charges incurred.

MEDICAL RELEASE AUTHORIZATION:
I authorize the release of any medical information necessary to process insurance claims for services and/or supplies provided by Central Arkansas Rehabilitation Experts.

Signature_____
Date_____

PAYMENT OF BENEFITS CONSENT:
I authorize payment of medical benefits to Central Arkansas Rehabilitation Experts for services and/or supplies provided by them. I am financially responsible for charges not covered by insurance and hereby give my consent for treatment.
Signature_____
Date_____

CONSENT FOR PURPOSES OF TREATMENT

PAYMENT AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my Protected Health Information (PHI) by Central Arkansas Rehabilitation Experts (CARE) for the purpose of diagnosing or providing treatment to me, obtaining payment for healthcare bills, or to conduct healthcare operations of Central Arkansas Rehabilitation Experts. I understand that diagnosis or treatment of me by CARE may be conditioned upon my consent as evidenced by my signature on this document. I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment, or health care operations of this practice. CARE is not required to agree to the restrictions that I may request. However, if CARE agrees to a restriction that I request, that restriction is binding on CARE. I have the right to revoke this consent, in writing, at any time, except to the extent that CARE has taken action in reliance on this consent.

My PHI means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This PHI relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information my identify me. I understand that I have a right to review CARE Notice of Privacy Practices (NPP) prior to signing this document. The NPP describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my therapy services, or in the performance of health care operations or CARE. This NPP also defines the rights and responsibilities of both me and CARE with respect to my PHI.

CARE reserves the right to change the privacy practices that are described in the NPP. I may obtain a revised NPP at any time by requesting a copy from the office, either in person, by phone, fax, mail, or email.

Signature_____ Date _____

Printed Name _____ Date_____

CARE is restricted from releasing any of your PHI without your permission. Therefore, if there is anyone that you DO want to allow access to, then you will need to write their name(s) on this page. Do not include your doctor/insurance company as they automatically have access to your info. If there is no one, please write "NO ONE".

Please check statement(s) below to authorize PHI access to:

- ○ All of the following
- ○ Allow this person to make appts for me
- ○ Allow this person to know my appt times
- ○ Allow this person to know if I am here
- ○ Allow this person to know my arrival time
- ○ Allow this person to know my departure time
- ○ Allow this person to know my account balance

_____
Additional Name and Relationship

Other Info_____
_____

Central Arkansas Rehabilitation Experts
6020 Warden Road, Suite 230, Sherwood, AR 72120
Phone: (501)-392-9180 Fax (501) 392-9184

FINANCIAL POLICY

Central Arkansas Rehabilitation Experts * 6020 Warden Road, Suite 230 * Sherwood, AR 72120
Phone: (501) 392-9180 * Fax: (501) 392-9184

Our goal at Central Arkansas Rehabilitation Experts (CARE) is to provide you with the best care possible. We also want to assist you to the best of our ability in estimating what your financial responsibility will be.

If you will be using your health insurance:
To process claims with your health insurance we will need a copy of your Driver's License and Insurance Card(s). We will call to verify your eligibility and benefits; please provide us with complete and accurate information.

If you will be using *your* auto insurance due to an accident:
We will a copy of your Driver's License and your auto policy information including the insurance company name, address, phone number, adjuster's name, and claim number. We will call to verify that the claim is open, that benefits are payable for your treatment, and follow claim procedure.

If you will be using a third-party auto insurance due to an accident:
In a third party claim, you do not have a direct contract with the insurance company and their primary obligation is to their own policyholder. **Therefore, we do not accept third-party insurance.** We will encourage you to contact your personal auto accident carrier about opening a Med-pay claim.

If you will be using worker's compensation:
We will need a copy of your Driver's License and policy information including the insurance company, name, address, phone number, adjuster's name and claim number. We will call to verify that the claim is open, that benefits are payable for your treatment, and follow claim procedure. Your worker's compensation insurance is a direct contract between you and your employer's insurance company.

If you do not have insurance or are private pay:
Payment is expected at the time services are rendered. Fees are pre-determined and will be discussed prior to treatment. It is the policy of CARE to charge all patients a reasonable amount for services provided. Managed health care plans, government programs, and other third party payers use standardized rate tables based on negotiated contracts. For those without insurance, we may offer reduced fees and/or a payment plan in certain situations. Self -pay rates do not apply to insurance deductibles.

Patient Responsibility:
The patient/guarantor is fully responsible for and agrees to pay for the services, supplies, and products provided by CARE. The patient/guarantor is liable for any amounts not paid, whether the insurance company or third-party payer makes partial payment or declines to pay. All unpaid amounts following payment from the insurance company must be paid within thirty (30) days. If the insurance or third-party payer fails to pay the account within ninety (90) days, the patient/guarantor must pay the account and wait for reimbursement by the insurance company.

Payment Options:

- Cash
- Personal Check
- Visa
- MasterCard

Account balances not paid as agreed or become delinquent may be referred to a collection agency and/or attorney for collection. If that occurs, the patient/guarantor will be responsible to pay for all costs of collection, including court costs, reasonable attorney fees, and interest at a rate allowed by law.

"You agree, in order for us to service your account or to collect any amounts that you may owe us, we may call you at any phone number associated with your account, including wireless numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact many include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that 'your office or agent' may contact me as described above."

Patient Consent and Signature:

I have read and understand this financial policy and may obtain a copy of this document in its entirety upon request. I understand what my financial responsibility is and hereby agree to the terms of this policy. I hereby authorize the release of any medical information necessary to process my insurance claims and authorize the assignment of benefits from any insurance company directly to CARE for services and/or supplies provided to me by them. I also authorize the release of any billing and/or payment information regarding claims filed on my behalf.

Signed_____ Date:_____

Witness_____ Date: _____

CENTRAL ARKANSAS REHABILITATION EXPERTS
NO SHOW/CANCELLATION POLICY

In an effort to decrease unnecessary expenditures and to contain our fees, we have implemented a **No Show/Cancellation Policy** for all our patients effective **August 1, 2019**. Please be advised that you are allowed **one no show or same day cancellation** appointment at which we will gladly reschedule without any charges. On your **second no show or same day cancellation,** you will be charged a **$40.00 fee** that must be paid prior to making any new appointments. On your **third no show or same day cancellation**, we reserve the **right to terminate** the patient-therapist relationship at this office.

After your third cancellation of future appointments a $40.00 fee per discipline (PT/OT/SLP) will be charged.

We understand that everyone might have an unforeseen event in which you cannot make your appointment with us. We only ask that you have the courtesy to call us at least **24 hours in advance** to reschedule your appointment. We allow the one grace appointment in which you are not charged a fee for that sudden emergency. For the subsequent missed appointments, we are charging the nominal fee to cover for the staff that is at hand to provide your needs. Please be assured that we want to run this office as efficiently as possible in order to provide you the best care. This policy is in place to help us achieve that goal. We appreciate your understanding and cooperation in this matter.

_____ _____

Signature Date