CONSENTS AND HIPPA NOTICE

INITIAL STATEMENTS and SIGN AT THE BOTTOM

Name: _____ **Date: _____**

Consent to Treatment: I consent to rehabilitation and related services at Energy Rehab Wellness and Training, LLC . In doing so, I understand and affirm that such rehab and related services may involve bodily contact/direct contact._____

Treatment of Minors: I, as a parent/guardian do herby agree and understand that I have been advised to remain present during such treatment and waive any claim I may have resulting from failure to do so. _____

Liability: I know and agree that Energy Rehab Wellness and Training, LLC. it's agents, representatives, affiliates, employees or assigns, of and from all liability, claim, damage, cause of action, or 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. _____

Authorization of Payment: I herby assign all benefits directly to Energy Rehab Wellness and Training, LLC. and release of medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I fully understand that in the event my insurance company or financially responsible party does not pay for services I receive, I will be financially responsible. _____

Acknowledgement of Co-Pay: I understand that I will be billed the amount of $_____ for each visit. _____

Energy Rehab utilizes an outside billing agency for all insurance billing. Bills will be mailed every two weeks to reduce the size of the bills when patients have a large co-pay or co-insurance. Sometimes this frequency of billing causes an overlap or "crossing in the mail" of the next bill and your prior payment. We understand this occurs at times and we don't want patients to be concerned. If we receive overpayments or an error occurs, we will resolve it immediately upon realizing it. Please do not hesitate to call the billing department or Energy management at any time with questions or concerns. Self-pay visits are billed monthly. _____

HIPPA NOTICE: I authorize Energy Rehab Wellness and Training, LLC to disclose information to healthcare providers involved in my care and my insurance company for all past, present and future periods. I authorize release of my complete health record including records related to mental health, communicable disease, HIV/AIDS and substance abuse. This medical information may be used for my medical treatment/consultation, billing or claims payment. This authorization will be in effect until I request it expire. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that revocation is not effective to the extent that any authorization as obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand my treatment, payment, enrollment or eligibility for benefits will not be conditioned on signing this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of Patient/Guardian: _____ Printed Name_____

Relationship to Patient: _____ Date: _____

Permission to Share Medical Information with: _____

_____

PATIENT INTAKE

First Name_____ MI ___ Last Name_____ DOB: _____

Address _____City_____State ____ Zip_____
Phone 1_____ Phone 2_____Email_____

Age_____ Sex: M / F Reason for attending therapy: _____

Date of Injury _____ Treatment to Date: _____
Employer_____ Emergency Contact: _____ Phone:_____

Referring Physician_____ Primary Care Physician _____

Date of Next Doctor's Appt: _____ How did you hear about Energy:_____

PRIMARY INSURANCE Co.:_____Member/Policy #_____

Group #_____ Policy Holder Name_____ DOB_____

Phone#_____ Relation to patient _____

SECONDARY INSURANCE Co:_____Member/Policy #_____

Group #_____ Policy Holder Name_____ DOB_____
Phone#_____ Relation to patient _____

Auto Related: Y / N Work Related: Y / N Attorney Involved: Y / N

Adjuster Name/Phone: _____Attorney Name/Phone:_____-___ _____

PAIN RATING – 0=NONE TO 10=WORST IMAGINABLE (CIRCLE 3 RATINGS

Location of Pain:_____**AT BEST =_____ AT WORST: _____ AVERAGE:_____**

CIRCLE CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST

ANEMIA	DEPRESSION	RESPIRATORY PROBLEMS	HEART PROBLEMS WHAT _____	
ARTHRITIS	DIABETES	HIGH BLOOD PRESSURE	HEPATITIS/HIV	HEADACHES
ASTHMA	SEIZURES	KIDNEY PROBLEMS	THYROID PROBLEMS	PACEMAKER
CANCER WHERE_____			SUBSTANCE ABUSE	LOW BLOOD PRESSURE

CURRENTLY PREGNANT: Y / N METAL IMPLANTS WHERE_____ ALLERGIES_____

Other:_____ Major Surgeries: _____

Medications:

_____

_____

I certify that the above information is true and correct. I hereby, authorize/instruct my insurance carrier to pay Energy Rehab Wellness and Training, LLC. for services performed. I understand that I am financially responsible for payment of all co-pays, deductibles and balances not covered by my insurance.

Patient /Guardian Signature: _____**Witness Signature: _____**