West Rehab Services

Physical, Speech, & Occupational Therapy – Sports Medicine – Wellness

REGISTRATION INFORMATION

○ Savannah	○ Hinesville	○ Richmond Hill	○ Rincon	○ Pooler	○ Pembroke	○ Whitemarsh Island	○ Skidaway Island
7135 Hodgson Mem Dr Savannah, GA 31406 (912) 353-WEST (912) 353-9232 fax	475 South Main Street Hinesville, GA 31313 (912) 368-4131 (912) 368-4132 fax	2709 US Highway 17, 2A Richmond Hill GA 31324 (912) 756-5699 (912) 756-5388 fax	804 Towne Park Drive Rincon, GA 31326 (912) 826-5450 (912) 826-6413 fax	1000 Towne Center Blvd Pooler, GA 31322 (912) 330-0155 (912) 330-0153 fax	205 East Bacon Street Pembroke, GA 31321 (912) 653-0040 (912) 653-0038 fax	107 Charlotte Rd, Ste. D Wilmington Is, GA 31410 (912) 897-1114 (912) 897-6114 fax	11 West Cross Road Savannah, GA 31411 (912) 598-8557 (912) 598-2569 fax

Patient: ______________________________ Home Phone: ____________
Last First MI

Address: ______________________________ Cell Phone: ____________

City: ______________ State: ________ Zip: ____________ Work Phone: ____________

E-Mail Address: ______________________________ Social Security#: ____________

Emergency Contact : ______________ Contact Phone: ____________ Patient Birth Date: ____________

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed Patient Sex: ○ M ○ F

Student: ○ Full Time ○ Part Time ○ Not a student Accident Status: ○ Auto ○ Work ○ Other ○ Not an accident. State: _______

Patient's Employment: ○ Full Time ○ Part Time ○ Retired ○ Not Employed Attorney: ______________

Employer: ______________________________ Occupation: ____________

Employer's Address: ______________________________ Contact Person: ____________

City: ______________ State: ________ Zip: ________ Contact Phone: ____________

Referring Physician: ______________ Phone: ____________ When did you last see physician? ____________

When is your next appointment with this physician? ____________ When did you become ill or injured: ____________

Problem: ______________________________ Have you received therapy for this condition before? ○ Yes ○ No

Who will be responsible for the charges: ○ Patient ○ Employer ○ Other: ______________

Address: ______________________________ Phone Number: ____________

City: ______________ State: ________ Zip: _______ Relationship to patient: ____________

Insurance Company 1: ______________________________ Phone Number: ____________

Insured's Name: ______________________________ Policy Number: ____________

Insured's Employer: ______________________________ Group Number: ____________

Insured's Sex: M F Insured's Birthday: ____________ Insured's Relation to Patient: ____________

Insurance Company 2: ______________________________ Phone Number: ____________

Insured's Name: ______________________________ Policy Number: ____________

Insured's Employer: ______________________________ Group Number: ____________

Insured's Sex: M F Insured's Birthday: ____________ Insured's Relation to Patient: ____________

Insurance Company 3: ______________________________ Phone Number: ____________

Insured's Name: ______________________________ Policy Number: ____________

Insured's Employer: ______________________________ Group Number: ____________

Insured's Sex: M F Insured's Birthday: ____________ Insured's Relation to Patient: ____________

Taken: ____/____/____ Where is Rx? ______________

Date: ____/____/____ Time: __________ Service: __________

Signature: ______________________________ **Date:** ______________

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PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY AND INITIAL BEFORE YOU SIGN:

______ I have been provided a HEALTH INFORMATION PRIVACY NOTICE and a NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT and agree to the terms of these documents.

______ I understand that my therapist will set aside between 30 and 90 minutes for my treatment. If I fail to call and cancel any scheduled appointment I cannot attend, I will be responsible for a **$20 charge for missed appointments without calling.**

______ I understand that my charges will be submitted to my insurance company as a courtesy to me, and that I am financially responsible to West Rehab Services, Inc. for deductibles, co-insurance, and per visit fees not covered by my insurance company or Medicare.

______ I understand that a 1.5% finance charge per month (18% per annum) will be added to my account if my balance is more than 30 days past due, and that attorney fees and/or collection agency fees of up to 30% of my balance may be added for any amounts turned over to them for collection.

______ I hereby consent to treatment and authorize West Rehab Services, Inc. to furnish my insurance company, attorney or legal representative all information they request regarding my account or present illness or injury. I hereby assign to West Rehab Services, Inc. all money I am entitled for all medical expenses relative to the service they provide, but not to exceed my indebtedness to them. All money received that exceeds my indebtedness to them will be refunded when my bill is paid in full.

______ We have contacted your insurance company and they have advised us that you should pay $______ and/or _____ % of your charges per visit in addition to your $ _______ deductible. We will not know if this information is accurate until after your insurance company processes your claims, and we receive an Explanation of Benefits from them. We recommend that you verify these benefits with your insurance company, since you will be responsible for any amount not covered. Auto accident patients are responsible for the full amount of all charges.

______ Counseled by ____

____ ________________________________
Patient's or Responsible Party's Signature Date

OFFICE USE ONLY

Are we in the network? PRIMARY INS: _____ Yes _____ No / SECONDARY INS: _____ Yes _____ No

Contact Phone if not: Primary Insurance: ___________________ / Secondary Ins: _______________________ (Notified Kris: ____ Yes)

Primary Insurance

Benefits to be verified: ☐ PT ☐ OT ☐ ST ☐ SS Insurance coverage 1 was verified with _____________________(______). Effective Date: ___/___/___
Name of Representative (Ext)

In-Network Benefits: Co-Insurance: _____% • Co-Pay: $_____ per visit • Annual Deductible: $_______ • **Remaining** Deductible: $______

Deductible Renewal Date: ___/___/___ • Out of Pocket: $_________ • Out of Pocket **Met**: $_________ • Visit Limit: ______ • Visits Used: _______

Out-of-Network Ben: Co-Insurance: _____% • Co-Pay: $_____ per visit • Annual Deductible: $_______ • **Remaining** Deductible: $______

Deductible Renewal Date: ___/___/___ Out of Pocket: $_________ • Out of Pocket **Met**: $_________ • Visit Limit: ______ • Visits Used: _______

Is Pre-Certification Required? ☐Yes ☐No Pre-Cert No.: ______________________ No. Of Visits: _________ Pre-Cert Dates: _____________________

Contact Name: ____________________________ Phone: (_____)______________________ Fax: (_____)________________________

Documentation required with claim ____

Complete Claim Address: Company: ____

Address: ____

City: __________________________ State: _________ Zip: _________________

Secondary Insurance

Benefits to be verified: ☐ PT ☐ OT ☐ ST ☐ SS Insurance coverage 1 was verified with _____________________(______). Effective Date: ___/___/___
Name of Representative (Ext)

In-Network Benefits: Co-Insurance: _____% • Co-Pay: $_____ per visit • Annual Deductible: $_______ • **Remaining** Deductible: $______

Deductible Renewal Date: ___/___/___ • Out of Pocket: $_________ • Out of Pocket **Met**: $_________ • Visit Limit: ______ • Visits Used: _______

Out-of-Network Ben: Co-Insurance: _____% • Co-Pay: $_____ per visit • Annual Deductible: $_______ • **Remaining** Deductible: $______

Deductible Renewal Date: ___/___/___ Out of Pocket: $_________ • Out of Pocket **Met**: $_________ • Visit Limit: ______ • Visits Used: _______

Will they pick-up the primary insurance's deductible (if not met)? ___ yes ___no

Is Pre-Certification Required? ☐Yes ☐ No Pre-Cert No.: ______________________ No. Of Visits: _________ Pre-Cert Dates: ____________________

Contact Name: ____________________________ Phone: (_____)______________________ Fax: (_____)________________________

Documentation required with claim ____

Complete Claim Address: Company: ____

Address: ____

City: __________________________ State: _________ Zip _________________ Employee:_____________

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