Bethlehem Rehabilitation Specialists
PATIENT INTAKE AND CONSENT FORM

☐ **new changes**
Date:__________

First Name___________________________________ Last Name ______________________________________MI____

Street Address_______________________________________City________________________State_____Zip________

Home #____________________________ Cell #______________________________ Work#__________________________

Date of Birth ______/_______/_______ Social Security #________-_______-______ Sex: ◯Male ◯Female

Marital Status: ◯Single ◯Married ◯Divorced ◯Widowed

Email Address____

Emergency Contact____ Phone#________________________________

Referring Physician____ Phone#________________________________

Primary Care Physician____ Phone#________________________________

Attorney involved:____Phone:_________________________

Please Initial

Authorization of Payment: I hereby assign all benefits directly to Bethlehem Rehabilitations Specialists 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 any balance that remains outstanding for more than 15 days, I understand I may be charged a monthly service charge of 1.5%. ________

Waiver and Release: I hereby release, discharge, and acquit Bethlehem Rehabilitation Specialists, it's agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim, demand, damage, cause of action, 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, Emergency Medical Technician, physician or urgent care services. ________

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

Consent to Treatment: I consent to rehabilitation and related services at Bethlehem Rehabilitation Specialists. In doing so, I understand, acknowledge and affirm that such rehab and related services may involve bodily contact, touching, and/or direct contact of a sensitive nature. ________

Supply Charge: I am aware that insurance companies do not cover or reimburse Bethlehem Rehabilitation Specialists for incidental medical supplies used during my physical therapy. I understand there is a fee for these products, which may include: suture/staple removal kits, electrodes, splints and exercise equipment such as Therabands. ________

I certify that all the above information provided herein is true and correct. I hereby, authorize and instruct my insurance carrier to pay Bethlehem Rehabilitations Specialists directly for any physical therapy services performed. Additionally, I understand that I am financially responsible for payment of all co-pays, deductibles and balances not covered by my insurance carrier, provided my specific plan does normally pay for the services and/or products rendered to me by the medical providers at this facility. If I cancel or do not show for an appointment within 24 hours of the appointment date, I understand that I may be charged a $15 fee. In the event an outstanding balance is referred to an attorney for collection, I will be responsible for all costs of collection to include but not limited to, litigation expenses, court costs, service of process fees and attorney's fees not to exceed 20% of the outstanding balance.

Patient Signature	**Date**	**Therapist Signature**	**Date**