

Patient Express Registration

Advanced Rehabilitation Clinics, Inc.

Today's Date: _____

1. Personal Info

Please Fill-Out Entire Form Completely & Legibly.

Last Name First Name Age Male Female

Street Address City State ZIP

(_____) (_____) _____
Home Phone Cellular Email Address (Important)

Emergency Contact Person Phone # (if minor) Parent/Guardian Name and Signature

Occupation Employer Name Phone #

● My condition is related to: Work Auto Accident (State _____) Other _____

Social Security # _____ Date of Birth ____/____/____ Single Married

Work Status: Currently Employed: Retired Disabled/Off work (__Total or __Temporary) Student (__P/T __F/T)

2. Referral Info

ALL INFO REQUIRED

How did you hear about us? (Check all that apply)

- Brochure or Sign: (Location?) _____
 ARC Event: (Location?) _____
 Friend or Family: (Name?) _____

LifeStart Wellness:

- I am a Club Member
 Referral: (Name of Trainer?) _____

Online:

- ARC Website
 Facebook
 Insurance Website
 Search Engine
 Physician Referral: (Physician Name)

(Physician Address) _____

(Physician Phone #) _____

- Other: _____

Do you have a follow up appointment with this physician? _____

If yes, when? _____

3. Payment Info

(check only one box)

I am paying by CASH, CHECK, CREDIT and would like a . . .

- 30% discount by paying the entire bill at the time of service. (Ask the front desk person for details)
 Payment plan. Fees may apply.

I have INSURANCE and would like to . . .

- Have you deal directly with them. I will assign my benefits to you by completing the "Assignment of Benefits Form". Fees may apply. The following information is required prior to 1st visit.

My insurance company is _____

My coinsurance/copay is \$ _____

My deductible is \$ _____

I have an ATTORNEY and would like to . . .

- Get a 30% discount by paying up front. I'll get reimbursed after my case settles.

4. Credit Card on File

Safe and Secure. I understand I will be notified of any and all charges prior to processing.

__ Visa __ MC __ AmerX __ Discover Card # _____

Name on Card _____ Exp Date _____ CVV code _____

I attest the information on this form is true and accurate, and do hereby agree and give my consent for Advanced Rehabilitation Clinics, Inc. to provide services to _____ that are considered necessary and proper. I further acknowledge that treatment is being provided to me solely by **Advanced Rehabilitation Clinics, Inc., which is separate from and unaffiliated with the Lifestart Wellness Network. I hereby release the Lifestart Wellness Network and its affiliates, and waive any and all claims against them, arising out of or relating to any act or omission of Advanced Rehabilitation Clinics, Inc, its agents or employees.**

Important Company Policies for a Successful Relationship

We strive to provide you the best personalized care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial all the boxes, and indicate your agreement by signing at the bottom.

Initial
All
Boxes

Late Policy “10-minutes”

Being late by more than 10 minutes will require you to either reschedule or wait for the next available opening. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap because this undeservedly compromises the care of another patient.

24-Hour Advance Notice Fee

If you wish to change or cancel an appointment we require a minimum **24-hour advance notice**. Anything less than 24 hours will result in a \$25 fee charged to your account. It costs us money to make appointments available to you. Whether you attend or not we still accrue the expenses (for staff wages, rent, etc.). We don't charge you the actual cost for that appointment but rather a mere **\$25 fee**. We do NOT make money with this charge; it's only to act as a deterrent from making last minute changes. Advance notice allows someone else (who needs it) time to reserve it in place of you. **Please be courteous and responsible. It is your responsibility to pay this fee prior to your subsequent visit.** Thank you.

Copays are due upon arrival

If you happen to forget your wallet or checkbook we may still be able to see you upon completion of an “Extension Request” form. This is a “promise-to-pay” form and carries a minimal fee that allows you to keep your appointment.

No-shows are bad

If you fail to show for an appointment without notice all future appointments will be removed and a **\$25 fee** assessed to your account. You may re-schedule appointments again on a “first come, first serve basis”.

Children requiring supervision are NOT allowed to attend sessions with you.

Unless your facility offers child care services, you may not bring children who require supervision with you to your appointment. If your child does not require supervision and is capable of waiting for you quietly then you may bring them. If any disturbance is caused to other patients or staff members you may be asked to terminate your session early and attend to your child.

Financial Hardship

If you are experiencing financial difficulties and are unable to afford the cost of our services we have a “Financial Hardship Form” which may be filled-out. If you qualify for financial assistance according to the Federal guidelines, we may legally assist you by waiving or discounting your (patient responsibility) portions of the bill. Ask the front desk person for assistance.

Important Notice from the Federal Government:“It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments . . . even if your doctor allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under Federal Standards, you may NOT routinely evade paying your responsibility portions for medical care as outlined in your insurance plan even if your doctor allows it. You both may be charged for breaking the law. This includes services deemed as “professional courtesy” and “TWIP’s - Take what insurance pays”. Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A(a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202 619-1343, by fax: 202 260-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W., Washington, D.C. 20201, Joel Schaeer, Office of Counsel to the Inspector General, 202 619-0089.”

I have read and agree to all the policies on this form. Signed _____

We look forward to building a successful relationship with you that lasts a lifetime!

