HEALTHY CORE
WELLNESS & REHAB, LTD.
Specialized Physical Therapy

Patient Information

Name: _____ DOB: _____ Marital Status: S M D W

Address: _____ City, State, ZIP: _____

Phone Number: (cell) _____ (home) _____
(Please place an asterisk(*) next to the best # to call and/or leave a message)

Email Address: _____ (for appointment reminders and monthly newsletters)

Emergency Contact's Name: _____ Phone: _____ Relationship: _____

DIRECT ACCESS to Physical Therapy in Ohio

We are required by Ohio law, upon your consent, to notify your Primary Care Provider or Physician of Record regarding the initial evaluation and treatment within 5 business days. Please check one to indicate your preference.

I **WANT** my physician of record notified: _____ I **DO NOT** want my physician of record/provider notified: _____

Name: _____

Address: _____

Phone Number : _____ Fax: _____

*Please notify us if you would like to add more providers.

Request for Reimbursement

Please check if you would like a Superbill to submit for reimbursement: _____

Other Pertinent Information

- HIPAA: Healthy Core's Privacy Policy has been made available to me.
- H.C.W.R. can discuss my account or care with the following individual: _____
- I give my consent for treatment, authorize the release of necessary information to my physician or healthcare provider.
- I understand services are considered out-of-network and I agree to pay the fee for service at the time of the visit.
- **I understand that I am financially responsible for any and all charges incurred, and reimbursement by my insurance company is not guaranteed**.
- I understand that my medical record is the property of the practice and a copy is available to me, upon my request, for a fee in accordance with Ohio law.
- I understand that this is a teaching environment and that occasionally a student may observe or participate in my care.
- I understand that the practitioner reserves the right to discharge me from care for failure to meet the obligations under this agreement or due to lack of compliance or progress.

Patient/Guardian Signature: _____ **Date:** _____

1330 Corporate Drive, Suite 500, Hudson, Ohio 44236