STARS
REHAB

PATIENT INFORMATION

Last Name: _____First Name: _____M.I: ____Birth Date: _____
Street Address: _____ Apt #_____
City: _____State: __Zip Code: _____
Home Phone: _____Cell: _____Work Phone: _____
Email Address: _____Social Security #: _____Gender: Male Female

I authorize this organization to leave a message on my voice-mail. Yes [ ] No [ ] Home [ ] Cell [ ]

Marital Status: Married Single Divorced Widowed
Student: Not a student Full-time student Part-Time Student

Employer Name: _____
Employer Address: _____

EMERGENCY CONTACT

Name: _____Relation: _____
Home Phone: _____Cell:_____Work:_____

I authorize this organization to discuss my condition with the person/s listed. Yes [ ] No [ ]

INSURANCE
GUARANTOR/RESPONSIBLE PARTY
Last Name: _____First Name: _MI:_ Date of Birth: _____Social
Security: _____Telephone: _____

PRIMARY INSURANCE NAME: _____Effective Date: _____
Address: _____
Subscriber Number: _____Group Number: _____
SECONDARY INSURANCE NAME _____Effective Date: _____
Address: _____
Subscriber Number: _____Group Number: _____

HOW DID YOU HEAR ABOUT US
[ ] Physician [ ] Friend/Relative [ ] Google [ ] Former Patient [ ] Social Media [
] Shores Observer [ ] Beaches Observer [ ] Event _____
[ ] Other_____

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FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, Consent to treat, Notice of Privacy Practices, and Certification of Information which we require you to read and sign prior to starting treatment.

ALL PATIENTS MUST COMPLETE OUR INFORMATION AND INSURANCE FORM BEFORE STARTING TREAMENT

We have contracts with most commonly used insurance companies. Please check to see if we accept your insurance. Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If we bill your insurance company and they have not paid your account in full within 60 days, the balance will be billed directly to you. Any subsequent visits must be paid in full at the time the services are rendered. Please be aware that some insurance companies, including Medicare, may determine treatment to be non-covered or find it not to be reasonable or necessary. If such a determination is made, you will be responsible for such services. Such services will be billed, and payment is due upon receipt of bill.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER

All co-pays and deductibles are due at the time of treatment. If there are any additional procedures performed, they may be subject to an additional Co-Payment, Deductible or Co-Insurance. Please refer to your Health Care Plan for additional information. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of what constitutes a usual and customary rate.

MINOR PATIENTS

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

CANCELLATION/NO-SHOW POLICY

A "no-show" is missing a scheduled appointment. A "late-cancellation" is canceling an appointment less than 1 business day prior to the scheduled appointment. A charge up to $25.00 will be assessed for each no show or late cancellation. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of healthcare to other patients needing care.

CO-PAY AND BALANCES

Co-pays are due at the time of service. You will also be asked to pay any outstanding patient balance. We will charge a $25.00 late fee for every 30 days your account goes unpaid.

INSUFFICIENT FUND FEE

Checks that are returned will be charged a $25.00 insufficient funds fee.

COLLECTIONS FEE

Unpaid balances may be turned over to an outside collection agency. In the event your account is turned over for collections, you as the patient will be responsible for a 30% collection fee associated with collecting the balance.

CONSENT TO TREAT

I consent to the procedures which may be performed during my treatment and care at SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC, (STARS REHAB) including emergency treatment or services. These may include, but are not limited to, any and all testing and measurements necessary for my evaluation, and any and all therapeutic procedures (exercise, joint mobilization, manual stretching, etc.) necessary for my treatment and under the direction and supervision of my therapist. I understand that it is my right and responsibility to question freely any treatment, and in no way am I being guaranteed a certain result from the procedures rendered. That being noted it is the responsibility of your therapist at ST.A.R.S. to practice with the most current and reasonable experiential and evidence-based methods.

NOTICE OF PRIVACY PRACTICES (HIPAA ACKNOWLEDGEMENT/CONSENT)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Saint Augustine Rehabilitation Specialists LLC. In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

CERTIFICATION OF INFORMATION

I certify that the information I have provided Saint Augustine Rehabilitation Specialists, LLC for payment including, but not limited to, related accidents, illnesses or other insurance information is accurate and truthful.

_____ _____

Signature of patient or responsible party Date

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Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, billing statements, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice, knowing this type of communication is not encrypted at time.

_____(Patient Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information, and statements is

_____

The email that I authorize to receive email messages for appointment reminders, general health feedback, and reminders/information, and statements is

_____

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

_____I hereby revoke my request for future communications via email and/or text messages.

_____I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

_____I hereby revoke my request to receive any future billing statement reminders via email or text.

Note: This revocation only applies to communications from this Practice.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Date _____Patient Name _____

Patient/Patient Representative Signature _____

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AUTHORIZATION FOR CREDIT CARD UTILIZATION

AUTHORIZATION

Until further notice, I authorize SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC, (STARS REHAB) to charge my patient responsibility balance on my account to the following credit card:

CIRCLE ONE: Visa MasterCard Discover American Express

Last Four Digits of Credit Card Number: _____ Expiration. Date (mm/yy):_____ CVV: _____

Per insurance contractual obligations, a patient's copay, co-insurance, deductible is due at the time of service. All self-pay balances are due at the time of service. If I do not pay my patient responsibility or self-pay balance at the office at the time of my appointment, I understand my credit card will be charged immediately.

I understand that once the health plan has paid their portion for my care, I will receive an Explanation of Benefits (EOB) from them. The health plan's EOB will state any remaining balance to be paid by me. I expect to receive a statement with my balance due. I understand that I have 30 days to pay the statement or communicate with SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC, (STARS REHAB) regarding any discrepancies discovered or to set up a payment plan. I understand that my statement may include "No Show" fees, non-covered services fees or supply fees not paid at the time of service or by my insurance. I was advised, prior to receiving a non-covered service, that I would be responsible for payment, in full, for certain services that are considered non-covered by my insurance. In some case I might be requested to sign a financial liability form prior to non-covered services being rendered.

If no payment is received or arrangements made, SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC, (STARS REHAB) will automatically charge the card on file after 30 days for the statement balance.

NOTE: SAINT AUGUSTINE REHABILITATION SPECIALISTS LLC, (STARS REHAB) has attested that its credit card system is registered with Visa, MasterCard, Discover and American Express and independently certified as a PCI-DSS Level One Service Provider.

Patient's Printed Name: _____

Patient's Signature: _____ Date: _____

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Photography Release Form

I hereby give Saint Augustine Rehabilitation Specialists, LLC the absolute and irrevocable right to take and permission to use photographs and/or video and/or audio of me, or in which I may be included with others.

- To copyright the same in said organization's own name or any name that they may choose, and/or
- To use/re-use, publish and republish the same in whole or in parts, individually or in conjunction with other photographs, in any medium and for the purpose of medical information of the public, medical staff of clinic employees, including (but not by the way of limitation) illustration, promotion, and advertising (STARS website, social media outlets such as Facebook, Instagram, Snap Chat) and trade.

By signing this form, the patient affirms in understanding that the images may be used for different purposes indicated hereunder.

By consenting to the release of images, you agree that you will not receive any form of compensation in cash.

Your refusal to consent to the release of your photographs will not, in any way affect the medical care you will receive.

You may rescind your authorization to the release of the photographs at any time.

I hereby release and discharge Saint Augustine Rehabilitation Specialists, LLC from any and all claims and demands arising out or in conjunction with the use of photographs, including but not limited to any and all claims of libel, invasion of privacy, etc.

☐ CONSENT ☐ I DO **NOT** CONSENT

_____ _____

Patient/Guardian Signature **Date**

STARS REHAB

Medical History

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High/Low blood pressure	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

- ☐ Injury as a result of a fall in the past year?
- ☐ Two or more falls in the last year?

Surgical History

Body Region:_____ Surgery Type:_____ Date:_____,_____, _____

Body Region:_____ Surgery Type:_____ Date:_____,_____, _____

Body Region:_____ Surgery Type:_____ Date:_____,_____, _____

Body Region:_____ Surgery Type:_____ Date:_____,_____, _____

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Medication List

Medication/Drug or Supplement Name	Prescription		Dosage	Frequency Per Day				Route of Administration				
	Yes	No		1	2	3	4	Oral	IV	Injection	Patch	Other

Therapist Reviewed _____ Date _____

Patient Name: _____ DOB: / /
Medical History