Patient Intake Form

Date: _____

Patient information

Name: _____ Date of Birth: _____

Address: _____ Social Security #:_____

City/State/Zip: _____ Primary phone #:_____

Power Of Attorney: ☐ YES ☐ NO For (medical, financial, both):_____

Name, Address, Phone of POA: _____

_____

Do you have a prescription for outpatient therapy? ☐ Yes (keep for file) ☐ No (obtain prior to eval)

Who can we thank for referring you?

Referring Provider/Physician: _____ Location: _____

Are you receiving any other therapy services currently? ☐ No ☐ Yes

If yes, list provider name here: _____

Primary Insurance: ☐ Medicare Part B ☐ Other ☐ Copy of insurance card on file

Insurance:_____ ID Number: _____

Group Number: _____ Effective Date: _____

Secondary Insurance

Insurance:_____ ID Number: _____

Group Number: _____ Effective Date: _____

Insurance and Billing:

Please sign below to confirm that the information above is correct. Goodcare AtHome Rehab, LLC will submit a billing to insurances listed, and any remaining amount noted as patient responsibility will be invoiced to the patient for payment. As a courtesy, Goodcare AtHome Rehab, LLC will call to verify eligibility and benefits on patient's primary insurance, but this will not be a guarantee of eligibility and benefits as understanding insurance coverage and benefits is ultimately the responsibility of the patient.

Medicare will not cover therapy services in conjunction with patients receiving home health services billed under Part A at the same time. If at any point during your therapy you are receiving home health services, please let us know immediately. You must be completely discharged from home health prior to beginning or returning to therapy to ensure Medicare payment for services by Goodcare AtHome Rehab, LLC.

Signature of Patient or Responsible person/POA: _____

Date ____/____/_____

Goodcare AtHome Rehab

FINANCIAL RESPONSIBILITY: I agree to pay and guarantee payment in full of any and all charges for services provided or to be provided to the patient ("Patient") by Goodcare AtHome Rehab, LLC ("Company") and by healthcare providers employed by the Company who may provide services during this patient visit or stay (a "Provider"). I acknowledge that I may be responsible for my co-pay, co-insurance or services not covered by my insurance plan. In addition, I authorize the transfer of monies paid to the Company by or on behalf of the Patient and otherwise refundable to the Patient or Guarantor, to other accounts at this Company or any other entity for which the Patient or Guarantor is responsible.

PATIENT RESPONSIBILITY: As part of our mission, we make every effort to see our patients on a timely basis. This requires certain patient responsibility, your cooperation, and your effort to be present at the location and time of treatment session. I agree that if there are 2 consecutive missed appointments, no shows or erratic / inconsistent attendance, I may be subject to discharge and in this event the Company may notify my physician and insurance provider (for work comp cases). All missed visits become part of my medical record.

APPOINTMENT CANCELLATION: If I need to cancel, I will provide our office with 24 hour prior notice. Missed appointments, late cancellations, and no-shows will incur a $40.00 fee, are subject to our policy above and must be paid prior to the next visit. X_____

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of medical benefits payable to me, directly to the Company and/or Provider. The rates will not exceed regular charges for similar services. I understand that BILLING OF INSURANCE IS A SERVICE ONLY AND NOT A GUARANTEE OF PAYMENT. If my insurance carrier requires pre-certification for services, I understand that I may need to get the necessary approvals.

MEDICARE CERTIFICATION: The information given by me in applying for payment under Titles V, XVII and/or XIX of the Social Security Act is correct. I request that payment of benefits under Title XVII (Medicare) of the Social Security Act for any services provided by this Company be made on my behalf.

CONSENT FOR HEALTHCARE AND RELEASE OF MEDICAL INFORMATION: I consent to services from healthcare Providers practicing with this Company. I am aware that the provision of healthcare is not an exact science and I agree that no guarantees have been made or implied. I consent to the use and disclosure of protected health information about me for treatment, payment, claims processing and healthcare operations. I understand and agree that my health information may be disclosed to my family member, other relatives, close personal friends, or others who are involved in my healthcare or payment for my healthcare. I give my permission to be photographed and or/or filmed for treatment and general marketing purposes.

HIPAA – Acknowledgement of Receipt of Notice of Privacy Practices: Upon my request, I certify that I have been provided with a copy of the Notice of Privacy Practices. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice by requesting one at the Provider location.

If you approve release of information to someone other than your referring physician, medical POA, or care facility staff where you reside, please list the names and their relationship to you:

Name: _____ **Relationship:**_____

MY SIGNATURE BELOW INDICATES ACKNOWLEDGEMENT AND APPROVAL OF THE ABOVE UNLESS OTHERWISE MARKED AND INITIALED.

_____ Relationship: _____ Date: _____

Signature of Patient or POA/Responsible party*

_____

Address, City, State, Zip code (if responsible party is someone other than patient) Phone number

* Anyone signing on behalf of a Patient hereby confirms that he/she is authorized to consent on the Patient's behalf.