

Today's Date: _____**Patient's Name:** _____ **Date of Birth:** _____Social Security #: _____ Single Married Divorced Widow Sex: M FEmployment Status: Employed Full Time Student Part Time Student Preferred Language: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Alt. Phone: _____

Email Address: _____

We are working to improve communication with our valued patients and occasionally send out newsletters with helpful health related articles. We are implementing a new monthly newsletter to improve communication with our valued patients. We'll also keep you informed about new services and upcoming events & programs in our office, any changes to our office hours, and new additions to our team.

Occupation: _____ Employer: _____

Employer Address: _____ City: _____ Zip Code: _____

Employer Phone: _____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Primary Insurance Name: _____

I.D. #: _____ Group #: _____

Primary Insured Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to Insured: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Alt. Phone: _____

Secondary Insurance Name: _____

I.D. #: _____ Group #: _____

Primary Insured Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to Insured: _____

Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Alt. Phone: _____

Patient Last Name: _____**Primary Doctor's Name:** _____ **Phone:** _____**Address:** _____ **City:** _____ **Zip Code:** _____**Date of Last Visit:** _____

CONSENT TO TREAT: (1) I authorize the doctor to take x-rays, or any other diagnostic aids deemed appropriate to make a thorough diagnosis. (2) I authorized the doctor to perform all recommended treatment mutually agreed upon. I also agree the use of appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. (3) I understand that all responsibility for payment for medical services provided in this office for myself or my dependents is mine. I understand that payment is due and payable at the time services are rendered unless other arrangements have been made. (4) I understand that it is my responsibility to advise your office of any changes in the information contained in this form.

INITIAL HERE: _____

TREATMENT OF MINORS: I, as parent/guardian of a minor receiving treatment hereunder, do hereby agree and understand that I have been advised to remain on the premises during any such treatment, and waive any claim I may have resulting from failure to do so.

INITIAL HERE: _____

LIABILITY/ WAIVER AND RELEASE: I know and agree that Dr. Rahimi is not responsible for loss or damage to personal valuables. I hereby release, discharge and acquit Dr. Rahimi, it's agents, representatives, affiliates, employees, or of and from any and all liability, claim, demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and/or medical services, including but not limited to ambulance service, EMT or Physician services.

INITIAL HERE: _____

AUTHORIZATION OF PAYMENT: Payment is requested at the time of your appointment. I hereby assign all benefits directly to Dr. Rahimi and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the services I receive I will be financially responsible for payment. For patients without health insurance, we require payment at the time of your appointment. If you need to make financial arrangements, please let us know. Patients that have an outstanding balance after 90 days will be considered delinquent and will be referred to a collection agency. Collection fees will be added to any patient balance that is referred to a collection agency. Those patients referred to a collection agency will only receive services on a cash basis and payment is due before services are rendered.

INITIAL HERE: _____

INSURANCE: As a service to you, we will file insurance claims for each of your policies. You will need to provide the clinic with all necessary insurance information. Please bring your insurance cards to every visit. Please note, your insurance

Patient Last Name: _____

policy is an agreement between you and your insurance company to pay certain amounts for your medical care. Your physician's bill is an agreement between you and Dr. Rahimi. You are responsible for full payment of your account, regardless of the status of your insurance claim.

INITIAL HERE: _____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS: Starting with services rendered on January 1, 2013, coverage by Medicare will be limited for outpatient physical therapy (PT) and speech-language pathology (SLP) services combined. The combined limits are \$1900 per year. Medicare pays up to 80% of the limits. A law called the Balanced Budget Act of 1997 put these financial limits for therapy services in place. These limits were in effect for 1999, but not in 2000 through 2005 because Congress passed other laws to put a "hold" on the limits. This will further be evaluated by your Physician and Physical Therapist. If you reach the 2013 limits, you may receive more therapy services from a hospital outpatient department. The limits will not apply to these services, but you will have to pay the 20% co-payment. You should expect some delays in service should you choose this route.

I hereby certify that I have read and understand the therapy limits and warrant that: **PLEASE INITIAL ONE BELOW**

I have not received physical therapy or speech-language pathology during the current year.

INITIAL HERE: _____

I have received some of these services from another provider during the current year.

INITIAL HERE: _____**And I therefore elect to:**

Receive the therapy from this provider and accept the responsibility for the payment in excess of the Medicare limits.

INITIAL HERE: _____

Receive only covered services from this provider.

INITIAL HERE: _____

I certify that all of the information provided herein is true and correct. By signing below, I acknowledge that I have read and understand the above policies and I give my consent to the terms discussed therein. I authorize the use of this signature on all insurance submissions.

Patient Signature_____
Date_____
Witness Signature_____
Date