REHAB ASSOCIATES OF CENTRAL VIRGINIA

New Patient Information

We are physical therapy…
Our goal is your success!

Name: _____ Preferred Name: _____
First Name Middle Name Last Name

Date of Birth: _____ Social Security #: _____ Gender: ☐ Male ☐ Female
Mailing Address: _____ City _____ State ____ Zip _____
Physical Address: (if different) _____ City _____ State ____ Zip _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____
Email Address: _____Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell
Employee Status: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Full-Time Student
Employer Name: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
Spouse: _____ Work Ph #: _____ Cell Ph #: _____
Emergency Contact (not living with you): _____
Relationship: _____ Home Ph #: _____ Work Ph #: _____
How did you hear about us? ☐ Sign ☐ Another Patient ☐ Physician Referral ☐ Print Ad ☐ Radio
☐ Website ☐ Yellow Pages ☐ Returning Patient ☐ Other _____

Is the patient under the age of 18? ☐ Yes ☐ No If yes, complete the following:
Guarantor Name: _____ Relationship: _____
First Name Middle Name Last Name
Guarantor information: (complete if different from patient information)
Mailing Address: _____ City _____ State ____ Zip _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

INSURANCE INFORMATION: Please be sure to complete all of the questions in bold print.

1. Do you have health insurance that you would like us to file? ☐ Yes ☐ No If No, skip to the back of page

a. Primary Insurance Carrier Name: _____

b. Have we copied your insurance card? ☐ Yes ☐ No **If No, please complete the section below**

Address: _____ City _____ State ____ Zip _____
Phone #: _____ Group #: _____ Policy #: _____

c. Who is the policyholder for this insurance? ☐ *Patient* ☐ *Other* **If other, please complete all fields below**

Policyholder's Name: _____ Your Relationship to Policyholder: _____
Policyholder's Social Security #: _____ Policyholder's Date of Birth: _____
Policyholder's Employer: _____ Policyholder's Ph #: _____

2. Do you have secondary insurance that you would like us to file? ☐ Yes ☐ No If No, skip to the back of page

a. Secondary Insurance Carrier Name: _____

b. Have we copied your insurance card? ☐ Yes ☐ No **If No, please complete the section below**

Address: _____ City _____ State ____ Zip _____
Phone #: _____ Group #: _____ Policy #: _____

c. Who is the policyholder for this insurance? ☐ *Patient* ☐ *Other* **If other, please complete all fields below**

Policyholder's Name: _____ Your Relationship to Policyholder: _____
Policyholder's Social Security #: _____ Policyholder's Date of Birth: _____
Policyholder's Employer: _____ Policyholder's Ph #: _____

Are you being seen for a Worker's Compensation Injury? ☐ **Yes** ☐ **No** If No, skip to the next section.

Date of Injury: _____ Employer when injured _____ Injury reported to: _____

Address: _____ City _____ State ____ Zip _____

Contact Name: _____ Contact Phone #: _____

Worker's Compensation Insurance Carrier: _____ Claim #: _____

Virginia Jurisdiction #: _____ Award from the VA Worker's Compensation Commission? ☐ Yes ☐ No

Are you being seen for an auto accident/liability injury? ☐ **Yes** ☐ **No** If No, skip to the next section.

Please check one: ☐ Auto ☐ Other _____ Date of Accident/Injury: _____

Do you have an insurance that you would like us to file (non-third party) ☐ **Yes** ☐ **No** If Yes, provide information:

Insurance Carrier Name: _____ Policy # _____

Address: _____ City _____ State ____ Zip _____Phone # _____

Are you being represented by an attorney? ☐ **Yes** ☐ **No** If No, skip to the next section.

Attorney Name: _____ Phone #: _____

Address: _____ City _____ State ____ Zip _____

Medical Information

What part of the body are you being seen for today? _____ ☐ Left ☐ Right

Primary Care Physician _____

Physician who referred you to Physical Therapy _____ ☐ None

When did you last see a physician for this condition? _____

Do you have a scheduled appointment to return to this physician? ☐ Yes ☐ No If yes, when? _____

Have you received Physical Therapy this calendar year? ☐ Yes ☐ No If Yes, where? _____

Have you received Speech Therapy this calendar year? ☐ Yes ☐ No If Yes, where? _____

Have you received, or are you currently receiving, Home Health Care? ☐ Yes ☐ No

If Yes, who is providing this service? _____

When did you last receive home health services? _____

By signing below, I certify that all information is correct to the best of my knowledge. I authorize treatment, authorize and direct my insurance carrier(s) to issue payment check(s) directly to Rehab Associates of Central Virginia for services rendered, and acknowledge that I am responsible for any and all fees incurred with Rehab Associates including insurance without limitation, deductibles and/or co-pays. Should I have insurance coverage that does not cover physical therapy or my plan is terminated and/or my plan does not pay for any reason, I acknowledge that I am responsible for all outstanding balances. I acknowledge receipt and acceptance of Rehab Associates of Central Virginia's Privacy and Financial policies. I acknowledge that balances older than 90 days will be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month). I agree to pay all costs of collecting balances including, but not limited to: legal fees, court costs, and attorney's fees equal to 33.3% of the unpaid balance. In order for us to service your account and/or to collect any amount you may owe, we may contact you using any of the contact information you have provided on this form. I also acknowledge that if I am not in agreement with said policies, it is my responsibility to respond in writing within five (5) business days.

Patient's Signature _____ Date: _____

Guarantor's Signature is **required** if patient is under 18 years of age

Reviewed by: _____

REHAB ASSOCIATES
OF CENTRAL VIRGINIA

Patient Policies

This notice describes the policies that Rehab Associates of Central Virginia follows regarding how medical information about you may be used and disclosed and how you can get access to this information. Please read it carefully and keep this copy for your records.

Notice of HIPAA Privacy Practices

Use and Disclosure: We may use health information about you for treatment, payment, and healthcare operations (TPO). Treatment examples include, but are not limited to: updates on progress to the physician who referred you to physical therapy, requests for additional visits to your primary care physician. Payment examples include, but are not limited to: insurance companies for claims processing, collection agencies. Healthcare operations examples include, but are not limited to: quality improvement activities, medical records audits. We may use or disclose identifiable health information about you without your authorization in certain situations such as when we are required to do so by law or in workers compensation cases. We may also call you and leave a message on voice mail or in person for purposes that assist us in carrying out appropriate treatment, payment, and healthcare operations, such as appointment reminders and insurance follow-up. We may also mail or email items, like appointment reminders, information about services that may benefit you, and other correspondence. We may share information with our Business Associates in order to provide you with complete services. Certain disclosures require your authorization, like using your information for marketing purposes or selling your information. In all other situations, we will ask for your written authorization before using or disclosing any identifiable health information about you. Such authorization may be revoked at any time. The revocation must also be in writing. We will abide by the terms of this notice currently in effect at the time of the disclosure. It is our responsibility to train all personnel concerning privacy and confidentiality of your PHI.

Your Rights: You have the right to request certain restrictions on the use and disclosure of your health information and in certain situations, we are required to abide by those restrictions. In most cases, you have the right to look at or obtain copies of health information about you. If you request copies, we will charge you only normal fees. You also have the right to receive a list of certain types of disclosures of your information. If you believe that information in your record is incorrect, you have the right to request that we correct the existing information. You have the right to request to receive confidential communication of your health information by alternative means or alternative locations. Such request must be in writing and the practice will accommodate reasonable requests or notify you if unable to accommodate your request.

Changes to this Notice: We reserve the right to change this notice and to make new provisions effective for all protected health information that we maintain. Before we make any significant change in our policies, we will change our notice and post the new notice in our waiting areas. You can also request a copy of our notice at any time or obtain a copy from our website.

Complaints: If you are concerned that your privacy rights have been violated, you disagree with a decision we made about access to your records, or you have questions about our privacy policy, you may contact the Privacy Officer at:
Rehab Associates of Central Virginia Inc. 20347 Timberlake Rd Suite B Lynchburg, Virginia 24052
Phone: (434) 845-9053; Fax: (434) 528-2788; Email: Privacy.Officer@racva.com

All complaints will be addressed by the privacy officer. Rehab Associates commits that no action will be made against any individual who submits or conveys such a complaint. In the event that any unsecured health information is released inappropriately, Rehab Associates is required by law to notify affected individuals

Notice regarding Record Retention

In accordance with Virginia regulations, Rehab Associates maintains patient medical and billing records a minimum of 6 years following the last encounter. Records for minors will be maintained until age 18 and/or a minimum of 6 years following the last encounter. Any documents containing patient information are destroyed using cross-cut shredders or are destroyed by a documentation management company in compliance with standards endorsed by the National Security Administration. This ensures that patient confidentiality is protected at all times.

Notice of Financial Policies

In order to continue operating our clinics and providing quality care, we must promptly collect for the fees that we charge. Please read the following financial policies carefully and keep this copy for your records.

Co-Payments: If your insurance requires a co-pay, we are required to collect it at each visit. If you have two insurance policies, the co-pay of your primary insurance policy will be due at the time of service. If you fail to pay your co-pay, you are in violation of your contract with your insurance company. If we participate with your insurance company and we fail to collect your co-pay, we are in violation of our contract with your insurance company. If we are no longer able to participate with your insurance carrier due to violation of this agreement, the cost of services will increase as will the amount that you are responsible for. If necessary, we will reschedule your appointment if your co-pay is not paid upon checking in.

Co-Insurance: Many insurance policies have a co-insurance percentage that the patient is required to pay. For example, the patient may be responsible for 20% while the insurance company pays 80%. If your insurance policy does not require a co-pay but does have co-insurance, we will collect $25.00 per visit or an estimation of your visit charges towards your co-insurance balance. This applies to all self pay and auto/liability patients as well.

Insurance: It is your responsibility to understand your insurance policy and provide Rehab Associates of Central Virginia with correct billing information. Payment is due at the time of service, however we will file with your insurance as a courtesy. You are financially responsible for all charges related to your treatment regardless of involvement by an insurance company, attorney, and/or other third party payer. You are responsible for all co-payment and co-insurance amounts, non-covered supplies and services, and yearly deductibles. **Due to varying coverage, it is important for you to verify your coverage with your insurance company to ensure that physical therapy services are covered under your policy prior to receiving treatment.** If your insurance coverage changes or is denied, please notify our office immediately.

Worker's Compensation: If you are injured on the job, you may have a worker's compensation claim. This agreement authorizes Rehab Associates to file a claim with the Virginia Worker's Compensation Commission in your name. We require your cooperation at all times concerning this claim and its status. Please notify our Worker's Compensation billing staff immediately if you hire an attorney to assist you with your Worker's Compensation claim.

Outstanding Balances: If full payment from your insurance company is not received, you will be responsible for the entire balance (see usual and customary section below). You will receive a statement each month with your balance. Balances older than 90 days will be assessed an 18% annual percentage rate (APR) finance charge (1.50% per month). You agree to pay all costs of collecting balances including, but not limited to: legal fees, court costs, and attorney's fees equal to 33.3% of the unpaid balance. In the event an account is turned over to collections, the patient authorizes the release of employment status information to Rehab Associates or their collection agencies. In order for us to service your account and/or to collect any amounts you may owe, we may contact you by telephone at any phone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded or artificial voice messages and/or use of an automatic dialing device, as applicable.

Usual and Customary Fees: Our fees are what are usual and customary in this area, not what your insurance company has deemed "usual and customary". You are responsible for any of our fees that your insurance company does not pay, unless we have contracted fee agreement with your insurance company or are an in-network participating provider with your insurance company.

Office Fees: If you are unable to keep a scheduled appointment and do not notify our office within 24 hours of your appointment, a fee will be charged to your account. If the appointment was for an evaluation, the charge will be $50. If the appointment was for a follow-up visit, the charge will be $10. Once this charge is incurred, we will be unable to schedule any future appointments for you until the balance has been paid.

Returned checks are subject to a $50 service charge.