Total Rehab
orthopedic & sports specialist

OUR LOCATIONS
www.totalrehab-pt.com

WILLIAMSBURG
507 Court Street
Williamsburg, IA 52361
Phone: 319-668-9453
Fax: 641-236-4316

GRINNELL
Southview Plaza-Suite #4
234 West Street South
Grinnell, IA 50112
Phone: 641-236-4506
Fax: 641-236-4316

SULLY
Diamond Trail Fitness Center
12498 Highway F62 East
Sully, IA 50251
Phone: 641-594-3303
Fax: 641-236-4316

**1)Patient Information**

Patient Name: First_____MI_____Last_____

Preferred Name:_____

Mailing Address: _____City:_____

State:_____Zip:_____ Reminder Type (circle one): Voice Call Text Email

Phone: Home_____Cell_____Work_____

Email Address:_____

Sex (circle one): Male/Female Gender Identity:_____ Pronouns:_____

DOB:_____ Social Security #:_____

Employer:_____Employer City & State:_____

Employment Status: Full-time/Part-time/Unemployed/Student Occupation:_____

**2)Primary Policy Holder** Same as above ☐

Name:_____ DOB:_____

Employer: _____Employer City & State:_____

**3)Responsible Party (Billing Address)** ☐ Same as above

Name:_____Street Address:_____

City:_____State:_____Zip:_____

**4)Workman Compensation Information or Motor Vehicle Accident Information (if applicable)**

Employer Contact:_____Phone:_____

Case Manager:_____Phone:_____

Date of Injury:_____Claim Number:_____

**I have read and agree to the Privacy Practices (HIPAA) of Total Rehab.**

_____ _____
Signature Date

**I have read and agree to the Financial Considerations for Service at Total Rehab.**

_____ _____
Signature Date

Total Rehab-Orthopedic and Sports Specialist, P.C.

**Consent for Care and Treatment:**

I, the undersigned, for myself or a minor child or another person for whom I have authority to sign, (hereinafter "Patient") hereby consent and authorize Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees, to provide care and treatment to Patient per program policy and/or as prescribed by a physician. A representative of Total Rehab-Orthopedic and Sports Specialists P.C., has explained my plan of care and all of my questions have been answered satisfactorily. I understand that the training plan may change and, if so, these changes will be discussed with me. I agree to promptly notify Total Rehab-Orthopedic and Sports Specialists, P.C., my physician or others providing care of any adverse reactions or other significant events relating to my health. Patient acknowledges that no guarantees have been made as to the effect of such examination or treatment of Patient's condition by Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees.

**Authorization to Release Information:**

I authorize Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees, to release any information acquired in the course of Patient's examination or treatment, to Patient's physician, health care provider or referring agency.

I authorize Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees to disclose and release such information from Patient's medical records as may be necessary for the completion of claims filed by Total Rehab-Orthopedic and Sports Specialist, P.C., for reimbursement from my insurance company, preferred provider organization, health maintenance organization or utilization review organization.

This authorization for release of records is valid until revoked by me in writing.

**Production of Confidential Information:**

In order to provide Patient with the best treatment possible, Total Rehab-Orthopedic and Sports Specialist, P.C., must obtain certain information. This information includes confidential information such as Patient or guarantor's Social Security Number. As a patient, I understand the need for Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees to obtain the most accurate information regarding my health and care. Total Rehab-Orthopedic and Sports Specialist, P.C., its agents, associates and employees will protect all confidential information you provide to the best of their abilities to prevent any re-disclosure of information without authorization. If confidential information is not provided, including Social Security Numbers, Patient understands that services may only be provided by Total Rehab-Orthopedic and Sports Specialist, P.C., on a prepaid cash basis.

**Assignment of Benefits and Liability of Payment:**

In consideration of the services rendered or to be rendered by Total Rehab-Orthopedic and Sports Specialist, P.C., I assign my insurance, Medicare and Medicaid benefits due me to Total Rehab-Orthopedic and Sports Specialist, P.C. I request and authorize my insurance company and/or Medicare to make payments of authorized benefits directly to Total Rehab-Orthopedic and Sports Specialist, P.C. I understand that I am financially responsible for any unpaid balance. I further authorize the release of any information necessary to satisfy my claim.

**I understand what I have read and what was explained to me and agree to the terms and conditions stated above. I understand that either party may terminate this agreement at any time, upon written notice to the other party.**

**Patient's Name (print):**_____

**Patient's Signature:**_____ **Date:**_____

**Parent or Guardian's Name (print):** _____

**Parent or Guardian's Signature (if applicable):**_____ **Date:**_____