

1301 Bertha Howe Ave., Ste. 7 - P.O. Box 757
Mesquite, NV 89024
Telephone: (702) 346-1899
Fax: (702) 346-8581



1170 N. Moapa Valley Blvd., Ste. B
Overton, NV 89040
Telephone: (702) 397-2000
Fax: (702) 397-2028

Date _____ Home Phone (____) _____ Cell Phone (____) _____

PATIENT INFORMATION

Name _____ SS/HIC/Patient ID # _____
Last Name First Name Middle Initial
Current Address _____ E-mail: _____
City/State/Zip _____ Sex M F Age _____ Birthdate _____
Permanent Address _____ Married Widowed Single Minor
City/State/Zip _____ Separated Divorced Partnered for _____ years
Patient Employer/School _____ Occupation _____
Employer/School Address _____ Employer/School Phone (____) _____
In case of emergency, who should be notified? _____ Phone (____) _____
Phone Number of nearest friend/relative not living with you. _____ Phone (____) _____

PRIMARY INSURANCE

Person Responsible for Account _____
Last Name First Name Middle Initial
Relation to Patient _____ Birthdate _____ Soc. Sec. # _____
Address (if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Person Responsible Employed by _____ Occupation _____
Business Address _____ Business Phone (____) _____
Insurance Company _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

Is patient covered by additional insurance? Yes No
Subscriber Name _____ Birthdate _____ Relation to Patient _____
Address (if different from patient's) _____ Phone (____) _____
City _____ State _____ Zip _____
Subscriber Employed by _____ Business Phone (____) _____
Insurance Company _____ Soc. Sec. # _____
Contract # _____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

ADDITIONAL INSURANCE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)
Dr. _____ all insurance benefits, if any otherwise payable to me for services rendered. I understand
that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and
their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This
consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

Consent for Treatment:

As either the Patient or on behalf of the Patient, consent is hereby given for health care/physical therapy services to be provided by Mesa View Physical Rehabilitation, LLC. It is understood that there is a risk of harm involved in such health care services. Such risk is accepted in the hope of obtaining beneficial results. No promises of any particular outcome or result have been made.

Financial Responsibility:

I, the undersigned, accept responsibility for charges incurred for the health care services rendered to the Patient in the Facility. Including, but not limited to, any amounts not paid by insurance or other third party payer.

I accept responsibility for all co-payments, deductibles, co-insurance, and/or non-covered services regardless of amount paid by Insurance or third party payer. I understand that co-payments are due at the time of services.

I understand that insurance payments are my responsibility. Although it is billed as a courtesy, I am ultimately responsible to see that they pay correctly and in a timely manner.

It is understood and agreed that charges not paid in a timely manner may be placed with a collection agency or attorney for purposes of collection. Should payment not be received, I/We will be responsible for all attorneys' fees, court costs, filing fees, including charges or commissions that may be assessed to us by any collection agency retained to pursue collection of the balance owing, which may be as much as 50% of the principle balance owing. I/We further agree to pay interest at the rate of 1 ½% per month (18% APR) pre and post judgment.

A service charge may also be assessed on all returned checks.

Medicare/Medicaid Patient's Certification:

I certify that the information given by me in applying for payment is correct. I authorize any information needed for the processing of a claim to be released. I request that payment of authorized charges be made, in my behalf, directly to Mesa View Physical Rehabilitation, LLC.

X _____ / _____
Signature Date

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Patient Consent / Acknowledgement Form Regarding Notice of Privacy Practices

By signing below, you consent to the use and disclosure of your protected health information by Mesa View Physical Rehabilitation, LLC, our staff and our business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please review our Notice of Information Practices (“Notice”). You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice by simply contacting this office at (702) 346-1899 and requesting a revised Notice. We will also post any revised Notice in the office.

You have the right to request that we restrict our uses or disclosures of your protected health information that we are otherwise permitted to make for treatment, payment and health care operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding on us. Finally, you may refuse to consent to the use or disclosure of your protected health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your protected health information (PHI).

This form is also used to obtain acknowledgement of receipt of our Notice of Privacy practices or to document our good faith effort to obtain that acknowledgement.

I have reviewed, understand and agree to the consent of the Notice of Privacy.

Name _____

Date _____

Please specify the exact reason why patient chose not to sign the consent / acknowledgement of Notice of Privacy in the box below.

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To Our Patients Regarding Cancellations and No Shows

The following are our policies regarding cancellations and no-shows. We take this subject seriously at the clinic because it can make the difference between whether or not you succeed in your treatment. Usually your referring doctor and / or therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals in treatment.

- ◆ We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.
- ◆ There is a \$20.00 charge for cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.
- ◆ For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize you claim.
- ◆ Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you are feeling worse and you think the treatment is not working, or b) you are feeling better and it's a great day for golfing. Neither of these conditions is legitimate as a reason not to come: a) if you are in pain, come in and get it fixed, b) if you are out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem, and educate you so you will not re-injure yourself, etc.

When you do not show as scheduled, three people are hurt: You, because you do not get the treatment you need as prescribed by the doctor and /or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please cooperate with us in this regard. We are looking forward to working with you.

Patient Signature

Date

Interviewer Signature

Date