Long Prairie Rehabilitation

CARING AND EFFICIENT SERVICE WITH RESULTS

NEW PATIENT ENROLLMENT FORM

ACCOUNT # ________________

FIRST NAME__________________ MIDDLE INITIAL ____ LAST NAME _______________________ M___F___

ADDRESS ____________________________ APT # ______ CITY _______________ STATE _____ ZIP _________

HOME PHONE __________________ WORK PHONE __________________ CELL PHONE __________________

MARITAL STATUS: SINGLE _________ MARRIED _________ DIVORCED _________ WIDOWED __________

DRIVER LICENSE # _______________________ SSN ____________________ DATE OF BIRTH ______________

EMPLOYER _____________________________________ OCCUPATION __________________________________

EMPLOYER'S ADDRESS ____

REFERRING DOCTOR ____

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY ________________________________SELF____ SPOUSE____ PARENT____OTHER____

ADDRESS (if different from patient's) ____

HOME PHONE __________________ WORK PHONE __________________ CELL PHONE __________________

DRIVER LICENSE # _______________________ SSN ____________________ DATE OF BIRTH ______________

EMPLOYER ____________________________________ OCCUPATION ___________________________________

EMPLOYER'S ADDRESS ____

WORKERS' COMPENSATION INFORMATION

EMPLOYER ____ DATE OF INJURY ______________________

EMPLOYER'S ADDRESS ____

EMPLOYER'S PHONE ______________________ INSURANCE COMPANY _______________________________

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________________________ EFFECTIVE DATE __________________

INSURANCE PHONE # ___________________________ POLICY # _______________ GROUP # _______________

POLICYHOLDER'S NAME ___________________________ SSN ______________ DATE OF BIRTH ___________

RELATIONSHIP TO PATIENT: SELF_____ SPOUSE_____ PARENT_____ OTHER___________________________

SECONDARY INSURANCE INFORMATION

INSURANCE COMPANY ______________________________________ EFFECTIVE DATE __________________

INSURANCE PHONE # ___________________________ POLICY # _______________ GROUP # _______________

POLICYHOLDER'S NAME ___________________________ SSN ______________ DATE OF BIRTH ___________

RELATIONSHIP TO PATIENT: SELF_____ SPOUSE_____ PARENT_____ OTHER___________________________

ATTORNEY NAME (If applicable) ____ PHONE _____________________

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU ____

RELATIONSHIP ____ PHONE __________________________________

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HIPAA Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Long Prairie Rehabilitation, Inc. (LPRI) for the purpose of providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of LPRI. I understand that treatment of me by HPPS may be conditioned upon my consent, as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. LPRI is not required to agree to the restrictions that I may request. However, if LPRI agrees to a restriction that I request, the restriction is binding on LPRI.

I have the right to revoke this consent, in writing, at any time, except to the extent that LPRI has taken action in reliance upon this consent.

My protected health information includes my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review the HIPAA Notice of Privacy Practices prior to signing this document. The HIPAA Notice of Privacy Practices is available to me in its entirety on the LPRI website. The HIPAA Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of LPRI. The HIPAA Notice of Privacy Practices for LPRI may also be provided to me for my reference in the event that I do not have internet access. This HIPAA Notice of Privacy Practices also describes my rights and the LPRI duties with respect to my protected health information. LPRI reserves the right to change the privacy practices that are described in the HIPAA Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy to be sent in the mail or by asking for one at the time of my next appointment.

- Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnosis: ____
  ____
- May our office contact you at home with calls concerning appointments, testing results, or any other healthcare information? Yes ____ No ____
- Can confidential messages (i.e. appointment reminders) be left on your home answering machine or voicemail? Yes ____ No ____
- On you work machine or voicemail? Yes ____ No ____

I understand that I am responsible for all charges, whether covered or not by my insurance company.

_______________________________________ _______________________________________

Signature of Patient or Personal Representative Date

_______________________________________ _______________________________________

Name of Patient or Personal Representative Description of Personal Representative's Authority

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Patient Name: ______________________, _________________ _________________ Admit #: ___________________
(Last) (First) (Middle)

CONSENT TO TREATMENT

I hereby authorize Long Prairie Rehabilitation, Inc. (LPRI) to carry out all procedures as ordered by my physician on my plan of treatment. I understand that this plan of treatment will be discussed with me in detail. I also understand that my continued attendance for all scheduled appointments indicates my continued consent to treatment.

RELEASE OF RECORDS

I hereby authorize LPRI to release a copy, facsimile, or electronically encoded data of all records and information related to my care, including records of any examinations and/or treatments rendered to me, to be reviewed by authorized representatives of my third party payor(s), physicians, regulatory and accreditation agencies, or other health care providers. I authorize the review of my records for any agency audit of LPRI and the release of a copy of my physician plan of treatment and discharge summary from my medical record upon my transfer to or from another healthcare facility. I authorize LPRI to leave phone messages for me at my home as outlined in the HIPAA Notice of Privacy Form that I have concurrently completed. I certify that this authorization has been made voluntarily. I understand that I may revoke this authorization at any time.

ACKNOWLEDGEMENT AND AGREEMENT

I understand that the first visit is an evaluation visit to determine eligibility for skilled professional services based upon admission criteria and does not obligate LPRI to admit me to service.

ASSIGNMENT OF BENEFITS

In consideration of services rendered, or to be rendered, I hereby irrevocably assign and transfer to LPRI all right, title and interest in all benefits payable for services and/or supplies rendered, and in all causes of action against any party or entity that may be responsible for payment of benefits. I understand that it is the policy of LPRI to bill only one (1) payor on my behalf, but that LPRI may use its discretion and elect to bill other payors at any time. I agree to fulfill all policy provisions and conditions required for payment of benefits by any insurance company or plan. I understand that, regardless of my assigned benefits, I am fully responsible for the total charges, to the extent allowed by law, and that payment is due upon request. I agree that, if any payments result in a credit balance, the same shall be applied to any outstanding accounts due LPRI.

FINANCIAL AUTHORIZATION

I acknowledge that I will be informed of the charges that will be incurred for services and supplies rendered and the LPRI policy regarding payment. I understand that a detailed bill, including all service and supply charges, is available upon request. I certify that the information given by me in applying and authorizing payment for services is correct. I agree to pay all charges incurred that are not otherwise covered by third party payment, as allowed by law. I understand that this financial authorization covers only this admission for service. I understand that rates are subject to change and that I will receive prior notice of any rate changes. I understand that supervision of services is included in the charge.

STATEMENT OF NON-DISCRIMINATION

Long Prairie Rehabilitation, Inc. does not discriminate on the basis of race, color, national origin, disability, or access to treatment.

By my signature below, I agree to all of the above.

Signature of patient or legal representative: ____ Date: ________________

Printed name: ____ Staff Member Name: ______________________________________

Date: ____

3301 Long Prairie Rd., Suite 125, Flower Mound, Texas 75022 Phone: (972) 874-7171 Fax: (972) 874-7110