NEW PATIENT REGISTRATION

Date _____

Name _____ DOB _____

Age _____ Gender M____ F ____ SSN _____

Address _____

City/State/Zip _____

Phone (check preferred)

☐ Cell _____ ☐ Work _____ ☐ Home_____

Email (check preferred)

☐ Home _____ ☐ Work _____

Occupation _____

Employer_____

Phone_____

Spouse/ Significant Other Name _____

Occupation _____

Employer _____

Phone _____

Emergency Contact:

Name_____

Phone_____

Relationship_____

Whom may we thank for referring you? _____

Are you currently receiving therapy through any of the following?	**Yes**	**No**
Home health care	☐	☐
Other outpatient clinic(s)	☐	☐
A skilled nursing facility	☐	☐

Have you ever tested positive for COVID - 19? Yes ☐ No ☐

If yes, did you experience symptoms of the virus? Yes ☐ No ☐

Insurance Information

Who is responsible for this account? _____

Relationship to Patient _____

Primary Insurance _____

Policy Holder _____

Policy Holder's DOB _____

ID# _____ Group # _____

Secondary Insurance _____

Policy Holder _____

Policy Holder's DOB _____

ID# _____ Group # _____

Referring Physician _____ Phone _____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to NEUROWORX 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 hereby authorize NEUROWORX to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

Neuroworx Financial Policies & Procedures

This will explain the financial policies and procedures used by Neuroworx. We regard your complete understanding of the financial process and your role in it as an essential element of your care and treatment. We are dedicated to providing the best possible care and service to you. Neuroworx does not discriminate based on the basis of gender, race, national origin, religion, sexuality, or color.

Financing of Care

The financing of each individual's care will be determined according to his or her health insurance coverage and private funding.

Coverage Options

Commercial Insurance - usually known as regular insurance or 80%/20% coverage

Patient role: Payment of the patient responsibility for therapy sessions and any other charges incurred at the time of clinic visit. Become familiar with the benefits and restrictions of your policy in regards to physical therapy and your condition.

Neuroworx role: Call your insurance company to confirm benefits, determine co-pays, deductibles, etc. Track clinic visits and inform you when benefits are exhausted. File an insurance claim on your behalf.

Contracted HMO & PPOs

Patient role: All applicable copays and deductibles are requested at the time of the clinic visit. Become familiar with the benefits and restrictions of your policy in regards to physical therapy and your condition.

Neuroworx role: Call your insurance company to confirm benefits, determine co-pays, deductibles, etc. Track clinic visits and inform you when benefits are exhausted. File an insurance claim on your behalf.

Non-contracted HMOs

Patient role: Payment in full for therapy session and any other charges incurred at the time of clinic visit.

Neuroworx role: Provide the necessary information for you to complete and file your claim directly with the insurance company.

Point of Service Plans or Out of Network PPOs

Patient role: Payment of the patient responsibility- deductible, copay, non-covered services- at the time of the visit. Become familiar with the benefits and restrictions of your policy in regards to physical therapy and your condition.

Neuroworx role: Call your insurance company to confirm benefits, determine co-pays, deductibles, etc. Track your clinic visits and inform you when benefits are exhausted. File an insurance claim on your behalf.

Medicare/Medicaid

Patient role: If you have Regular Medicare, and have not met your deductible, we ask that it be paid at the time of service. Payment for any services not covered by Medicare or Medicaid are due at the time of the visit.

Neuroworx role: Call to confirm Medicare eligibility and benefits. File the claim on your behalf, as well as any claims to your secondary insurance.

Private Pay

Patient role: Payment in full at the time of the visit or using one of the discount plans.

Neuroworx role: Keep you informed of charges that are incurred. If patient desires, work with him or her to determine other funding options.

If any clinic services are not covered by the individual's plan, payment in full is due at the time of services unless arrangements are made with Neuroworx or its financial representative.

Each individual is ultimately responsible for understanding their personal coverage including benefits and restrictions. If changes in coverage or circumstances occur, Neuroworx must be informed immediately. Individuals will be financially responsible for all charges incurred during any period that policies and/or benefits change and Neuroworx has not received adequate notification.

Additional Resources:

Financial Aid

Neuroworx is a non-profit 501(c) 3 organization. It attempts to raise funds to supplement individuals with no or limited funding. To be eligible for assistance, a Financial Aid Application must be submitted. Determination of assistance will be based on a sliding income scale and criteria approved by the Board of Directors. Assistance may not be possible or limited based on availability of funds.

Timing of Payments

Full payment is due at the time of service unless agreement has been made in advance.

Payment Methods

Neuroworx accepts corporate and personal checks, cash and credit cards. Neuroworx reserves the right to collect fees associated with insufficient funds.

Billing

Neuroworx employs a professional coding and billing staff. Individuals should receive regular monthly statements regarding dates of service, services billed, payments and balances. Please contact Neuroworx directly for questions and concerns at (801) 619-3670.

Collections

All delinquent accounts will be charged an interest rate of 1.5% per month (18% per annum). In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee and all costs of collection. In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney fees. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any email address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Accounts may be sent to collections based on non-performance. If your account is sent to collections, a collection fee may be added to the amount owed. According to Utah law, Neuroworx can add up to 40% of the fee charged by a collection agency.

Missed/Cancelled Appointments

Appointments must be cancelled at least 24 hours before the scheduled time. Neuroworx reserves the right to charge individuals for missed appointments or late cancellations.

Minor Patients

For all services rendered to individuals who are minors, we will look to the accompanying adult or legal guardian for payment.

Power of Attorney

Individuals, who, because for incapacitating injuries or conditions, have designated someone with Power of Attorney, must have the appropriate documents signed by that designee.

I have read and understand the financial policy of Neuroworx, and I agree to be bound by its terms. I have received a copy of this document. I also understand and agree that Neuroworx may amend such terms from time to time.

_____ _____ _____

Signature of Responsible Party **Date** Relationship to Patient

_____

Printed Name

NOTICE OF PRIVACY
PRACTICE ACKNOWLEDGMENT

I acknowledge that I was provided a copy of NEUROWORX Privacy Practice Form in accordance with the Federally Mandated H.I.P.A.A. Law. I've had the opportunity to read and review this notice, and instructions have been given to me on how to obtain a copy for my personal records, should I desire.

Patient Signature _____

Patient Name _____
(Please print)

Date _____

Medical and Financial Information Authorization and Release

Neuroworx will collect both medical and financial information in the normal course of providing rehabilitative services. This information is confidential and protected pursuant to the Health Insurance Portability and Accountability Act (H.I.P.A.A.; Pub. L. 104 - 191, 110 Stat. 1936, 1996)

We cannot share any of your personal record information except with those persons or entities specifically designated in writing. The purpose of this form is to protect your personal information and to identify to the Neuroworx staff who may have access to the information.

PLEASE NOTE: We require separate permission to share medical and/or financial information.

Please complete BOTH sections.

I authorize Neuroworx to release my **MEDICAL** information to the following people:

Spouse_____

Partner_____

Parent/Guardian_____

Other_____ ☐ Do not release.

Signature_____ Date_____

I authorize Neuroworx to release my **FINANCIAL** information to the following people:

Spouse_____

Partner_____

Parent/Guardian_____

Other_____ ☐ Do not release.

Signature_____ Date_____

NEUROWORX NO-SHOW AND LATE CANCELLATION POLICY

The Neuroworx model is to provide one-on-one care sessions by experienced and licensed therapists. This focused treatment time is critical. It is where expert guidance and hard work combine into progress. Our goal is to give each individual optimal time and attention. As such, the number of sessions available per day for scheduling is very limited.

In order to continue providing the best therapy possible to the greatest number of individuals, Neuroworx needs to ensure the therapist's time is maximized. We understand that problems arise, however, in order to optimize the care we provide, we must try to keep the clinic running on time and all appointments spots filled and used.

NO-SHOW/LATE POLICY

A "no show" visit is recorded when an individual misses an appointment without cancelling. Late is defined as arriving 15 minutes after your appointment. The following are possible responses to these issues.

1. **If an individual is 15 minutes past their scheduled time, we may have to reschedule the appointment.**
2. **First Time No-Show:** Individual will be notified by phone or in-person.
3. **Second No-Show:** Individual may be charged a $25 fee. This fee is not covered by insurance.
4. **Third No-Show:** Individual may be removed from the schedule and all subsequent appointments cancelled. To return to the schedule requires payment of fee(s) and a Neuroworx director's approval.

LATE CANCELLATION POLICY

We understand that there are times when you must miss an appointment. However, when you do not call to cancel an appointment, you may be preventing another individual from getting much needed treatment.

A cancellation is considered "late" when cancelled within twenty-four hours of a scheduled appointment.

1. **First Late Cancellation:** Individual will be notified by phone or in-person regarding the policy.
2. **Second and Subsequent Late Cancellations:** Individual may be subject to a $25 fee per appointment and may lose their spot on the schedule. If removed from the schedule, the fee(s) must be paid and a Neuroworx director's approval required.

_____ _____

Signature Date

Patient History Intake Form

Date:_____

Name:_____

DOB:_____

Referring Physician: _____ □**n/a**

Surgeon:_____ □**n/a** □**unknown**

Diagnosis: □Brain Injury □Spinal Cord Injury □Stroke □MS □Other_____

Mechanism of Injury: □Traumatic □Acquired □Disease □Cancer □Unknown □Other

- Please provide details of your Injury:_____

_____

_____

- Loss of Consciousness: □Yes □No If Yes - For how long?_____
- Did you require surgery? □Yes □No If Yes - What Type and Where?

_____

_____

Prior Treatment Timeline:

- **ICU:** Location:_____ **Dates:** From_____ to _____ □**n/a**
- **Rehab:**Location:_____ **Dates:** From_____ to _____ □**n/a**
- **SNF:** Location:_____ **Dates:** From_____ to _____ □**n/a**
- **Home Care:** Location:____n/a_____ **Dates:** From_____ to _____ □**n/a**
- **Outpatient:** Location:_____ **Dates:** From_____ to _____ □**n/a**

Current Medical Restrictions/Precautions: □Yes □No If Yes - What? _____

_____

On a scale of 0 to 10, 0= no pain and 10= the worst possible pain, what is your current level of pain?"_____ Location/Description:_____

Have you experienced any falls in the past 6 months? □Yes □No If Yes how many: _____

Do you currently have any loss of function to the following?

Bowels: □Yes □No

If Yes - Current Bowel Management Routine?_____

Bladder: □Yes □No

If Yes - Current Bladder Management Routine? _____

- Do you have a history of UTIs? □Yes □No
  - ➢ **If Yes** - How often are you having UTIs? □Never □Rarely □Sometimes □ Often
- Are you currently being treated for a UTI? □Yes □No

Past Medical History: Please list all prior surgeries you have had and approximate dates:

Type of Surgery	Date (Month/Year)	Scheduled Follow-up?
		□Yes □No
		□Yes □No
		□Yes □No

Please list any other secondary conditions or illnesses in addition to your current injury?
Check ALL that apply: □Hypertension, □Orthostatic Hypotension, □High Cholesterol, □Diabetes, □Heart Disease, □Pulmonary Disease, □Autonomic Dysreflexia, □Stroke, □Pressure Sores, □Pneumonia, □Other:_____

Medications: Please list ALL current medications you are taking.

Medication	Dose	Frequency

Mobility Devices: Please check all current mobility devices you have and/or are using.

- □Power Wheelchair, □Manual Wheelchair, □Walker, □Crutches, □Cane, □Leg Braces.

Home Environment:

- Is your home wheelchair accessible? □Yes □No □n/a

Other Pertinent Information:

- Please list any other information that you feel will be of value prior to your evaluation with Neuroworx? □n/a

  _____
  _____
  _____

PHOTO/IMAGE RELEASE

I, _____, hereby give permission without restrictions to NEUROWORX and assignees to use my name, likeness, pictures and/or voice in connection with any videos for broadcast, duplication, distribution and direct exhibition in perpetuity.

The foregoing consent is granted with the understanding that NEUROWORX has the sole discretion to edit the pictures, video and/or voice recording of my appearance and interviews as they see fit for incorporation in the program, and I specifically waive any rights to compensation I may have with respect to such use of my name, likeness, pictures and/or voice.

Signature_____ Date_____

Address_____ _

City, State, Zip_____

Phone_____

Signature of Parent or Guardian (under 18 or unable to sign)

_____ Date_____

Relationship_____

Internal use only

Initials_____