New Patient Acknowledgements

Patient Name: _____

Consent to Treatment

_____ Initial

I consent to and authorize Zada Rehab Occupational & Physical Therapy to administrator rehabilitation therapy treatment. I understand and am informed that, as in the practice of medicine, rehabilitation therapy may have some risks. I understand that I have the right to ask about these risks and have any questions about my conditions answered prior to treatment. I know it is up to me to inform my provider of rehabilitation therapy about any health problems or allergies I have, as well as medications I am taking. I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/ or treatment results from the rehabilitation therapy.

Notice of Privacy Practices

_____ Initial

I hereby acknowledge that I have been made aware of Zada Rehab's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is available at the front desk and online, and that I may request a copy of any amended Notice of Privacy Practices at any time.

Authorization to Release / Obtain Information

_____ Initial

I hereby authorize the release of my patient health care information for the purposes of treatment or payment, to my physician, insurance company, adjustor, attorney, or other health care organizations pertinent to my case. Further, I authorize Zada Rehab to obtain needed information from my physician, insurance company, adjustor, attorney and any other health care organization pertinent to my case. These correspondence can be made via mailings, telephone and/or facsimile.

Insurance Eligibility

_____ Initial

Verification of benefits is NOT a guarantee of payment. Payment is determined by your insurance company at the time a claim is received. We provide you with the information as it is outlined by your insurance company. It is your responsibility to fully understand your insurance benefits.

Financial Responsibility

_____ Initial

Payment is due at the time of treatment. I agree to pay Zada Rehab all amounts that are due for services rendered which are not otherwise paid for by my insurance plan on my behalf. In the event that my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due for services rendered including, without limitation, reasonable attorney's fees.

Assignment & Release of Benefits

_____ Initial

I hereby appoint Zada Rehab Physical Therapy as my authorized representative, and assign to it my right, to file for, receive and recover any and all monies payable for the care which it rendered to me from any third party claims payment source, including my health insurer, Medicare, Medicaid or other governmental program (collectively, my "Plan"), while I was eligible to receive such claim payment. I authorize you to send and receive documentation related to my treatment to, and consent to your discussing my treatment with, my Plan." I also authorize PPT to take any and all actions necessary to assert and pursue my legal rights to receive such claim payment under the terms of my Plan through any appeals and/or grievances and/or litigation and/or arbitration available to me for such purpose. As the assignor of the foregoing payment amounts, I direct that such payment be sent by my Plan to PPT and, in the case that payment is made by my Plan to me, I agree to remit such payment in full to PPT not later than ten (10) days after my receipt.

Appointments / Cancellations

_____
Initial

We advise you to schedule your appointments in advance. Maintaining a consistent schedule ensures your best outcome for a speedy recovery. We expect you to keep all of your appointments with Zada Rehab and require 24 hours notice if you are unable to keep an appointment. Failure to show up for an appointment will result in a $50.00 charge. These charges are not reimbursed by any insurance company.

Electrical Stimulation Pad Policy

_____
Initial

I acknowledge that I have read and understand the Electrical Stimulation Pad Policy and agree to abide by its terms.

The undersigned patient or Responsible Party acknowledges that he/she has read and agrees to the information printed above.

_____ _____ _____

Patient Signature (Parent/Guardian if patient under 18 years) Printed Name Date