



Farmington & Desloge

SPORTS & REHAB

Physical & Hand Therapy

Registration Form

General Information

Have you been treated by us before? Yes No

Last Name First Name Middle Initial Gender: Male Female

_____-_____-_____
Social Security Number ____/____/____
Date of Birth Age _____
Occupation / Employer

Street Address City State Zip Code

(____) _____
Cell Phone (____) _____
Home Phone (____) _____
Work Phone

E-mail Address _____
Marital Status

Parent / Guardian's Name (if under 18) ____-____-_____
Parent's S.S.N. ____/____/____
Parent's D.O.B.

Emergency Contact _____
Relationship to Patient (____) _____
Emergency Contact Phone Number

Primary Insurance (Insurance Cardholder Information)

Insurance Company Member I.D. Group Number

Cardholder Last Name First Name Middle Initial Gender: Male Female

____/____/____
Date of Birth Age _____
Relationship to Patient

Secondary Insurance (Insurance Cardholder Information)

Insurance Company Member I.D. Group Number

Cardholder Last Name First Name Middle Initial Gender: Male Female

____/____/____
Date of Birth Age _____
Relationship to Patient

Office Policies

Appointment Reminder Service

- Please send me email messages to confirm my upcoming appointments to my email address listed on my patient registration.
- Please send me cell phone text messages to confirm my upcoming appointments to my cell phone number as on my patient registration. ***I recognize that normal text messaging rates may apply.***

We cannot set your account up to send text message reminders without knowing your cell phone carrier. Please indicate your carrier below, if you would like text message reminders:

- AT&T T-Mobile Boost Mobile US Cellular Cricket
- Verizon Nextel Virgin Mobile Sprint PCS Other: _____

Healthcare Privacy Notice

With my consent, Farmington Sports and Rehabilitation Center may use and disclose protected health information about me to carry out treatment, payment, and healthcare operations. Please refer to Farmington Sports and Rehabilitation Center's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practice prior to signing this consent. Farmington Sports and Rehabilitation Center reserves the right to revise its Notice of Privacy Practices at any time. A revised notice of Privacy Practices may be obtained by forwarding a written request to **Farmington Sports and Rehabilitation Center, 602 Maple Valley Drive, Farmington, Missouri 63640.**

With my consent, Farmington Sports and Rehabilitation Center may call my home or other designated location and leave a message on my voicemail or in person in reference to any item that assists the practice of carrying out my treatment, payment, and healthcare operations, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Farmington Sports and Rehabilitation Center may mail to my home or other designated location any item that assists the practice in carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements.

With my consent, Farmington Sports and Rehabilitation Center may e-mail to my home or other designated location any item that assist the practice of carrying out treatment, payment, and healthcare operations, such as appointment reminder cards and patient statements. I have the right to request that Farmington Sports and Rehabilitation Center restrict how it uses or discloses my protected healthcare information to carry out treatment, payment, and healthcare services. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Farmington Sports and Rehabilitation Center's use and disclosure of my protected health information to carry out treatment, payment, and healthcare operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Farmington Sports and Rehabilitation Center may decline to provide treatment to me.

Informed Consent

I have been informed that Farmington Sports and Rehabilitation Center is certified to provide outpatient rehabilitation services according to the plan of treatment established by my attending physician or the medical director of Farmington Sports and Rehabilitation Center and the facility rehab team. I understand and accept treatment accordingly.

Assignment of Benefits

I hereby assign medical and / or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans to **FARMINGTON SPORTS AND REHABILITATION CENTER**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am responsible for paying remaining charges that are not covered by said insurance company, if any. I hereby authorize said assignee to release all information necessary to secure payment.

Medicare Beneficiaries Only

Under Medicare Medical insurance (Part B), Medicare will pay Farmington Sports and Rehabilitation Center 80% of the rehabilitation fee schedule, if the client satisfies the following conditions:

- A. The client must satisfy the deductible in the current year. Medicare will typically pay 80% of the bill after the deductible has been satisfied.
- B. This form must be signed by the client or the responsible party, giving us permission to bill 80% to Medicare and 20% (co-insurance) plus any deductible not-met, to the client or the insurance company.
- C. If the client does not have sufficient funds to cover the 20% coinsurance and deductible, a Medical Indigence Determination form may be requested and, if the client meets the criteria, no further requests for payment will be made.

Therapy Cap Permanently Repealed: The Medicare Part B outpatient therapy cap no longer exists with the passage of the *Bipartisan Budget Act of 2018* and applies to all therapy services provided going forward. A pathway to care for medically necessary and appropriate care is now open, which means that the \$2,230 threshold for therapy services is no longer a ceiling and services beyond that amount can be provided to clients so long as those services are medically necessary under Medicare coverage criteria. The bill continues to require use of the KX modifier process, for Medicare record keeping purposes only, to indicate that services are medically necessary above a \$2,230 threshold in 2023. The dollar threshold for using the KX modifier will go up at a specific rate based on inflation annually. The bill permits Medicare contractors to request and perform targeted review of claims documentation for therapy services provided beyond a threshold of \$3,000 during 2023. The KX modifier and the \$3,000 review threshold applies to occupational therapy separately, and to physical therapy and speech-language pathology combined.

I authorize treatment and payment of medical benefits to Farmington Sports and Rehabilitation Center for services rendered as ordered by physician. I further authorize Farmington Sports and Rehabilitation Center to furnish medical or other information to all parties involved in the ordering, provision of, or reimbursement of these therapy services and to my physician, and / or any third party payors.

I understand that I am responsible for all charges (including charges the insurance does not cover).

Cancellation Policy

There is a \$45 charge for missed or cancelled appointments without 24 hours advanced notice. We have scheduled an agreed upon time especially for you which is now lost. We are unable to bill your insurance for this amount. We want to get maximum results from therapy and this means attending therapy on a regular basis. If you have more than three "no shows" you will be discharged from therapy.

Financial Policy

We are committed to providing you the best possible care at Farmington Sports and Rehabilitation Center, and we are pleased to discuss professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask the administrative staff if you have any questions about our fees, financial policy, or your responsibility.

- Payment is due at the time services are rendered.
- All co-insurances, co-payments, and deductibles are due as services are rendered.
- We will submit all billing to insurance companies as a courtesy for our clients; however, we will collect co-insurance charges, co-payments, and deductibles at the time of each visit.
- Verification of insurance benefits does not guarantee payment. I understand that I am responsible for all charges including those not covered by insurance and all collection costs including agency fees and attorney fees.
- All Workers' Compensation injuries must be verified and approved for eligibility by the facility administrative staff prior to receiving treatment. Approved Workers' Compensation cases will be excluded from payment at the time of service.
- Your insurance coverage is a contract between you and your insurance carrier. We will help to explain your benefits to you.
- If your insurance does not remit payment within 60 days, the balance will be due in full from you.
- Any money paid to you by your insurance company for services billed and rendered by Farmington Sports and Rehabilitation Center or any of its associates shall be paid to Farmington Sports and Rehabilitation Center immediately upon receipt. Failure to do so is illegal.
- I authorize payment of medical benefits from my insurance to **FARMINGTON SPORTS AND REHABILITATION CENTER** and release any medical information relating to all claims for benefits submitted on behalf of myself and / or dependents.
- By signing below, I understand my responsibilities as outlined in the above Financial Policy.

Your insurance deductible is \$ _____ per year. You have met \$ _____ of your deductible.

Your co-insurance amount is _____ per visit or approximately \$ _____ per visit.

Your co-payment is \$ _____ per visit.

Your insurance allows _____ visits per calendar year / per diagnosis. You have used _____ visits.

Your insurance has authorized _____ visits at this time.

THIS IS NOT A GUARANTEE OF PAYMENT.

THIS OUTLINE IS BASED ON INFORMATION PROVIDED BY YOUR INSURANCE COMPANY.

Patient Consent and Signature

By my signature below I agree to abide by above policies and acknowledge that I have read, or have had read to me, and have received a photocopy upon my request of this document including the Health Care Privacy Notice, facility terms and conditions, financial policies (including Medicare policies if applicable), and Informed Consent and fully understand and have had all of my questions answered to my satisfaction. A photocopy of this document shall be considered as effective and valid as an original.

Print Name of Patient

Patient Signature (Parent / Guardian if patient is a minor)

_____/_____/_____
Date

Witness Signature (Staff Only)

_____/_____/_____
Date

Past Medical History

- What made you choose us for your therapy needs? _____
- What injury / symptoms brought you to therapy? _____
- What is the date of injury or recent onset of symptoms? _____/_____/_____
- Check which apply to your symptoms:
 - Athletic / Recreational Injury Injury Related To Fall Injury Related To Lifting
 - Recurrence of Previous Injury Cause Unknown Other: _____
 - Work Related Injury. If checked, has your employer been notified? Yes No
 - Motor Vehicle Accident / Auto Accident
- Have you retained an attorney regarding this injury? Yes No If yes, who? _____
- Description of injury: _____

- Are you here because you had surgery? Yes No If yes, please describe: _____
- Date of next physician's visit: _____/_____/_____
- Do you have any special needs or requests? _____

• Do you have, or have you had, any of the following?

	Yes	No		Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Heat or Cold	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Allergies to Latex	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	Hernia	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain / Angina	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Metal Implants	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Are you Pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Skin Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Sexual Dysfunction	<input type="checkbox"/>	<input type="checkbox"/>
Bowel / Bladder Abnormalities	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Urine Leakage	<input type="checkbox"/>	<input type="checkbox"/>	ringing in your ears	<input type="checkbox"/>	<input type="checkbox"/>
Asthma / Breathing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Liver / Gallbladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>
Smoking-related Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>
Stroke / CVA	<input type="checkbox"/>	<input type="checkbox"/>	Special Diet Guidelines	<input type="checkbox"/>	<input type="checkbox"/>

Other: _____

Do you smoke or use tobacco products? Yes No Frequency: _____

Do you drink alcohol? Yes No Frequency: _____

If yes on any of the previous questions, please briefly explain and give approximate date:

Are you currently taking any medications? Yes No If yes, please list:

_____	_____
_____	_____
_____	_____
_____	_____

Do you have any drug allergies? Yes No If yes, please list:

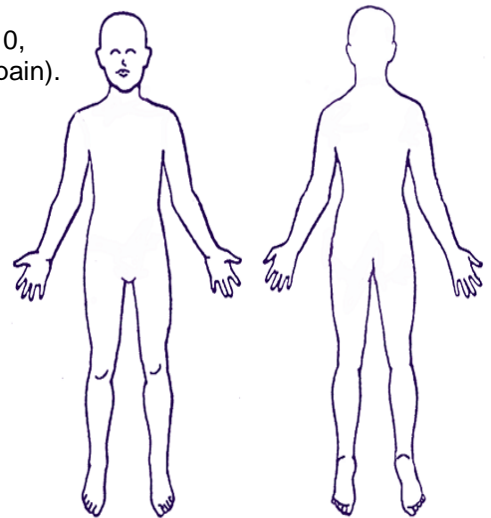
Do you participate in any sports, exercise programs, or activities on regular basis? Yes No

If you are having pain, please rate the intensity of your pain on a scale of 0 to 10, (with 0 being no pain and 10 being the worst pain possible, Emergency Room pain).

Pain Rating Now: _____

Pain Rating (Best): _____

Pain Rating (Worst): _____



Please indicate location of symptoms:
KEY:
===== Numbness
OOOO Pin & Needles
XXXX Burning Pain
//////// Stabbing Pain

Patient's Signature

____/____/____
Date

Parent / Guardian if patient is a minor

____/____/____
Date

I have reviewed the past medical history.

Therapist's Signature

____/____/____
Date



Farmington & Desloge

SPORTS & REHAB

Physical & Hand Therapy

SOCIAL SERVICES TRIGGER SHEET

Patient: _____

Date: _____

Cell Phone: _____

SOCIAL SERVICES COUNSELING TRIGGERS:

No.	Description	Yes	No
1.	Are you currently living in a nursing home type facility that is already responsible for providing social worker type services? (If yes, skip to the signatures of this form. If no, please continue with questions 2-11)		
2.	Are you currently under the care of a qualified social worker, psychologist, psychiatrist, or vocational rehabilitation counselor?		
3.	Do you have a spouse, partner, caregiver or family member at home to assist with your care if needed?		
4.	Do you have unresolved feelings regarding your current physical problems (For example: worry, anger, depression, fear, etc.)		
5.	Have you experienced recent notable weight loss OR gain?		
6.	Do you have difficulty preparing meals?		
7.	Are you UNABLE to bathe, feed or adequately conduct household activities?		
8.	Do you feel you are under any situations that are causing you distress?		
9.	Are your transportation needs met?		
10.	Have you ever been under the care of a nursing home or home health agency?		
11.	Do you request to speak with a social worker and/or vocational adjustment services professional? (Please note that under certain circumstances, we are legally required to refer your case or provide information to a social worker, another healthcare provider, or the appropriate governmental authority. Your decision not to request to speak to a social worker or vocational adjustment services professional does not relieve us of these obligations, if applicable.)		

Patient Signature: _____

Date: _____

*******FOR OFFICE USE ONLY*******

Trigger Sheet Referred To Social Worker: Yes No

Therapist Signature: _____

Date: _____

Social Worker Note (If Referred to Social Worker): _____

Social Worker Signature: _____

Date: _____

Last Name

First Name

Phone Number

E-mail Address

Are you interested in losing weight and achieving optimal health? Yes No

OPTAVIA offers four components to support you as you begin your journey toward **Lifelong Transformation, One Healthy Habit at a Time.**

1. Your OPTAVIA Coach guides and supports you throughout your journey to Optimal Health & Wellbeing.

OPTAVIA Coaches are the lifeblood of our program, they're one of the biggest differences we offer. Study after study shows that support and guidance increase your chances for success in reaching your optimal weight*. Your Coach will keep you accountable and will help you celebrate all the little victories that add up to the big ones!

2. The Habits of Health

OPTAVIA succeeds where other programs fail because we incorporate Healthy Habits in everything we do. Today, the world is searching for quick-fix weight-loss solutions. But we know quick fixes don't work. **OPTAVIA's** approach is radically different. The Habits of Health system will help you learn and adopt new healthy habits in bite-sized pieces we call micro habits, which can lead to Lifelong Transformation, One Healthy Habit at a Time.

3. Our OPTAVIA Community

Our **OPTAVIA** Community will support you alongside your Coach.

4. Our Scientifically Proven Fuelings and Plans

OPTAVIA works because it's simple and easy to follow. Our proven Optimal Weight 5 & 1 Plan® jumpstarts your optimal weight journey. Five of your daily meals are **OPTAVIA** Fuelings.



OPTAVIA