WELLSPAN®
Rehabilitation

New Patient Registration Information

WELLSPAN®
Rehabilitation

ADAMS COUNTY LOCATIONS

Adams Health Center . . . . . (717) 339-2620
Aspers Health Center . . . . . (717) 339-2580
Deatrick Commons . . . . . (717) 339-2540
Fairfield Town Center . . . . . (717) 642-6067
Herr's Ridge . . . . . (717) 337-4206

YORK COUNTY LOCATIONS

Apple Hill . . . . . (717) 741-8240
Bannister Street . . . . . (717) 812-5850
Queensgate Towne Center . . . . (717) 812-5800
Shrewsbury . . . . . (717) 812-5600
SPORT Center Hanover . . . . . (717) 632-3431
Wheatlyn . . . . . (717) 812-7400
York Hospital Pediatrics . . . . . (717) 851-2601

Welcome! Thank you for choosing WellSpan Rehabilitation for your therapy needs. We have a team of dedicated therapists who make high quality, personalized care a top priority.

There are several forms you will need to complete prior to your initial evaluation with the therapist. **Please assist us in our efforts to serve you efficiently by arriving 20 minutes before your scheduled appointment to allow for completion of these forms.** In addition, this provides our administrative staff the needed time to prepare your chart. **These steps will ensure that your therapist has more time to spend with you.**

1. Medical History ~ Please complete the medical history form thoroughly. If the question does not apply to you, fill in 'N/A'. The therapist will review this form with you, but to guarantee a comprehensive view of your overall health, we need all of this information to guide us in your plan of care.

2. WellSpan Rehabilitation Outpatient Services Consent & Authorization Form ~ Please read, sign, and date this form. If the patient is a minor, the parent or legal guardian authorizing consent must sign.

For your benefit and convenience, we also provide the following toll-free number to complete your registration in advance of your initial rehabilitation appointment. Please call **1.877.734.2213** and a call center representative will be happy to assist you. It is advised that you have insurance information available when you call. You may also pre-register for your appointment at **www.wellspan.org**.

REHAB NO SHOW/CANCELLATION POLICY

We strive to deliver the best possible outcome for all of our therapy patients. In order for you to feel better as quickly as possible, your attendance and follow through must be consistent and regular. If you are unable to keep a scheduled appointment, we ask that you contact us at least 24 hours prior to your appointment. Please note, it is our policy that if you miss three consecutive appointments without notice, you will be discharged. In order to return to therapy, you must obtain a new referral from your doctor.

INACTIVE ACCOUNTS

If your account is inactive for two weeks or more, it will be considered for discharge. To avoid discharge, it is important that you communicate with your therapist if there is a necessary lapse in your treatment.

BILLING AND INSURANCE INFORMATION

We present the following insurance and billing information to make you aware of your financial responsibilities as a patient. Please review carefully.

INSURANCE

- If your insurance plan requires you to have a referral from your primary care physician and this is not secured, you may be responsible for services provided until one is obtained.

- We do participate with many insurance companies. Please ask if you are unsure if we participate with yours.

    1. Certain services may not be covered depending on your particular plan of care. You need to contact your insurance company with any questions about what they will cover.
    2. If you have been advised of a noncovered service and you choose to proceed with treatment, you will be asked to sign a waiver indicating you are financially responsible.

- If your visit is related to workers compensation or automobile insurance, and you *do not* have health insurance coverage, you will be asked to sign a waiver agreeing to pay the balance of charges for all services provided by WellSpan Rehabilitation that are not paid by Workers Comp or Auto Insurance.

- If you do have health insurance coverage you are required to provide this information to our front office staff. This is necessary for several reasons:

    1. If benefits expire on the workers comp or auto claim, balances may then be submitted to your health insurance for consideration.
    2. If you choose to withhold your regular health insurance information, you will be asked to sign a waiver and assume responsibility for balances incurred.
    3. In addition, providing us this information will allow authorizations to be obtained and in place, if necessary, for proper benefit coverage.

- You are responsible to let us know of any insurance changes immediately. We cannot be responsible for costs you may incur due to a change in benefits, particularly if we are not aware of the change.

BILLING

- Billing for WellSpan Rehabilitation is done through Wellspan Health. They will send a bill to your insurance company for all services provided in our offices. Please note …

    1. If a patient balance (copayment or deductible) remains after your insurance processes the claim, you will be billed. Statements will be sent on a monthly basis. Payment of your bill is expected upon receipt.
    2. Any bill not paid by the due date will be forwarded for collection proceedings.
    3. If you need assistance or are having financial difficulty, we urge you to contact a Customer Service Representative who can advise you. They may be reached at **1-800-842-1783**.

WELLSPAN®
Rehabilitation

MEDICAL HISTORY

Name: _____ DOB: _____
Phone: (Home)_____ (Work) _____ (Cell) _____
Preferred DAYTIME contact # _____ Next appointment with referring doctor _____

ARE YOU CURRENTLY RECEIVING HOME HEALTHCARE? Y or N List Agency _____

PREVIOUS THERAPY: Please check which applies to you.
( ) I have NOT had previous outpatient physical/occupational therapy for ANY condition this year.
( ) I HAVE had previous outpatient physical/occupational therapy for ANY condition this year.

ALLERGIES _____

REACTIONS TO MEDICINE _____

PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING: _____
_____

Do you have a pacemaker, defibrillator, or any other similar implant? Y or N

Date of Injury _____ If none specific, please provide the date you saw the doctor and were referred for treatment _____

Physician(s) following you for this problem (please provide name and phone number)
Dr. _____ Phone _____
Dr. _____ Phone _____

How did your injury occur? Accident at work _____ Accident at home _____ Sports injury _____
Car Accident _____ Unknown injury _____ Other _____(*specify)*_____

What medical tests have you had related to this condition? (please check)
X-rays _____ Bone Scans _____ MRI _____ CAT scan _____ None _____

Please list any previous injuries and/or surgeries: _____
_____

What is your occupation? _____ Currently working? Y or N
If so, list any work restrictions:_____

Are you on disability in relation to this problem? Y or N

Medical Illness History: Please circle all those that apply.

thyroid disease pancreatitis diabetes seizures emphysema stroke blood clot anemia ulcers arthritis
hepatitis hearing loss chest pain hiatal hernia heart problems tuberculosis asthma cancer blood pressure
depression prostate problems kidney stones current pregnancy head trauma/concussion migraine headaches
epilepsy/seizures/convulsions fracture joint dislocation osteoporosis back/neck injuries circulatory problems

*Do we have your permission to leave a message on your answering machine? Y or N

*__Other than physicians__ involved in your care, is there anyone else we can speak with regarding your treatment? Y or N
*Please list_____

Patient signature _____ **Date** _____

WELLSPAN REHABILITATION – OUTPATIENT SERVICES

CONSENT & AUTHORIZATION FORM
TREATMENT, PAYMENT & BUSINESS OPERATIONS

Consent for Medical Treatment: I hereby consent and authorize Wellspan Rehabilitation – Outpatient Services, its agents, and employees, to the administration of medical care, including, but not limited to, routine diagnostic tests/procedures and such medical treatment as considered to be necessary by the ordering/attending physician, and/or his/her designee. I further understand that the physicians furnishing the services may be independent contractors who have been granted privileges or may be employees or agents of Wellspan Rehabilitation – Outpatient Services. Wellspan Rehabilitation – Outpatient Services cannot be held responsible for the acts of physicians who are independent contractors of the Wellspan Rehabilitation – Outpatient Services. I understand and have no objection to physicians in training or other hospital approved persons assisting in or observing my treatment when the purpose is to advance medical education.

Medicare Authorization: "Patients Certification Authorization to Release Information and Payment Request": I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Medical Assistance Recipient Statement: I certify that the information is true, correct and accurate. I understand that payment and satisfaction of this claim will be from Federal and State funds that any false claims, statements or documents or concealment of material facts may be prosecuted under applicable Federal and State laws.

Financial Agreement: The undersigned, in consideration of the services to be rendered to the patient, is obligated to pay Wellspan Rehabilitation – Outpatient Services in accordance with it's regular rates and terms and, if the account is referred to an attorney or agency for collection, to pay reasonable attorney's fees, collection expenses, court costs and other necessary and appropriate expenses incurred in collecting for services. The undersigned agrees to be responsible for charges not covered by insurance. It is understood that the obligation to pay Wellspan Rehabilitation – Outpatient Services may not be deferred for any reason, including legal actions against other parties to recover medical costs, and I consent to the release of information required for billing and collecting from third party payers".

Assignment of Benefits: I hereby assign to Wellspan Rehabilitation – Outpatient Services all medical and insurance benefits payable to me under the health insurance carrier(s). I understand that I am financially responsible for the charges not covered by this assignment.

My signature represents my acknowledgement of reading and understanding the statements. I have carefully read and understand this consent, authorization, and financial agreement, and accept the terms as initialed.

Signature of Person Authorized to Consent

Relationship to Patient

Date

Witness