HEALTHY CORE
WELLNESS & REHAB, LTD.

Patient Information

Name:_____ Date of Birth: _____ Marital Status (circle one): 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 law, upon your consent, to notify your Primary Care Provider or Physician or Record regarding the initial evaluation and treatment within 5 business days. Please check one to indicate your preference.

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

Name: _____

Address: _____

Phone Number: _____ Fax: _____

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

Insurance Information (if applicable)

Primary Insurance Name: _____ Policyholder's Name (if other that patient): _____

Policyholder's Date of Birth: _____ Policyholder's Home Address: _____

Policyholder's Phone: _____ Relationship to Patient: _____

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 insurance carriers & appropriate personnel, and request that my insurance carriers pay H.C.W.R. directly, if applicable.
- If my insurance carrier is not in contract with H.C.W.R., 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.

***For Medicare patients only*:**

- Have you had any Physical or Speech Therapy this year? **YES NO**
  If yes, how many visits of PT and ST combined? _____
- Are you receiving Home Health Services of any kind at this time? **YES NO**
  If yes, please inform the front office staff at this time as outpatient services cannot coincide with home care.

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