MOSSY CREEK REHAB

Patient Registration and Health History

In order to provide you the best possible care, please complete this form and bring it to your first appointment. All information is strictly CONFIDENTIAL.

Patient Data

First Name | Last Name | Date | Email*

*Your email will NOT be shared with any 3rd parties, and is used for occasional office announcements and promotions

Mailing Address

Address | City | State | Zip

Telephone (cell) | (work) | Referred by

Age | Birthdate | Social Security # _

Occupation | Employer

Marital Status | Spouse's Name | Spouse's DOB | Spouse's SS# xxx-xx-

Spouse's Employer | Emergency Contact | Phone

Current Complaints

Nature of Injury or complaint: ☐ Automobile * ☐ Work ☐ Other

Please describe:

Date of injury | Date symptoms appeared

Have you ever had same condition? ○ No ○ Yes If yes, when?

List of other practitioners seen for this injury/condition

Have you ever been under chiropractor care? ○ No ○ Yes Are you **currently** being seen by Home Health? ○ No ○ Yes

Insurance Information

Name of party responsible for payment | Phone

Address | Relationship to Patient

Do you have health insurance? ○ No ○ Yes Name of Company

Primary Policy Holder's Name | DOB | SS# xxx-xx-

***If an auto accident, please provide:**

Insurance Company Name | Contact Person

Phone | Claim #

Signature of Patient /Representative/Parent or Legal Guardian of Minor – Consent to Treat

X_____ Date _____

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Have you ever had:	Briefly Explain:
Broken Bones? ○ No ○ Yes	
Been in an Auto Accident? ○ No ○ Yes When? _____	
Sprains/Strains? ○ No ○ Yes	
Stroke? ○ No ○ Yes	
Cancer? ○ No ○ Yes	
Other? ○ No ○ Yes	

Do you have an Advance Directive/Living Will □Yes □ No If yes, please supply this office with a copy for our files.

Do you have?

Arthritis? ○ No ○ Yes
Diabetes? ○ No ○ Yes
Heart Disease? ○ No ○ Yes
Cancer? ○ No ○ Yes

Please list any allergies you may have:

_____

Pain Questions: Please rate your current pain (1-10) *10 being the worse*

_____

Do you experience pain every day? ○ No ○ Yes
Do your symptoms interfere with daily life? ○ No ○ Yes
Does pain wake you up at night? ○ No ○ Yes
Are symptoms worse during certain times of the day? ○ No ○ Yes
Do changes in the weather affect your symptoms? ○ No ○ Yes
What activities aggravate your symptoms? _____

Medications	Prescribed for?

PATIENT AUTHORIZATION

MCR FINANANCIAL POLICY

As a courtesy, Mossy Creek Rehab (MCR) will verify your insurance benefits; **however, it is ultimately your responsibility to be aware of your specific coverage**. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible, and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours – you will be billed for any balance not paid by your insurance. **Your Account MUST be paid in full within 120 days after your insurance has paid.**

ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/FINANCIAL RESPONSIBILITY

I authorize my insurer to pay benefits directly to MCR. I authorize MCR to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information. I understand that I am financially responsible for all charges incurred at MCR. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my MCR visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with the insurer.

HIPAA NOTICE OF PRIVACY PRACTICES

I understand that MCR and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that: I understand that MCR may use and disclose my protected health information for treatment, billing to obtain payments, and for related health care operations. A copy of HIPAA is available upon request.

X

_____

Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

MOSSY CREEK REHAB

General Conditions

By signing below, I agree to all of the following terms:

1. I am the patient whose information is given or a legal representative of the patient and all information given is true and accurate to the best of my and the patient's knowledge.

2. I agree to pay the final bill for all services within 120 days of statement issue. Late payment of bill at the service providers discretion can be subjected to late fees for every 30 days delay in payment and/or accrued interest up to the maximum allowed in the service providers state at time of service.

3. I authorize my insurer to pay benefits directly to Mossy Creek Rehab. I understand that I am financially responsible for the payment of any and all charges for services rendered which are not covered by my insurance. If I, or my insurance, fail to make payment for these services when due, Mossy Creek Rehab may declare the entire balance to be immediately due and payable. I further understand that copayments are due at the time of service and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with the insurer.

4. I agree that scheduled appointments must be cancelled or rescheduled prior to the time of the appointment. Any patient who fails to arrive for said appointment is considered a "no-show". After a patient has had 3 "no show" appointments, patient may be discharged from our facility. I also understand that if I am more than 15 minutes late in arriving to a scheduled appointment, that appointment may be cancelled or rescheduled at the discretion of my service provider.

5. If I selected to receive e-mail, voice, and/or text message reminders, I am giving full permission to my service provider and the 3rd party services to send the designated method of reminder in an automated manner. I understand that I may be charged by my communication service provider (such as text message fees) for these reminders and that I am responsible for these charges.

6. If any portion of this agreement is deemed unlawful the remainder of the contract is still accepted.

I have read the above information. I certify and acknowledge that I understand its contents and significance

Patient Signature: _____ **Date:** _____

Patient Representative/Guardian: _____ **Date:** _____

MOSSY CREEK REHAB

Consent to Treatment

1. Authorization is hereby given to Mossy Creek Rehab to perform medical treatment as ordered by my physician(s) and others working under their direction. I acknowledge that no guarantees have been made to me regarding the outcome of this treatment.

HIPPA Authorization

2. I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize Mossy Creek Rehab to use and disclose my protected health information to carry out:
    - Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment.)
    - Obtaining payment from third party payers (e.g. my insurance company)
    - The day-to-day healthcare operations of Mossy Creek Rehab

    I understand that Mossy Creek Rehab and its staff will make every effort to keep my protected health information confidential and private I release all HIPAA protected information given to all the providers and support staff of this service provider and any personnel essential to providing service. I also release this information to my designated emergency contact. A copy of HIPPA is available upon request.

Release of Information/Privacy

3. Mossy Creek Rehab may use and disclose your health information to treat you, bill for your care and for health operations. I authorize Mossy Creek Rehab to release all information necessary to secure payment including documentation on the medical record which may include present or past history of mental illness, alcohol abuse, drug abuse or HIV/AIDS related information You have the right to review the Notice of Privacy Practices before Treatment. A copy will be provided to you upon request.

I have read the above information. I certify and acknowledge that I understand its contents and significance

Patient Signature: _____ **Date:** _____

Patient Representative/Guardian: _____ **Date:** _____