Rehab Center Admission Form

Patient Name: _____ Birthdate: _____

Address: _____

_____

Phone Number: _____ Email: _____

How did you hear about us? _____

Please circle the service you are requesting:

Physical Therapy Occupational Therapy Speech Therapy

Physician that will provide referral *(ex. PCP, Neuro, Ortho):* _____

Funding Information

Medical Insurance *(we will need a copy of the front and back of insurance card)*

Primary Insurance Name: _____ Member ID: _____

Secondary Insurance Name: _____ Member ID: _____

Waiver

Waiver Type: _____ Provider: _____

Texas Workforce Commission

TWC Counselor Name: _____ Office Location: _____

Email: _____ Phone Number: _____

Basic Information

Living situation: _____

Are you employed: _____ Occupation: _____

Date of injury: _____ Type of injury: _____

Current symptoms: _____

_____

History of falls: _____

DME *(ex. walker, cane, tub bench, etc.):* _____

Are you currently receiving home health services? _____

Medical History

Please list medical diagnoses: _____

_____

Please list current medications: _____

_____

_____

Please list previous surgeries: _____

What are your goals for therapy? _____

_____

If you need assistance with any of the following please circle:

Bathing	Dressing	Grooming	Toileting	Driving	Chores	Walking at home
Walking in the community		Shopping	Laundry	Managing medications		Transportation

Return form to: admissions@maryleefoundation.org or fax (855) 978-1775

Consent for Treatment
I, the patient/guardian, acknowledge that I am of a sound mind and physically/mentally able to give consent for my care. I hereby give consent to receive outpatient physical, occupational, speech therapy services as deemed necessary by the therapist(s) on duty at MLFRC. I am aware that the practice of therapies is not an exact science and I acknowledge that no guarantees have been made regarding my treatments, results or outcomes. I understand that in some cases, treatment techniques may actually increase my pain. I understand that proper evaluation and treatment may require bodily contact, touching and/or direct contact by the therapists. I also acknowledge that as the patient/guardian I have the right to decline and/or refuse any portion of my treatment that I decide not to participate in.

Financial Responsibility Agreement
By signing this Agreement, the client (or the client's legal guardian, family member, or a representative of a financially responsible trust, signing on the client's behalf) understands and agrees as follows:

1. If I have provided my insurance information, Mary Lee Foundation Rehabilitation Center ("MLFRC") will bill my insurance carrier for the services I am receiving.
2. I understand that my co-pay and/or co-insurance is due at the time of service.
3. I understand that I am responsible for paying all deductible and co-insurance charges. If my insurance carrier deducts these amounts from its payment to MLFRC, then MLFRC will send me an invoice for these charges. I agree to pay this invoice within 30 days of the date of invoice.
4. I understand that my insurance carrier might not cover the services I am receiving.
5. If my insurance carrier does not cover the services I am receiving, then I am responsible for paying those services at the time of service.

Email Consent
Mary Lee Foundation Rehabilitation Center offers patients the opportunity to communicate with clinicians and office staff by email. Listed below is some information to consider:

- E-mails can be circulated, forwarded, or stored in paper and electronic files
- Both intended and unintended recipients can receive e-mails
- Sender can misread e-mail address
- E-mails are easier to falsify versus handwritten or signed documents
- E-mails may exist even after the sender or the recipient has deleted their copy
- E-mail accounts can be hacked without authorization or detection
- E-mails can be used to introduce viruses into recipient's computer systems
- E-mails can be used as evidence in court

Private Pay Agreement
I agree to pay $80 per session rendered by the Mary Lee Foundation Rehabilitation Center for Physical, Occupational, or Speech therapy services. Payment is due day that session occurred.

Information Usage
We respect your privacy and do not tolerate spam. We will never sell, rent, lease or give away your information (name, address, email, etc.) to any third party with the exception of: the payor(s) you have provided for us to send your claims to for processing, court subpoena, in compliance with relevant laws or per your written request.

Privacy Practices
MLFRC follows HIPAA standards and PHI "protected health information" *"individually identifiable health information"* held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral.

Patient / Guardian Signature: _____ Date: _____