IN-SYNC REHABILITATION SERVICES INC.

PATIENT REGISTRATION

A. PATIENT (please print legibly)

First Name:	Last Name:	Middle Initial:
Address:		
City:	State:	Zip:
DOB (mm/dd/yy): / /	Gender: ☐ Male ☐ Female	SSN #:
Mobile Phone:	Home Phone:	Work Phone:
Preferred Contact Method: ☐ Mobile Phone ☐ Home Phone ☐ Work Phone		
Email Address:		T-Shirt Size:
How did you hear about our facility?: ☐ Word of Mouth ☐ Drive-by ☐ Google Search ☐ Facebook ☐ School Sports ☐ Billboard ☐ Newspaper ☐ Other		
If "other" was selected, please describe:		

B. EMERGENCY CONTACT

First Name:	Last Name:	Middle Initial:
Mobile Phone:	Home Phone:	Work Phone:
Relationship to Patient: ☐ Spouse ☐ Parent ☐ Child ☐ Grandparent ☐ Sibling ☐ Friend ☐ Other		
If "other" was selected, please describe:		

C. GUARANTOR / RESPONSIBLE PARTY (fill out if patient is a minor)

Relationship to Patient: ☐ Self ☐ Parent ☐ Spouse ☐ Other		DOB (mm/dd/yy): / /
If "other" was selected, please describe:		
First Name:	Last Name:	Middle Initial:
Mobile Phone:	Home Phone:	Work Phone:

D. REFERRAL SOURCE

Source: ☐ Physician ☐ Direct Access (Self)		
Referring Physician:		Phone:
Fax:	Email:	
Address:		
City:	State:	Zip:

Patient Name:	DOB:

E. MEDICAL HISTORY

DATE OF INJURY (When did your current symptoms begin?):
If you had surgery, list the type of surgery _____ and date / /
Are you currently receiving home health services or have you within the last 4 weeks? ☐ Yes ☐ No
Have you had any physical, occupational, or speech therapy this calendar year? ☐ Yes ☐ No
Please explain your current problem requiring therapy:
How did your injury occur or symptoms begin? (check all that apply): **☐ Accident- Work Related ☐ Standing ☐ Walking ☐ Lifting ☐ Bending ☐ Computer** **☐ Accident- Auto ☐ Accident- Liability ☐ No Apparent Reason ☐ Other:**
What daily activities are you having trouble with due to this injury or onset of symptoms? (check all that apply): **☐ Sitting _____ min. ☐ Rising ☐ Stairs ☐ Reaching ☐ Bending ☐ Turning ☐ Lying ☐ Housework** **☐ Standing _____ min. ☐ Housework ☐ Athletics ☐ Driving ☐ Dressing ☐ Grooming** **☐ Sleeping _____ hrs. ☐ No Apparent Reason ☐ Other:**
What treatment have you received? (check all that apply): **☐ Physical Therapy ☐ Bracing ☐ Injection ☐ MRI ☐ Medication ☐ Occupational Therapy** **☐ Orthotics ☐ Myelogram ☐ X-Ray ☐ Chiropractic ☐ Nerve Conduction Study ☐ CT Scan** **☐ Other:**
How do you rate your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Do you currently exercise, play sports, or have hobbies? (If yes, please describe):
Do you currently have any "flu-type" symptoms (i.e. fever, coughing)? ☐ Yes ☐ No **If "yes", please describe:**
Do you have any open cuts, lesions, or wounds? ☐ Yes ☐ No **If "yes", where?**
Do you wear glasses or contacts? ☐ Yes ☐ No
What goals do you have for therapy? What do you hope to accomplish?
My next appointment with my doctor is on / / ☐ No appointment scheduled

Patient Name:	DOB:

F. EMPLOYMENT STATUS

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired ☐ Student ☐ Other:
Employer:
Occupation:
Was your injury work-related? ☐ Yes ☐ No
Work activities mostly include: ☐ Sitting ☐ Standing ☐ Walking ☐ Lifting ☐ Bending ☐ Computer ☐ Driving ☐ Varied ☐ Other:
PATIENT SIGNATURE: **DATE:** / /

AUTHORIZATION & GUARANTEE

INSURANCE BENEFITS (if applicable): As a courtesy, we will make every effort to contact your insurance company to obtain your therapy benefits. The benefit information obtained cannot be considered a guarantee of actual benefits or insurance payment for services rendered. We encourage you to contact your insurance company to verify your benefit information.

MEDICARE (if applicable): "I certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of other information about me to release to the Social Security Administration or its intermediaries any such information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and coinsurance."

GUARANTEE OF PAYMENT (not applicable for Worker's Compensation patients): "In consideration of services rendered to me by IN-SYNC REHABILITATION, I hereby guarantee payment for any and all services not covered or allowed by insurance. I also understand that all bills are due and payable upon receipt. I understand that the patient responsibility portion of my bill will be due and payable at the time of service. I understand that should my account with IN-SYNC REHABILITATION become delinquent and turned over to a collection agency, that I, the undersigned, will be responsible to pay all collection agency fees, court costs or any other fees / costs associated with resolving my account balance."

RETURNED CHECKS: We are happy to accept your personal check, however, if your check is returned for any reason, you expressly authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

CONSENT TO TREATMENT: "I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at IN-SYNC REHABILITATION."

WAIVER AND RELEASE: "I hereby release, discharge and acquit IN-SYNC REHABILITATION, 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."

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: "I consent to allow IN-SYNC REHABILITATION, to use and disclose my protected health information (PHI) within IN-SYNC REHABILITATION to carry out my treatment, to obtain payment and to carry out health care operation. My PHI may be disclosed to my health plan and/or its agents as necessary to verify benefits, authorize services and process medical claims. My PHI may be disclosed to outside health agencies or institutions involved in my continuing care and/or for emergency care purposes. My PHI may include medical information or any information pertaining to the evaluation, treatment and history. This may include psychiatric, HIV/AIDS, sickle cell, alcohol and/or drug information, coded medical information and charges to my health plan and/or their intermediaries. This consent is subject to revocation at any time to the extent that action has been taken in reliance on it. Withdrawal of consent shall be address in writing."

ASSIGNMENT OF BENEFITS: "I authorize my health plan to pay benefits directly to IN-SYNC REHABILITATION. I understand that in the event my health plan or healthcare contract does not cover services, I will be responsible for payment. I understand that if my health plan does not consider IN-SYNC REHABILITATION a participating provider, charges incurred will be paid by me. I further agree to accept full responsibility for payment of charges rendered to the above patient."

NOTICE OF PRIVACY: "I acknowledge that a copy of the Notice of Private Practices is posted in the clinic and available for my review. Furthermore, I understand that I can request, and immediately receive, a copy of this document."

PATIENT SIGNATURE:	**DATE:** / /