Insurance Information: As a courtesy to you, we will bill your insurance company. Please provide us with your insurance card and any additional information we may need. Your benefits and co-payments will be discussed with you at your first visit. We recommend that you call your insurance company to verify your physical therapy coverage if case of any discrepancy between what our office has been informed of and what you thought your benefit coverage was. **It is your responsibility to know your policy benefits and limitations.** Our billing office is available to answer questions you may have regarding our billing procedures and benefits quoted.

Payment Options: We accept personal checks, cash, Visa, Mastercard, and Discover. **Insurance co-payments are due on each visit unless other arrangements have been made with our billing department.** Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old.

Return Check Fee: A $35 fee will be charged to the patient for each incident that a check is returned to us for insufficient funds.

Worker's Compensation Claims: We will bill your OPEN, approved worker's compensation claims. Please be advised that in the event your claims is denied, you are financially responsible for all charges.

Scheduling: We are happy to reschedule your appointments when a conflict occurs; however, we request a 24-hour notice if at all possible. If you fail to attend your appointments and do not give us 24 hours prior notification, you may be charged a fee of $25.00 for the time slot alloted for you.

Non-Discrimination: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our clinic for services are protected against discrimination assured by Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the above information or any uncertainity regarding your insurance coverage, please do not hesitate to ask for our assistance.

_____ _____

Patient/Legal Guardian Signature Date

IWR Therapy Systems

2048-A SOUTH BROAD STREET • BROOKLEY COMPLEX • MOBILE, AL 36615-1285 • 251-433-1414 • FAX 251-433-9634
627 HWY 43, SUITE B • SARALAND, AL 36571 • 251-675-3390 • FAX 251-675-9976
3280 DAUPHIN STREET • SUITE B 100-A • MOBILE, AL 36606 • 251-586-0067 • FAX 251-586-0071
7965 MOFFETT RD. • SUITE B • SEMMES, AL 36575 • 251-645-3708 • FAX 251-645-5837

PATIENT INFORMATION

NAME:		First time patient? ☐ Yes ☐ No	
Address:			
City:		ST.	Zip
Home telephone: ( )	Cell phone: ( )		
Social Security No.:	D.O.B.		
EMPLOYER:	Occupation:		
Address:			
City		ST.	Zip
Work Telephone: ( )	Contact Person:		
In case of an on-site emergency, I.W.R. should notify:			
Relationship to patient:		Telephone:	

Consent for Treatment: I, the undersigned, understand that my treatment is under the direction of my referring physician and consent to therapy treatment, including but not limited to:

☐ Physical Therapy ☐ Work Prep Program ☐ Work Simulation Program ☐Splinting
☐Work Capacity Assessment ☐ Functional Capacity Assessment ☐Pre-Placement Screen
☐Other:_____

ASSIGNMENT OF INSURANCE BENEFITS: I assign payment directly to I.W.R. Therapy Systems in accepting this assignment of all therapy benefits and applicable and otherwise payable to me, but not to exceed the reasonable and customary charge for these services rendered by said group. I authorize the refund of overpaid insurance benefits in accordance with my insurance policy conditions where my coverage is subject to a coordination of benefits clause. Where Medicare and/or Medicaid benefits are applicable, I certify that the information given by me in applying for payment under Title XVIII of XIX of the Social Security Act is correct, and request that said payment of authorized benefits be made on my behalf.

FINANCIAL AGREEMENT: I understand that I am responsible to I.W.R. Therapy Systems for all reasonable charges incurred to me. The undersigned agrees, whether he/she signs as agent or as patient, he/she hereby individually obligated himself/herself to pay the account in accordance with the regular rates and terms of I.W.R. Therapy Systems. Furthermore, he/she obligates himself/herself to make weekly payments if requested. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorneys fees and collection expenses. All delinquent accounts bear interest at the legal rate. The undersigned agrees that any monies collected on the above services may be applied directly to a delinquent account of the patient should one exist.

☐ **All clients filing Workman's Comp claims are excluded from any charges incurred by I.W.R. Therapy Systems.**

☐ **MOTOR VEHICLE ACCIDENT**: I understand in the event of a MVA, IWR Therapy Systems will have to have on file, a letter of guarantee from attorney or responsible insurance party. This does NOT release patient from responsibility. In the event of third party non-payment, patient will be responsible for charges incurred at IWR Therapy Systems. Initial Here:_____

☐ **BLUE CROSS / BLUE SHIELD**: By initializing this paragraph, I certify that I am responsible for any and all amounts not paid by BC/BS, including deductibles and percentages for each visit. Initial Here:_____

RELEASE OF INFORMATION: I authorized I.W.R. to release and any all information required in the course of my examination and treatment in connection with therapy treatments for any and all purposes involved in medical treatment, professional services and/or billing. This consent and authorization specifically includes but is not limited to: psychological, psychiatric, alcohol, drug abuse, and HIV/AIDS information.

LEGAL AUTHORIZATION: I authorize I.W.R. Therapy Systems in 1) the collection of benefits from any responsible third party through whatever means may be deemed necessary, and 2) the endorsement of benefit checks made payable to myself or to I.W.R. Therapy Systems.

I, the undersigned, certify that I have read and understand the above.

Client Signature: **Today's Date**:

CONTACT INFORMATION AND HOW TO REPORT A PRIVACY RIGHTS VIOLATIONS

If you have questions and/or would like additional information regarding the uses and disclosures of your Health Information, you may contact our Privacy Officer at:

Address: 3280 Dauphin Street
Suite B-100A
ATTN: Privacy Office
Mobile, Al. 36606

Telephone: (251) 586-0067

Fax: (251) 586-0071

If you believe that your privacy rights have been violated or that we have violated our own privacy practices, you may file a complaint with us. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services at 200 Independence Avenue, S.W., Washington, D.C. 20201. Complaints filed directly with the Secretary must be made in writing, name us, describe the acts or omissions in violation of the Privacy Rules or our privacy practices, and must be filed within 180 days of the time you knew or should have known of the violation. Complaints submitted directly to us must be in writing and to the attention of our Privacy Officer. There will be no retaliation for filing a complaint.

The effective date of this Privacy Notice is March 24, 2003.

BY SIGNING BELOW, I HEREBY ACKNOWLEDGE RECEIPT OF THIS PRIVACY NOTICE.

_____ _____
Printed Name of Patient Date

_____
Signature of Patient or Patient's Representative

_____
Printed Name of Patient's Representative (if applicable)

_____
Representative's Relationship to Patient (if applicable)

To be completed by Industrial Wellness Rehab, Inc.

After a good faith attempt to obtain an Acknowledgment of receipt, the patient or representative refused or was unable to sign the Privacy Notice for the following reason(s):

_____
_____

_____ _____
Signature of IWR Representative Date

PAST MEDICAL HISTORY QUESTIONNAIRE

Name:_____Height:_____Weight:_____

Reason for Physical Therapy evaluation:_____

Location of Injury / Pain:_____

List of current medications you are taking:_____

_____

_____

List of any allergies to medication:_____

Check the boxes that apply to your medical history and explain if applicable.

☐ Angina: _____
☐ Ankle Swelling: _____
☐ Arthritis: _____
☐ Asthma: _____
☐ Back Injury: _____
☐ Black Outs: _____
☐ Cancer: _____
☐ Diabetes: _____
☐ Dizziness/Vertigo: _____
☐ Epilepsy: _____
☐Heart Abnormality: _____
☐ Heart Attack: _____
☐ Hernia: _____
☐ High Blood Pressure: _____
☐ High Cholesterol: _____
☐Kidney Disease: _____
☐ Liver Disease: _____
☐Muscle cramping: _____
☐ Muscle spasms: _____
☐ Neck Pain: _____
☐ Pace Maker Implant: _____
☐ Prosthesis/Brace: _____
☐Headaches: _____
☐ Seizures: _____
☐Shortness of Breath: _____
☐ Stroke / CVA: _____
☐ Surgery: _____
_____

How did you hear or learn about our services:
☐MD referral ☐ Friend ☐ Billboard ☐ Saw location ☐ High school function ☐Radio advertisement

Patient Signature:_____Date:_____