Sense-Ability, LLC
Rehabilitation Center
http://www.senseabilitytherapy.com

PATIENT INFORMATION/AUTHORIZATION TO TREAT

Patient Information

Patient's Name: _____

Patient's Date of Birth: _____ Patient's Age: _____ Gender: ☐ Male ☐ Female

Address: _____
Address City Zip

☐ Home Phone: _____ ☐ Cell Phone: _____
(Check Preferred Contact Phone)

May we leave a message at your preferred phone number? ☐ *Yes* ☐ *No*
May we send you text message reminders of your appointments? ☐ *Yes* ☐ *No*

Email Address: _____

Patient SS# _____ Driver's License # or State ID # _____

Patient Employer: _____

Occupation: _____ Work Phone#: _____

Person to Contact in Case of Emergency: _____

Relationship: _____ Phone#: _____

May we contact this person regarding your therapy care? ☐ Yes ☐ No

How did you hear about us?: _____

*** If Patient is a minor please provide us with the following information:*

Parent/Guardian Name: _____ SS#: _____

Parent/Guardian Employer: _____ Work Phone: _____

Insurance Information

Name of Insurance: _____ Member ID#: _____

Name of Insured (Policy Holder): _____ Group #: _____

Insured Date of Birth: _____ Relationship to Insured: _____

Was this a work related injury? ☐ Yes ☐ No

Was this a motor vehicle accident? ☐ Yes ☐ No

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Referral Information

Referring Physician:_____ Phone: _____

Diagnosis: _____

Have you had surgery within the past 6 months: ☐ No ☐ Yes Date: _____

Have you been hospitalized within the past 6 months: ☐ No ☐ Yes Date: _____

Do you have a prescription written within the last 30 days: ☐ No ☐ Yes

Informed Consent

I,_____, do hereby agree and give consent for Sense-Ability, LLC to furnish medical care and treatment. These services are considered consistent records as necessary for medical review by insurance providers, referring physicians, attorneys or medical case managers. All patient information is confidential. I understand that I may refuse treatment at any time for any reason. I agree to hold Sense-Ability, LLC or its clinical staff harmless from any claims in excess of professional liability limits. I authorize submission of reimbursement claims to my health insurance providers or workers' compensation carrier as directed by case management when applicable. I agree to pay any and all collection fees associated with bad debt on my account for services rendered. I understand that all consent is valid from the initial visit to Sense-Ability, LLC.

I hereby agree to the following:

- I hereby agree and consent for Sense-Ability, LLC to provide evaluation and treatment as prescribed by my physician.
- I hereby assign all insurance benefits for services rendered to be paid directly to Sense-Ability, LLC.
- I understand that if my insurance co/third party payer denies payment or makes partial payment I am responsible for the balance due as permitted by law.
- I hereby authorize the release of medical records to Sense-Ability, LLC for physical and occupational therapy and any pertinent information concerning the patient for the provision of care and for obtaining insurance reimbursement.
- I understand that I am legally responsible for payment of all services rendered by Sense-Ability, LLC. Insurance is being billed as a courtesy.
- I am responsible for paying any deductible or co-insurance amounts.
- I understand that co-payments are due at the time of service.

_____ _____

Signature of Patient/Parent or Guardian/Legal Conservator Date