

# Bethlehem Rehabilitation Specialists PATIENT INTAKE AND CONSENT FORM

<input type="checkbox"/> new <b>changes</b> <b>Date:</b> _____
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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:** \_\_\_\_\_

**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:** If applicable, 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