Patient Authorization and Guarantee Form

Release of Protected Health Information ☐ I DO NOT consent.

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, Align Rehabilitation LLC to the physician who referred me for therapy as well as any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Assignment of Insurance Benefits ☐ I DO NOT consent.

I hereby authorize that the payment of authorized benefits be made directly to Align Rehabilitation LLC of any services that are reimbursable by Medicare, Medicaid, or Payor source.

Consent for Treatment ☐ I DO NOT consent.

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist may be considered necessary or advisable while I am a patient of Align Rehabilitation LLC.

Guarantee of Account ☐ I DO NOT consent.

In consideration of services rendered to me by Align Rehabilitation LLC, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation. I understand that the patient responsibility portion of my bill shall be due and payable at time of services.

Notice of Privacy Practices ☐ I DO NOT consent.

I acknowledge that I have been offered a copy of the Notice of Privacy Practices and/or know where to locate the document on the Align Rehabilitation LLC website.

Photo & Video Authorization ☐ I DO NOT consent.

I grant Align Rehabilitation LLC the unlimited right and permission to use my photograph, video footage, actions, and/or testimonial, in any professional manner and in any media for any lawful purpose, including but not limited to, all promotion, marketing, advertising, and publicizing of Align Rehabilitation LLC's services.

Medicare (if applicable) ☐ I DO NOT consent.

I hereby certify that the information given by 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 such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

By signing this document, I acknowledge that I have read the entirety of this document and my signature serves as my consent to all the above, unless indicated by checking the "I DO NOT consent" box.

Signature: _____ **Date:** _____

ALIGN REHABILITATION

Align Rehabilitation - New Patient Packet

Demographics			
Name:		**Date of Birth:**	**Sex:**
Height:	**Weight:**	**Marital Status:**	
Cell Phone:	**Home Phone**	**Email**	
Address:		**State:**	**Zip Code:**

Occupation (Current or Previous): _____

Employment status: ☐ Full-time ☐ Part-Time ☐ Retired ☐ Disabled ☐ Unemployed

Emergency Contact(s)		
Name:	**Relationship**	**Phone:**
Name:	**Relationship**	**Phone:**
May we discuss scheduling/appointments with your emergency contacts, if needed?	☐ **Yes** ☐ **No**	

Past Medical History		
Do you have any of the following medical conditions?		**Comments/Dates:**
High blood pressure / hypertension	☐ Yes ☐ No	**Typical BP?**
Heart attack	☐ Yes ☐ No	
Pacemaker, implantable cardiac defibrillator, etc.	☐ Yes ☐ No	
Heart disease or heart failure	☐ Yes ☐ No	
Anemia	☐ Yes ☐ No	
Diabetes (high blood sugar)	☐ Yes ☐ No	
Hypoglycemia (low blood sugar)	☐ Yes ☐ No	
Kidney Disease / Renal Failure	☐ Yes ☐ No	
Arthritis (e.g., osteoarthritis, rheumatoid arthritis)	☐ Yes ☐ No	
Osteoporosis or history of bone fractures	☐ Yes ☐ No	
Musculoskeletal problems (explain)	☐ Yes ☐ No	
Pulmonary Conditions (e.g., COPD, asthma, emphysema)	☐ Yes ☐ No	
Depression	☐ Yes ☐ No	
Neurologic Conditions (e.g., Parkinson disease, stroke, TBI)	☐ Yes ☐ No	
Neuropathy	☐ Yes ☐ No	
Seizures or epilepsy	☐ Yes ☐ No	
Cancer	☐ Yes ☐ No	
Thyroid problems	☐ Yes ☐ No	
Bowel or Bladder Issues	☐ Yes ☐ No	
Wounds/ulcers/skin diseases	☐ Yes ☐ No	
Infectious disease (e.g., tuberculosis, hepatitis, COVID19)	☐ Yes ☐ No	
Allergies (seasonal or other)	☐ Yes ☐ No	
Other:		

Past Surgical History	
Procedure	Date / Comments
1.	
2.	
3.	
4.	

Medications *(Please attach a copy of your medication list)*			
Name	Dose	Frequency	Route of Administration (e.g., oral)
1.			
2.			
3.			
4.			

Home Environment	
Who do you live with? ☐ Alone ☐ Spouse ☐ Children ☐ Parents ☐ Other: _____	
☐ single-story ☐ multi-Story	# Stairs:
Do you use any of the following devices? ☐ Cane ☐ Walker ☐ Crutches ☐ Wheelchair ☐ Scooter. ☐ Rollator ☐ Shower chair ☐ Bedside commode ☐Hospital bed ☐ Ramp ☐ Other: _____	

Insurance Information		
Responsible Party: Self ☐ *(only complete below if OTHER than self)*		
Name:	**DOB:**	**Relationship to patient:**
Phone:	**Address**: Same ☐	
DO YOU HAVE MEDICARE? Yes ☐ **No** ☐		
PRIMARY INSURANCE		
Name of Insurance:		
Member ID:	Group #:	
SECONDARY INSURANCE ☐ N/A		
Name of Insurance:		
Member ID:	Group #:	

Referral Information	
Primary Care Doctor:	
Phone:	Practice Name:
Surgeon:	
Phone:	Practice Name:

My signature confirms that the information provided on pages 2-3 is complete and true to the best of my knowledge and I will alert Align Rehabilitation LLC immediately of any changes.

_____ _____

Patient/Guardian Signature **Date**

Communication Preferences

Text messaging and e-mail are forms of communication that may be used between you and Align Rehabilitation and are not secure methods of communication (we currently do not encrypt email and/or text communications). More information on encrypted messaging and security is available at your request.

We may use text messaging or e-mail to remind you of upcoming appointments and/or care coordination activities, if you elect to do so. We will limit information sent via text message to the minimum necessary.

Email and text communications may become a part of your patient medical record and be accessible as needed for our operations. If you elect to communicate from your workplace phone and/or computer, you should be aware that your employer may have access to these communications between us. Additionally, we will not leave specific information on a voicemail system, unless we have permission to do so.

I give the Align Rehabilitation permission to communicate information about scheduling and follow up care/questions using the methods marked below:

☐ **Call** me on this phone number and leave a voicemail: _____.
☐ **Text** me on this mobile number: _____. *
☐ **Email** me at this email address: _____.
☐ **NO,** I DO NOT consent voice message, text, or email me with appointment reminders.

*message and data rates may apply

By signing below, you are expressly consenting to receive text, email, and/or phone messages regarding appointment reminders, confirmations, surveys, and other communications specific to your physical therapy treatment. I understand that I may change my communication preferences at any time, in writing.

_____ _____

Patient / Legal Guardian **Date**