Marden Rehabilitation Associates of WV

PATIENT: _____

FACILITY: _____

PATIENT ACCOUNT NO: _____

CONSENT TO TREATMENT

I consent to the following treatment as ordered by my physician and outlined in the treatment plan of care. I understand the risks and benefits of the treatment and I understand that I can ask the treating staff at any time questions regarding the treatment.

- ❑ Physical Therapy - Physical therapy includes, but is not limited to, therapeutic exercise, manual therapy and the application of modalities. The goal is to relieve pain, restore movement, and maximize function.

- ❑ Occupational Therapy – Occupational therapy is the practice of restoring function to individuals with disability or following injury or illness through the use of functional and/or purposeful activities. These activities may address all occupations of life including, but not limited to, activities of daily living, work skills, leisure skills, educational skills and independent living skills.

- ❑ Speech Language Pathology – Speech therapy incorporates assessing the speech, language, cognitive-communication, and swallowing skills of children and adults. Speech-language pathologists most often treat problems in the areas of articulation; dysfluency; oral-motor, speech, and voice; and receptive and expressive language disorders.

I understand the treatment will consist of services outlined in the plan of care. I further understand that these services and alternative treatment options will be explained at the initial evaluation and each time the plan of care is updated.

PATIENT'S SIGNATURE:_____ Date:_____

PATIENT REPRESENTATIVE'S SIGNATURE:_____Date:_____

DESCRIBE RELATIONSHIP TO PATIENT:_____

MARDEN REPRESENTATIVE'S SIGNATURE:_____Date:_____

THERAPIST'S SIGNATURE:_____Date:_____

PATIENT REGISTRATION FORM

Marden Rehabilitation Associates of WV

FACILITY: _____

SECTION I **Fill in all blanks. Please print**

PATIENTS FULL NAME	DATE OF BIRTH EMAIL ADDRESS	MARITAL STATUS M S W D	SEX ❑ MALE ❑ FEMALE
COMPLETE STREET ADDRESS	HOME PHONE # ( ) CELL PHONE # ( )		SOCIAL SECURITY #
CITY / STATE / ZIP	SPOUSE / PARENT NAME		SPOUSE / PARENT SS#
PATIENT'S EMPLOYER	PHONE ( )	CITY/STATE/ZIP	OCCUPATION
SPOUSE/PARENT'S EMPLOYER	PHONE ( )	CITY/STATE/ZIP	OCCUPATION
NAME OF PERSON TO NOTIFY IN CASE OF AN EMERGENCY	RELATIONSHIP	HOME/WORK PHONE H( ) W( )	DO YOU: ❑ OWN ❑ RENT
Referring Physician Name and Phone Number:		Family Physician Name and Phone Number:	

SECTION II

Is Treatment for ❑ Injury ❑ Medical Condition **Date of injury/onset of Symptoms**_____(current)

Are you receiving home care services?	❑ Yes	❑ No
Was injury work related?	❑ Yes	❑ No
Was injury related to an automobile accident?	❑ Yes	❑ No
Insurance Co. Responsible: _____	Insured's Name:	_____
Will an attorney be involved?	❑ Yes	❑ No
If yes, complete the attorney information on the reverse side.		
Were you hospitalized prior to admission of therapy for this injury? (Medicare patients only)	❑ Yes	❑ No
Do you have health insurance?	❑ Yes	❑ No
Have you had previous physical therapy for this condition?	❑ Yes	❑ No
If yes, was it within the last 12 months?	❑ Yes	❑ No
Have you received therapy or chiropractic treatment this year?	❑ Yes	❑ No
Are you a returning Marden patient?	❑ Yes	❑ No

FOR OFFICE USE ONLY

Acct. type:	_____	Ref Physician	_____	Referring Physician Information (if new)	
Dx1:	_____	Dx2:	_____	Name:	_____
Dx3:	_____	Dx4	_____	Address:	_____
					_____
				Telephone #:	_____
Returning Pt?	❑ Yes	❑ No		UPIN #:	_____
Check Status?	❑ Yes	❑ No		Tax ID#:	

SECTION III

PRIMARY INSURANCE COVERAGE

INSURANCE COMPANY		TELEPHONE ( )
COMPLETE MAILING ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)		
INSURED	RELATIONSHIP TO PATIENT	EMPLOYER
ID/CERT#	POLICY #/CLAIM	GROUP #/PLAN#

SECONDARY INSURANCE COVERAGE

INSURANCE COMPANY		TELEPHONE ( )
COMPLETE MAILING ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)		
INSURED	RELATIONSHIP TO PATIENT	EMPLOYER
ID/CERT#	POLICY #/CLAIM#	GROUP #/PLAN #

WORKERS COMPENSATION COVERAGE

EMPLOYER (AT TIME OF ACCIDENT)	TELEPHONE ( )	CLAIM #
COMPLETE MAILING ADDRESS (STREET ADDRESS, CITY, STATE, ZIP)		

MEDICARE COVERAGE

MEDICARE #	EFFECTIVE DATE, PART B
DOES THE PATIENT HAVE AN HMO? ❑ yes ❑ no :	INSURANCE CO. NAME: ADDRESS: GROUP NUMBER:

MEDICAID COVERAGE

MEDICAID # IS THIS A HMO PLAN? ❑ yes ❑ no	EFFECTIVE DATE
DOES THE PATIENT HAVE PAAS? ❑ yes ❑ no (if yes, please provide the authorization number)	AUTHORIZATION #

PERSONAL INJURY INFORMATION

NAME OF ATTORNEY	TELEPHONE ( )
COMPLETE ADDRESS (STREET ADDRESS CITY, STATE, ZIP)	
Is a letter of protection on file: ❑ yes ❑ no	

PATIENT RELEASE

RELEASE OF INFORMATION: I authorize the release of any medical or billing information that is needed to obtain payment on my account, regardless of my diagnosis

CONSENT FOR CLAIM VERIFICATION: I give permission to MARDEN to have any and all information regarding my claim to benefits verified

ASSIGNMENT OF BENEFITS: I hereby assign, transfer and set over to MARDEN all of my rights, title and interest of medical reimbursements and all other rights and privileges otherwise payable to me for those services provided by Marden Companies

ACKNOWLEDGEMENT OF PATIENT INFORMATION SHEET: I certify that I have received a patient information sheet, read it, and understand all information contained on it.

AGREEMENT TO PAY FOR SERVICES: For and in consideration of services rendered or to be rendered for said patient named on this form, I hereby guarantee payment of any and all bills rendered for said patient which are with all collection costs, including MARDEN attorney and legal fees for collection action of delinquent accounts. I understand that I am responsible for payment of any charges in excess of payment limitations imposed by third-party payers.

SOCIAL SERVICES I do ❑ I do not❑ wish to receive social services.

PATIENT/GUARANTOR SIGNATURE:_____ Date:_____

MARDEN REPRESENTATIVE:_____ Date:_____

THERAPIST'S SIGNATURE:_____ Date:_____

IMPORTANT INFORMATION FOR OUR PATIENTS

Welcome to ***Marden Rehabilitation Associates***. We are committed to providing you with the best possible care and assisting you with the administration of your insurance claim. In order to achieve these goals, we need your cooperation with our administration and payment policies.

PATIENT REGISTRATION: At your first visit, we need basic information about you and your insurance coverage. Please resolve any missing registration information prior to your next visit.

OUR RELATIONSHIP WITH YOU: As a medical provider, our relationship is with you, not your insurance company, Medicare, Workers' Comp, etc. While the administration of your claim is a courtesy extended to our patients, all charges incurred are your responsibility from the date of service. As part of our service, we will attempt to verify your insurance benefits at the onset of your therapy. This verification process, unfortunately, does not always result in obtaining conclusive information from your insurance carrier. If your claim is denied, or paid at lesser amounts than anticipated responsibility for payment of the final account balance is your own.

PAYMENT REQUIRED AT THE TIME OF SERVICE: Self-payer or co-pay amounts are due at the time of service.

ASSOCIATED FEES: Returned checks are assessed a $25.00 service charge. A charge of $35 will be assessed upon your third no-show and each additional no-show thereafter.

PRIMARY INSURANCE'S: You should check with your insurance company to determine therapy benefits and requirements. You may have a visit or dollar limitation for treatment, or need special forms completed by your referring physician before payment can be made. Also, any therapy equipment or supplies you receive are charged to you directly.

SECONDARY INSURANCE: We will bill your secondary insurance if you provide us with the billing information; however, even with two types of coverage, you may still have a balance to pay.

FOR OUR WORK-RELATED INJURY PATIENTS: We will attempt to verify your Workers' Compensation claim with your employer. ***A claim number is not a guarantee of payment***. If your claim or authorization for services is denied for any reason, you are responsible for payment of the account balance.

FOR MEDICARE PATIENTS: We will file a Medicare claim on your behalf, but you are responsible for any amount not paid by Medicare or your secondary insurance.

QUESTIONS ABOUT YOUR TREATMENT: Please contact our clinic or your therapist.
QUESTIONS ABOUT YOUR ACCOUNT: Please call **our Billing Office at 1-800-937-2597.**

Signature:_____ **Date:**_____
Marden Representative:_____ **Date:**_____
Therapist's Signature:_____ **Date:**_____

Cancellation and No Show Policy

Marden Rehabilitation Associates continually strive to deliver the highest quality of care in a timely manner. In order for us to stay on schedule and minimize your time in the waiting room we need your assistance. Please consistently arrive at your scheduled appointment at the time assigned. Tardiness of ten minutes or more may result in necessary modifications of your treatment for that day. If you are fifteen minutes late, your treatment may be canceled at the therapist's discretion in order to stay on schedule for the other patients. If you need to cancel an appointment, please notify us 24 hours prior to your scheduled visit or at the earliest opportunity. If you miss an appointment without notifying our office, we will call to notify you of your missed appointment. A charge of $35 will be assessed upon your third no-show and each additional no-show thereafter. We reserve the right to discontinue your treatment (after 3 or more no-shows). At this time we will inform your doctor that your therapy has been discontinued.

Our goal is to make your treatment as beneficial and rewarding as possible. We will do our best to stay on schedule and minimize your waiting period. Please respect our time as well as the time of the other patients by being punctual for your appointment or informing us as soon as possible if you will miss your visit. We welcome any comments or concerns you have regarding this policy.

I have read and understand this policy and agree to abide by it.

_____ _____

(Signature) (Date)

MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME: _____OCCUPATION_____

ARE YOU CURRENTLY WORKING? ❑ Yes ❑ No If NO, tentative back to work date: _____

REFERRING PHYSICIAN_____PHONE #:(___)_____

FAMILY PHYSICIAN_____PHONE #(___)_____

MAIN PROBLEM (How and when it started) _____

PLEASE LIST YOUR GOALS FOR THERAPY: _____

_____

PRIOR LEVEL OF FUNCTION:_____

PRESENT LEVEL OF FUNCTION: _____

PLEASE LIST ANY FUNCTIONAL LIMITATIONS or WRITE NONE:_____

_____

LIST ANY TEST RESULTS – MRI, CT SCAN, X-RAY, ETC or WRITE NONE:_____

_____

CURRENT MEDICATIONS or WRITE NONE:_____

ALLERGIES or WRITE NONE: _____

PAST MEDICAL HISTORY:

INJURIES	WHAT	WHEN (MONTH/YEAR)	TREATMENT AND IF SUCCESSFUL
❑ Previous similar injury			
❑ Back			
❑ Neck			
❑ Lower extremity			
❑ Upper extremity			
❑ Head			
❑ Surgeries			
❑ None			

D i s e a s e s

❑ Diabetes
❑ Heart
❑ High Blood Pressure
❑ Pacemaker
❑ Cancer
❑ Tuberculosis
❑ Lung
❑ Stroke
❑ Arthritis
  ❑ Rheumatoid
  ❑ Degenerative
❑ None of the above

❑ Paralysis
❑ Loss of hearing
❑ Loss of vision
❑ Unexplained Weight Loss
❑ Stomach
❑ Hepatitis
❑ Epilepsy
❑ Fainting/Dizziness
❑ Anemia
❑ Infectious/Contagious
❑ Metal Implants
❑ Other (please list)

THE ABOVE STATEMENTS ARE TRUE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____Date:_____

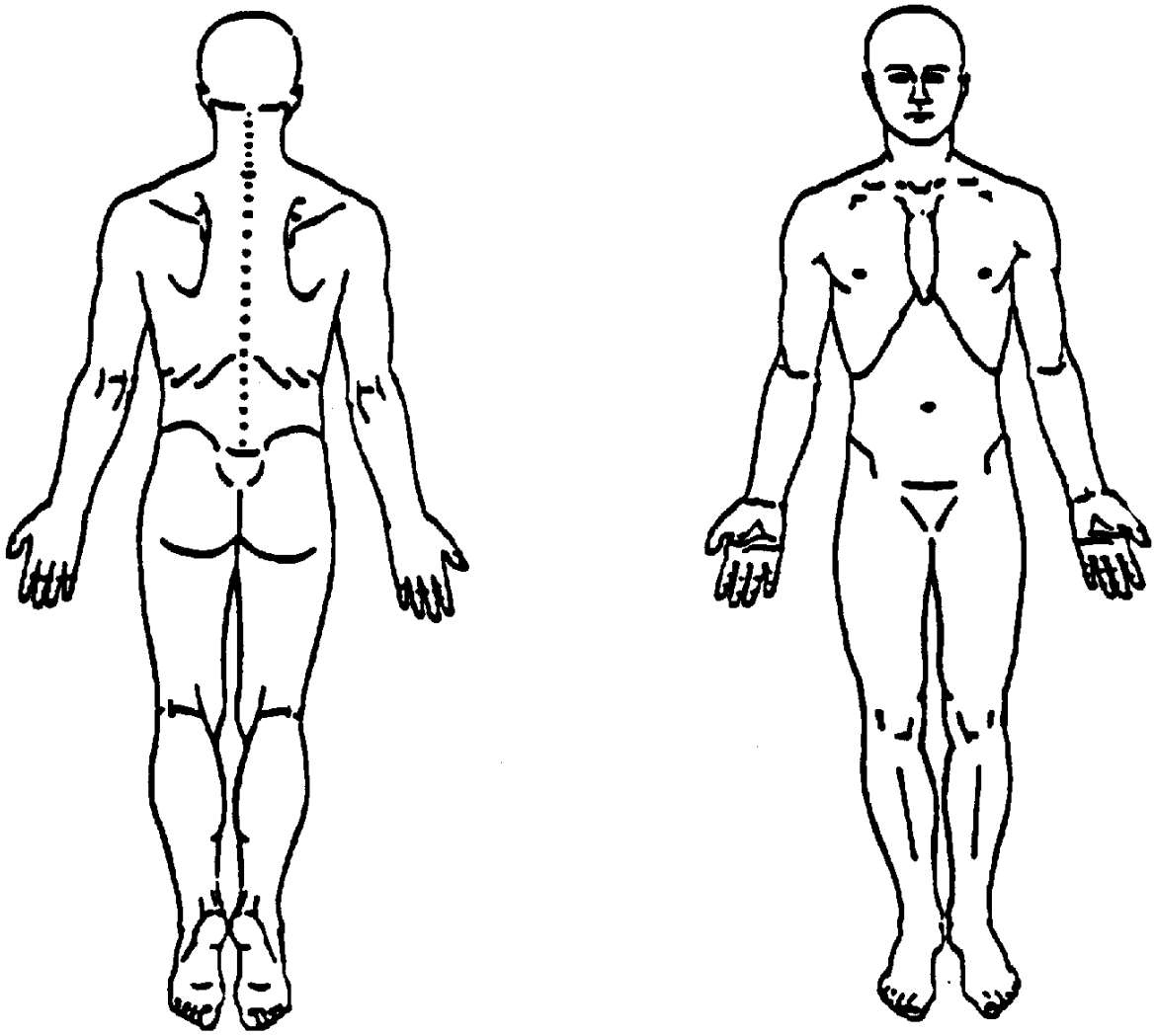
Therapist's Signature: _____Date:_____

INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

Key

/// Stabbing	XXX Burning	000 Pins and Needles	= = = Numbness



Patient Initials: _____

Please circle the level or intensity of pain or discomfort that you are currently experiencing.
0 = No Pain 10 = Excruciating pain; requires emergency room attention

0 2 3 4 5 6 7 8 9 10