CONDITIONS OF REGISTRATION

Thank you for trusting Merit Rehab with your physical therapy needs. We take our commitment to you very seriously and look forward to working with you to enhance your health and well-being.

By signing the authorization for consent to treatment and Merit Rehab registration form, patient acknowledges and agrees to the following:

1. RELEASE OF INFORMATION: I authorize Merit Rehab to release my medical records to my health insurance for the purpose of billing and processing of my claim. I also agree to allow Merit Rehab to release my medical records and discuss health related and financially related issues to all health care providers, case managers, insurance representatives and lawyers that are involved in my case. A photocopy or a faxed copy of the release may be used in place of the original.

2. ASSIGNMENT OF INSURANCE BENEFITS: Merit Rehab has my permission to submit billings to my insurance company on my behalf and I authorize these payments to be made directly to Merit Rehab. I agree to pay all outstanding balances on my account within 30 days of receiving a balance due statement. I also agree to pay all insurance co-payments, deductibles and non-covered charges at the time of service. Should my account be referred to an attorney or collection agency for collection, I will pay actual attorney fees and collection expenses.

3. CANCELLATION AND MISSED APPOINTMENT POLICY: In the event that I am not able to make a scheduled appointment I agree to give at least **24 hours notice or (1 business day)** prior to my scheduled appointment. This policy enables Merit Rehab to schedule other clients who are in need of service in a prompt and timely manner.

No Show Fee = $35
Late Cancellation Fee = $25

MERITREHAB

Today's Date:

PATIENT REGISTRATION

Name: Last First MI

Address: Street City State Zip Code

Home Phone Cell Phone Work Phone

Birth date Social Security # Email Address

Gender: ☐ Female ☐ Male Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Employer Occupation

Emergency Contact Name Phone #

Referring Physician Phone #

INSURANCE INFORMATION

Primary Insurance Insured's Name Birth date of Insured

Policy Number/ID Number Group Number Relationship to Insured

Secondary Insurance Insured's Name Birth date of Insured

Policy Number/ID Number Group Number Relationship to Insured

MVA / WORKER'S COMP INSURANCE INFORMATION

☐ Work Comp ☐ MVA Date of Accident: ________________

Insurance Company Name Address Phone #

Claim Number/Policy # Adjuster Name Phone #

How did you hear about us?

☐ Family or Friend ☐ Physician referral ☐ Insurance Website ☐ Internet

☐ I was a former patient ☐ Clinic Sign ☐ Yellow Page Advertisement

Other:

SIGNATURE

I, the undersigned, hereby request evaluation and treatment by Merit Rehab and consent to care and treatment as ordered by my physician(s). I authorize the release of information related to my rehabilitation to my physician(s). I hereby authorize my health insurance to make payment directly to Merit Rehab for any benefits I may receive. I realize that this may not represent the full payment for services rendered and that I will be responsible for the balance due within 90 days. I authorize the release of any information necessary to process my insurance claims and facilitate payment of my account by a third party.

Patient / Guarantor Signature: ____Date: ____________________________

Print Patient / Guarantor Name: ______________________________________

Relationship to patient: (please check one) ☐ Self ☐ Parent ☐ Legal guardian ☐ Power of Attorney