NEW PATIENT INTAKE/RE-ADMIT FORM

From:______________________________________ @ LA Fitness Perimeter Point 9047
(Therapist Name) (Facility Name) (Facility #)

Today's Date:____________________ Patient MRN#____________________________

Patient Name:______________________________ Phone Number:______________________

Email Address:___________________________________

Mailing Address: ____

Social Security Number:______________________ Date of Birth:______/______/______

Gender: ☐ Male ☐ Female Marital Status: Married☐ Single☐ Widow☐ Divorced ☐

Attending Physician: ______________________________ Phone #:__________________________

Primary Care Physician if applicable: ____________________________ Phone#____________________

Have you been receiving Home Health Services: ☐ **Yes** ☐ **No**

If YES: Agency Name:________________________ Phone #:____________________
Date of Last Visit, Discharged: _________________________

Referral for what Discipline(s) and Dx:

OT (Dx/s: ______________________) PT (Dx/s: ______________________) ST (Dx/s: ______________)

Primary Ins Name: (___) Med B (___) Medicare Advantage ______________ (___) Other ______________

Policy Number:__________________________________ **Group#:**____________________

Insurance Phone Number ______________________ Name of Insured/subscriber:____________________

Policy# of insured/subscriber: ______________________ DOB of insured/subscriber: ________________

Patient Relationship to Subscriber: ________________________________

Secondary Ins Name: ____

Policy Number:__________________________________ **Group#:**____________________

Insurance Phone Number ______________________ Name of Insured/subscriber:____________________

Policy# of insured/subscriber: ______________________ DOB of insured/subscriber: ________________

Patient Relationship to Subscriber: ________________________________

Have you had previous therapy under Medicare B this year? ☐**Yes** ☐ **No**

If so, when and where?______________________________ What Type(s) ☐ PT ☐OT ☐ST

Person to notify in case of emergency:

Name:____ Relationship:______________________

Home Phone:____________________ Cell Phone:________________________ Work Phone:____________

Guarantor/Guardian/Responsible Party (POA): (THIS ENTIRE SECTION MUST BE COMPLETED)

Name:_____________________________ Relationship:____________________ or Self (same as above)

Address: ____

City/State/Zip: ____

Home Phone: ____________________ Mobile/Cell Phone:____________________________

Work Phone: ____________________ E-mail Address: ______________________________

Patient Name:____________________________

General Medical/Social Information

Do you now have or have had any of the following

Cancer			Glaucoma Disorder	Yes	No
Diabetes	Yes	No	Sensitivity to Heat/Ice	Yes	No
High Blood Pressure	Yes	No	Stroke	Yes	No
Heart Disease	Yes	No	Allergies	Yes	No
Heart Attack	Yes	No	Previous Surgery	Yes	No
Pacemaker	Yes	No	Hernia	Yes	No
Frequent or Migraine	Yes	No	Breathing Disorder	Yes	No
Headaches	Yes	No	Seizures/Epilepsy	Yes	No
Kidney/Liver Problems	Yes	No	Metal Implants	Yes	No
Nervous Disorders	Yes	No	Currently Pregnant	Yes	No
Circulatory Disorders	Yes	No	Other Illness	Yes	No

If YES on any of the above, please explain and give approximate dates:________________________

____

____

Have you had previous therapy for your present condition for which you are to receive treatment here?

Yes No

If YES, state where,when, and what treatment was given: ______________________________

____

____

Is this treatment related to worker's Compensation? Yes ___No ____

Is this treatment related to an accident? Yes No

If so, Attorney Name and Phone Number:____________________________________

Are you currently receiving Home Health Services? Yes___No ____

If so, with which Home Health Agency? _______________________________________

Are you presently taking any medication? Yes No

If YES, list medications and for what condition: ________________________________

____

____

Do you rely on others for transportation? Yes_____No __

Does your illness/injury prevent you from caring for yourself? Yes_____No __

Does your illness/injury prevent you from participating in recreational and/or social activities? Yes____No _____

Do you have a spouse who is dependent on you? Yes____No _____

Do you have friends or family in the area that are able to assist you when needed? Yes No

Do you have adequate family connections and support? Yes No

Do you feel you have some needs that could be addressed regarding family issues? Yes No

Have your eating or sleeping habits changed since your illness/injury? Yes No

Has your illness/injury changed your lifestyle?

Do you have any needs or require any information regarding community resources that may assist you in your recovery? Yes No

OUPATIENT THERAPY TREATMENT AND FINANCIAL AGREEMENT **9047**

Please read this agreement **before** *signing. This agreement creates legal obligations.*

This agreement is made this _____ day of ___________ by and between **Aegis Therapies d/b/a Aegis Group Practice LLC** located at **1155 Vernon Hwy NE #650, Dunwoody, GA 30338** ("FACILITY") and ______________________________ ("PATIENT")

The Above-name parties agree as follows:

FACILITY shall provide outpatient therapy services to PATIENT in compliance with the specific instructions and orders of PATIENT's attending physician, ____.

(Name of Physician)

I. A. Consent to Treatment

The undersigned consents to outpatient therapy services as ordered by the PATIENT's attending physician. PATIENT and/or Patient's Representative acknowledges that Outpatient Therapist has discussed the need for the procedure and treatment which are to be rendered in the FACILITY on an outpatient basis. The PATIENT and/or Patient's Representative also consents to treatment by health care trainees under supervision as required by law.

B. Right to Refuse Treatment

The PATIENT and/or Patient's Representative has the right to refuse treatment and to revoke consent for receipt for treatment. The PATIENT and/or Patient's Representative also has the right to be informed of the medical consequences of such refusal or revocation of consent, and to be informed to alternate treatments available.

II. A. Physician Services

PATIENT and/or Patient's Representative acknowledges that he or she is under the medical care of a personal attending physician and that the FACILITY provides services based on the general and specific instructions of this physician.

PATIENT and/or Patient's Representative recognizes and agrees that all providing services to the PATIENT including those designated by the FACILITY are independent contractors. The PATIENT and/or Patient's Representative recognizes and agrees that such physicians are not associates or agents of the FACILITY and that the FACILITY's liability for any physician's act or omission is limited.

B. PATIENT's Personal Property

FACILITY shall not be responsible for personal belongings left in the treatment area.

C. PATIENT Treatment Areas

For the safety of PATIENT and others, only PATIENT, (as indicated) Patient's representative are permitted in the patient treatment areas.

III. Payments

a. PATIENT and/or Patient's Representative agrees to assume and be liable for all charges of whatever nature incurred by or on behalf of PATIENT and to pay such charges as they become due..

b. If services rendered by FACILITY to PATIENT are covered by Workman's Compensation, a managed care company, private insurance or benefits under Medicare of Medicaid, PATIENT and/or Patient's Representative shall cooperate with FACILITY in providing any information necessary to process such claims and agrees to pay any charges for which he/she is legally responsible, including any co-insurance or deductible amounts required by any third-party payer.

c. PATIENT and/or Patient's Representative understand that charges due will be billed monthly following the services. PATIENT and/or Patient's Representative further agrees that any charges which are not paid in full when due will be subject to a late charge of 1.5% per month or 18% annum until paid in full. In the event PATIENT's account is referred to an attorney for collection, PATIENT and/or Patient's Representative agrees to pay, in addition to all sums due, all reasonable attorney fees, court costs and all reasonable costs of collection.

IV. Patient Certification

a. PATIENT and/or Patient's Representative certifies and warrants that all information submitted by him/her for purposes of applying for or receiving benefits under title XVIII or XIX (Medicare/Medicaid) is true and correct.

b. PATIENT and/or Patient's Representative agrees to indemnify and hold harmless FACILITY from and against any and all loss, damage, cost or liability arising from submission by PATIENT and/or Patient's Representative of false or incorrect information to FACILITY.

c. FACILITY does not make any assurance of any kind that PATIENT's care will be covered by Medicare, Medicaid or any third-party insurance or other reimbursement source. PATIENT and/or Patient's Representative hereby releases FACILITY, its agents, servants, and employees from any liability or responsibility in connection with any potential claim for or failure to obtain such coverage.

d. PATIENT and/or Patient's Representative authorizes any physician or health care facility to furnish FACILITY and/or Social Security Administration, its fiscal intermediaries, carrier, or Medicare Administrative contractor all requested information for PATIENT's medical or financial records. PATIENT further authorizes AGENCY to disclose all or any part of PATIENT's medical or financial records to any person or entity which is or may be liable under contract to FACILITY to PATIENT or to a family member of employer of PATIENT to pay all or a portion of the costs of the care provided to PATIENT, including but not limited to companies, insurance companies, Workman's Compensation carrier, welfare fund or PATIENT's employer. PATIENT further authorizes FACILITY to disclose all or any part of PATIENT's medical or financial records to any independent auditor of FACILITY. PATIENT and/or Patient's Representative requests that payment of authorized benefits be made to FACILTY on his/her behalf.

V. Patient Representative

Any person who signs this agreement on behalf of or in place of PATIENT shall be referred to as Patient Representative. The Patient Representative represents that he/she is authorized by PATIENT to so sign. By signing this agreement, the Patient Representative accepts all the terms of this agreement and agrees to perform all obligations set forth herein.

THE PATIENT AND HIS/HER REPRESENTATIVE CERTIFY THAT EACH OF THEM HAS READ THIS AGREEMENT AND RECEIVED A COPY OF IT AND AGREE TO ALL THE PROVISIONS IN THIS AGREEMENT. THERE ARE NO REPRESENTATIONS MADE BY FACILITY OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAN THOSE SET FORTH IN THIS AGREEMENT.

______________________________	______________________________
PATIENT SIGNATURE	DATE
PATIENT REPRESENTATIVE SIGNATURE	DATE
FACILITY REPRESENTATIVE SIGNATURE	DATE

01/07/13

9047

Aegis Therapies at LA Fitness Perimeter Point
1155 Vernon Hwy NE #650
Dunwoody, GA 30338

INTENT TO CHOOSE OUTPATIENT THERAPY SERVICES

Patient Name (Print) ____

Responsible Party (if applicable) ___________________________
has elected to receive outpatient therapy services using Aegis Therapies effective ________________(date)

REGARDING INSURANCE

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some of the services provided may be non-covered services and not considered reasonable and necessary under your contract. If your insurance company does not pay your account in full, the balance will be billed to you.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS (AOB)

I hereby authorize payments of medical benefits directly to:

Aegis Therapies, Inc. d/b/a Aegis Group Practice LLC
1000 Fianna Way
Fort Smith, AR 72919

I agree that a photographic copy of this authorization shall be as valid as the original.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE (HIPAA)

As a patient of Aegis Therapies, I have been provided with its Notice of Privacy Practices, which describes how medical information about me may be used or disclosed and informs me of my individual privacy rights.

I acknowledge I have received the Notice of Privacy Practices. I understand your Compliance Officer is available to answer any questions I may have regarding issues of privacy.

______________________________________ ____________________
Patient Signature Date

______________________________________ ____________________
Patient Representative Signature if applicable Date

______________________________________ ____________________
Witness Signature Date