Texas United Rehab Therapy Specialists

Admission Packet

Date: _____

Date of Birth: _____ Sex: ▢ Male ▢ Female

Last name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Referring Physician: _____

Date Last seen by MD: _____ Next follow up appt: _____

Emergency Contact: _____ Phone: _____

Relationship: _____

Texas United Rehab Therapy Specialists

Consent to Eval and Treatment: I hereby authorize Texas United Rehab Therapy Specialists to evaluate conditions relative to my pain/ injury. I consent to receive rehabilitation therapy treatment and any supplementary services that are deemed medically necessary or appropriate by my therapist and/or treating physician. However, I understand that the practice of rehabilitation therapy is not an exact discipline and I acknowledge that no guarantees have been made to me regarding treatment and/or the treatment results from the rehabilitation therapy.

By signing below, I hereby confirm that I have read and agreed to comply with the Consent of Treatment:

Signature of Patient or Legal Guardian:

_____ **Date: ____/____/_____**

AUTHORIZATION TO RELEASE RECORDS

I authorize Texas United Rehab Therapy Specialists to release evaluations and progress notes to my treating doctor, and to my insurance company.
I authorize Texas United Rehab Therapy Specialists to request and obtain all medical records pertaining to my pain/injury.

Signature of Patient or Legal Guardian:

_____ **Date**: ___/____/_____

Financial Responsibility: I agree to pay my rehabilitation therapy provider ("Provider") all amounts that are due and owing for services rendered by Provider which are not otherwise paid for by Medicare, a third party insurance plan, a third party payor, or other payor source on my behalf. In the event my account is referred to a collection agency or an attorney, I further agree to pay all reasonable costs incurred to collect any amounts that are due and owing for services rendered by Provider including, without limitation reasonable attorney's fees.

By signing below, I hereby confirm that I have read and agreed to comply with the Financial/Privacy Policy Disclaimer:

Signature of Patient or Legal Guardian:

_____ **Date**: ___/____/_____

Texas United Rehab Therapy Specialists

HIPPA PRIVACY POLICY SUMMARY

We have a detailed HIPPA Notice of Privacy Policies which fully explains your rights and our obligations under law. You have the right to receive a copy and one will be provided for you at your request.

By signing below, the patient acknowledges that he/she is aware of the HIPPA Privacy Policy and that he/she understands and will comply with our financial policies.

Signature of Patient or Legal Guardian:

_____ **Date: ___/ ____/ _____**

CONFIDENTIALITY

I understand that Texas United Rehab Therapy Specialists will respect the confidentiality of my records and that he agrees to not release them to any other party than those listed above without the signed consent except in the case of court subpoena or imminent threat of harm to life or property such as a required by state law.

By signing, I agree to the authorizations above, and show consent to all the above:

Signature of Patient or Legal Guardian:

_____ **Date: ____/____/_____**