SOUTH FLORIDA
REHABILITATION CONSULTANTS

# WELCOME TO SOUTH FLORIDA REHABILITATION CONSULTANTS

As a team of Rehabilitation Specialists, our goal is to provide the highest quality of therapy to our patients, in a cost effective manner and a pleasant environment.

## INSURANCE CLAIMS:

We will file all the necessary insurance forms for your treatment within a reasonable time. However, if your insurance company should deny payment for any reason, the outstanding balance then will become your responsibility.

## BROKEN APPOINTMENT POLICY:

In an effort to provide timely, quality care at a reasonable fee, it is extremely important to maintain and efficient appointment schedule. If you need to re-schedule or cancel your appointment, please call us 24 hours in advance, so we can reschedule this time efficiently. Otherwise a fee of $100 will be assessed and payable by you, since we cannot bill insurance for missed appointments.

## RETURN CHECK POLICY:

Personal checks are accepted as a method of payment at our office. Should your check not clear with our bank, a return check fee of $39.00 will be charged to you so we can clear our costs.

_____

**Patient Signature**

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**(PLEASE FILL IN ALL INFORMATION REQUESTED AND SIGN AT THE BOTTOM)**

Date (FECHA):_____

First Name (NOMBRE):_____ Last Name (APELLIDO):_____

Sex (SEXO) M ◯ F ◯ DOB (FECHA DE NACIMIENTO):_____ Age (EDAD):_____

Marital Status: M ◯ S ◯ D ◯ W ◯ (ESTADO CONYUGAL: C ◯ S ◯ D ◯ V ◯ )

Address (DIRECCION):_____ City (CIUDAD):_____ State (ESTADO):_____

Zip Code (CODIGO DE AREA):_____

Phone (TEL.):_____ Emergency Phone (TEL. EMERGENCIA):_____

Employer (EMPLEADOR):_____ Phone (TEL.):_____

Primary Physician (MEDICO PRIMARIO):_____ Phone (TEL.):_____

Referring Physician (MEDICO QUE LO REFIERE A TERAPIA):_____

Address (DIRECCION): _____ Phone (TEL.):_____

Insurance (SEGURO):_____ Policy # (PÓLIZA):_____

Name of Policyholder (NOMBRE DEL ASEGURADO):_____ _____

Relationship to Patient (RELACION CON EL PACIENTE):_____ _____

Other Insurance (OTRO SEGURO) _____ Policy # (PÓLIZA):_____

Name of Policyholder (NOMBRE DEL ASEGURADO):_____ _____

Relationship to Patient (RELACION CON EL PACIENTE):_____

Name of Person to Notify in Case of Emergency _____

Phone (TEL.):_____

Are You Currently or Will Be Receiving the Services of a Home Health Aide or any Services in Your Home? YES☐ NO☐

If YES, please explain if this is paid by insurance or out of pocket:_____

_____

In the current year, have you received any Physical/Occupational or Speech Therapy? YES☐ NO☐

If YES, when and how many sessions? _____

Please provide us with your email: _____

Allergies (ALERGIAS):_____

Signature (FIRMA):_____

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**AUTHORIZATION TO TREAT:** I hereby authorize South Florida Rehabilitation Consultants, Inc.'s personnel to provide me /minor child, therapy services as per plan of care. I am aware of the reason for treatment and agree to the use of therapeutic modalities, exercise, etc., to treat me as needed.

**ASSIGNMENT OF BENEFITS:** I hereby assign my insurance benefits (primary and secondary) to South Florida Rehabilitation Consultants, Inc. to be reimbursed directly for therapy services (including evaluation and treatment) provided to me.

**FINANCIAL RESPONSIBILITY:** I understand that I am ultimately responsible for payment of services rendered by South Florida Rehabilitation Consultants, Inc. I shall pay any remaining balances billed by South Florida Rehabilitation Consultants, Inc., and not covered by insurance.

**RELEASE OF INFORMATION:** I hereby authorize South Florida Rehabilitation Consultants, Inc., to obtain information from my insurance company, place of employment and /or Physician in regards to this claim. This authorization shall remain in effect for 5 years or until this claim is paid in full.

**TREATMENT EVALUATION POST DISCHARGE:** South Florida Rehabilitation Consultants, Inc. evaluates the effectiveness of the treatment provided on an ongoing basis and we like to provide follow up to our patients according to their diagnosis. We may contact you in the future to assess how well you are doing after your discharge from our program. I hereby authorize South Florida Rehabilitation Consultants, Inc. to contact me for the above mentioned purposes by telephone or by mail.

**EMERGENCY CARE:** I hereby authorize South Florida Rehabilitation Consultants, inc. to provide emergency care and contact appropriate persons/Emergency agencies. I understand I am responsible for any costs which may arise in the provision of those services.

I fully understand the foregoing paragraphs and I am in agreement.

Patient's Signature:_____ Date:_____

Legal Representative:_____ Date:_____

I have read the Notice of Privacy Practices / He leido Aviso de Practicas de Privacidad

| _____ | _____ | _____ |
|---|---|---|
| Print Name | Patient Signature | Date |