BRISTOL REHAB
PHYSICAL THERAPY

PHONE: (808) 800-1178
FAX: (808) 443-0570
EMAIL: contact.bristolrehabhi@gmail.com

PATIENT INFORMATION

Patient First Name: _____ MI: _____
Patient Last Name: _____
Preferred Name: _____ DOB: ___/___/_____ Age: ____ Sex: M F

Contact:
Phone: Home: _____ Cell: _____
Email: _____
Address: _____
City State Zip

Emergency Contact:
Name: _____ Relationship: _____ Phone: _____

How did you hear about us and who referred you? Check all that apply.
__Doctor
__Former patient
__Website
__Advertisement/Flyer
__Event
__Friend/Family: _____
__Other: _____

Insurance Information: *Please provide your insurance card to the receptionist.*
Call your insurance company for your individual physical therapy benefits.
The cost of your treatment may be covered in whole or in part by your insurance company. You are responsible for payment of any deductibles, co-pays or denied claims. Cash, check, or credit card may be used for payment. There is a $25 fee for returned checks.

Primary Insurance Company: _____
Policy Holder: (Last)_____ (First)_____ (MI)___ Sex: M F
DOB: ___/___/_____ Relationship to policy holder: __Self __Spouse __Child __Other:_____

Secondary Insurance Company: _____
Policy Holder: (Last)_____ (First)_____ (MI)___ Sex: M F
DOB: ___/___/_____ Relationship to policy holder: __Self __Spouse __Child __Other:_____

Tertiary Insurance Company: _____
Policy Holder: (Last)_____ (First)_____ (MI)___ Sex: M F
DOB: ___/___/_____ Relationship to policy holder: __Self __Spouse __Child __Other:_____

Employment Information:
Occupation: _____
Employer: _____ Work Phone: _____
Employer's Address:
_____
City State Zip

Patient Name: _____

PATIENT ATTENDANCE POLICY:
As we have reserved your appointment time for you, we kindly request that you notify our office 24 hours prior to your scheduled appointment time should you need to cancel or reschedule. If someone is not available to take your call, please leave a message on our answering system.
If you no show **and/or late cancel with less than 24 hours notice** for two consecutive appointments without notifying us, we may cancel any future appointments you have, you may be referred back to your Physician, or your therapist may choose to discharge you.
ALL PATIENTS, regardless of insurance/third party payor, will be charged a $50 CANCELLATION FEE for each late, late-cancelled, or no-show appointment. THE PATIENT IS RESPONSIBLE FOR THE FEE, NOT THE INSURANCE/THIRD PARTY PAYOR.
All cancellations and no-shows will be documented in our medical records and in certain situations such as workers' compensation cases, we are required to report treatment compliance to your adjuster/nurse case manager.
We recommend that you make up a missed appointment within the same week in order to comply with the treatment plan approved by your physician.
Signature: _____ Date: _____

HIPAA NOTICE OF PRIVACY PRACTICES
Our Notice of Privacy Practices provides a description of our treatment, payment activities, and healthcare operations as it outlines the use and limitations of the disclosure of your health information and your rights as a patient. We reserve the right to change our privacy practices in accordance with the law. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office.
Acknowledgement of Receipt
By signing this form, you acknowledge that you have been offered a copy for review of **Bristol Rehab LLC** Notice of Privacy Practices.
Signature: _____ Date: _____

CONSENT TO TREAT & AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF BENEFITS
I hereby authorize **Bristol Rehab LLC**, through its appropriate personnel, to perform the evaluation and treatment procedures that are deemed necessary by my physician and therapist in the treatment of my condition. I further authorize **Bristol Rehab LLC** or its representative for the purpose of billing, any information acquired, including the diagnosis and the records of any treatment or examination rendered to me, during the course of my treatment.

I hereby assign my therapy benefits to **Bristol Rehab LLC** for the services in which I receive and authorize my insurance carrier to make payments to **Bristol Rehab LLC** on my behalf. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event of default, I (we) promise to pay legal interest on the indebtedness, together with collection costs (plus $20.00 processing fee) and reasonable attorney fees as may be required to affect collection of this note.
By signing this document, I acknowledge that I have read, understand and agree that the information contained in this document including insurance benefits and any information I have presented to verify my own identity, and if applicable any information used to verify the identity of a minor beneficiary is current, correct and complete to the best of my knowledge.
I agree to the financial terms stated above.
Signature: _____ Date: _____

Bristol Rehab LLC *reserves the right to seek reimbursement from any and all of your insurers regardless of whether you provide us with their contact information, unless you instruct us to bill you directly. All records released require an administrative and copying fee paid to* ***Bristol Rehab LLC*** *before they are released, regardless of requestor.* ***Bristol Rehab LLC*** *is HIPAA compliant with regard to information sharing policies.*