Primary Insurance Company Information

Primary Insurance Company Name	Identification #	Group #
Address	City	State	Zip Code	Phone
Policyholder	Policyholder's Address	Policyholder's DOB	Gender
Policyholder's SS #	Phone Number	Relationship to Patient
Employer of Policyholder		

Secondary Insurance Company Information

Secondary Insurance Company Name	Identification Number	Group Number
Address	City	State	Zip Code	Phone
Policyholder	Policyholder's Address	Policyholder's DOB	Gender
Policyholder's SS #	Phone Number	Relationship to Patient
Employer of Policyholder		

Medicare Patients Only Questionnaire

I am covered by Medicare because I am:

65 and older ☐ under 65 and disabled ☐ over 65 and have ESRD or on disability ☐ under 65 and have ESRD ☐

- Official retirement date:
- Are you currently being seen by a Home Health Agency? Yes ☐ No ☐
- Is your ailment due to: Motor vehicle accident ☐ Work related injury ☐ Liability ☐
- Are you receiving Black Lung Benefits: Yes ☐ No ☐

Assignment of Benefits/Authorization to Release Medical Information/Consent to Treatment/Consent to SMS Communication

- I hereby assign all medical benefits to which I am entitled to Transcend Rehab & Wellness in the event they file insurance on my behalf (Medicare patients).
- *I understand that I am financially responsible for all charges whether insurance covers or denies reimbursement.* In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt (up to 40% of outstanding balance). This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt (up to 40% of outstanding balance). By providing us with your wireless/cell phone number, you are hereby granting us and our agents or independent contractors, your consent to receive calls and or texts on your cell phone number for appointment reminders, care coordination and clinic communication, as well as for billing and debt collection purposes.
- Interest may be charged at a rate of 1.5% per month (18% annually for unpaid balances over thirty days old).
- I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original.
- I do hereby consent to such treatment by the authorized personnel of Transcend Rehab & Wellness as may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.
- I consent to receive SMS text messages from Transcend Rehab & Wellness. Reply STOP to opt-out; Reply HELP for support; Message & data rates may apply; Messaging frequency may vary. Visit https://www.transcend.rehab/general-4 to see our Privacy Policy and Terms of Service.

Patient Signature:	Today's Date:

PATIENT CONSENT FORM (HIPAA)

I have read and fully understand Transcend Rehab & Wellness LLC (TRW) Notice of Patient Information Practices. I understand that TRW may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation of the quality of services provided and any administrative operations related to treatment or payment.

I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify Transcend Rehab & Wellness LLC in writing.

I also understand that Transcend Rehab & Wellness LLC will consider requests for restriction on a case-by-case basis. TRW does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in Transcend Rehab & Wellness LLC Notice of Patient Information Practices.

I understand that I retain the right to revoke this consent by notifying Transcend Rehab & Wellness LLC in writing at any time.

_____
Patient Name

_____
Signature of Patient or Legal Guardian

_____
If not patient, Relationship to the Patient

_____/_____/_____
Date

Consent for Physical TherapyTreatment

I understand that I am a patient of Transcend Rehab & Wellness LLC and their independent physical therapy practitioners. My care is the exclusive responsibility of the practitioners of Transcend Rehab & Wellness LLC.

Consent to Physical Therapy Evaluation and Treatment: I hereby consent to the evaluation and treatment of my condition by provider of Transcend Rehab & Wellness LLC. The provider will explain the nature and purposes of these procedures, evaluation, and course of treatment. The physical therapist will inform me of expected benefits and complications, and any discomforts, and risk that may arise, as well as alternatives to the proposed treatment and the risk and consequences of no treatment.

Cooperation with treatment: In order for physical therapy treatment to be effective, I must come to scheduled appointments unless there are unusual circumstances. I understand and agree to cooperate with and perform the home physical therapy program intended for me. If I have trouble with any part of my treatment program, I will discuss it with my therapist.

No warranty: I understand that there are no guarantees regarding a cure for or improvement in my condition. I understand that my physical therapist will outline and discuss goals of physical therapy treatment for my condition and will discuss treatment options with me before I consent to treatment.

Informed consent for treatment: The term "informed consent" means that the potential risks, and benefits, as well as alternatives to physical therapy treatment have been explained to me. The therapist provides a wide range of services and I understand that I will receive information at the initial visit concerning the treatment and options available for my condition.

Potential risks: I may experience an increase in my current level of pain or discomfort, or an aggravation of my existing injury or condition. This discomfort is usually temporary; if it does not subside in a reasonable time period, I agree to contact my physical therapist.

Potential benefits: I may experience an improvement in my symptoms and an increase in my ability to perform daily activities. I may experience increase strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

Alternatives: If I do not wish to participate in the therapy program, I will discuss my medical, surgical, or pharmacological alternatives with my physical therapist, as well as my physician or primary care provider.

Payment: I understand that I am responsible for paying for all services, equipment and/or supplies on the same day of service (DOS). I understand I will receive a superbill (medical receipt of services rendered) and may submit it to my health insurance for reimbursement.

I have read the above information and I consent to physical therapy evaluation and treatment.

_____ _____

Patient Signature (parent/guardian if pt is a minor) Date

_____

Signer's relationship to the patient

Transcend
Rehab & Wellness

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Referring/Primary Provider:_____

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Telephone Number: _____

Clinic:_____

☒ Produce a copy of Medical Records as Specified Below

☐ Complete Forms as specified in the purpose section below

☐ Allow Transcend Rehab & Wellness provider to view Electronic Medical Records

Transcend Rehab & Wellness May Disclose this information to:

Recipient/Provider:_____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: _____

Fax Number: _____

Email: _____

Purpose: For continuing care

Please Specify the Health Information Needed for Use or Disclosure:

☒ PMH & Current Medications & Most Recent H & P

☐ Medical Records dated from _____ to _____

☐ Hospital Records dated from _____ to _____

☐ Specific Injury/Treatment _____ Dept _____ Dated from _____ to Current

☐ Imaging: Images and/or Films Radiology Reports

☐ Laboratory Results dated from _____ to _____

☐ ENT Notes ____ Neurology Notes _____ Cardiology Notes _____ Audiogram

☐ Audiology _____ Vestibular Test Results

☐ Other (specify): _____

Media Preference: Paper Encrypted E-mail **Delivery Preference:** Mail Pick Up Fax Email

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: _____.
Revocation: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.
Redisclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

Date _____ Signature _____ If not patient, print your name & relationship to the patient _____

Transcend Rehab & Wellness LLC | 2800 1st St South Suite 110 Willmar MN 56201 | T: 320-318-8812 |F: 320-318-8813

Transcend
Rehab & Wellness

AUTHORIZATION FOR USE OR DISCLOSURE OF PATIENT HEALTH INFORMATION

Note: Fees may apply to certain requests

Referring/Primary Provider:_____

Patient Name: _____

Date of Birth: _____

Address: _____

City: _____

State: _____ Zip Code: _____

Telephone Number: _____

Clinic:_____

☒ Produce a copy of Medical Records as Specified Below

☐ Complete Forms as specified in the purpose section below

☐ Allow Transcend Rehab & Wellness provider to view Electronic Medical Records

Transcend Rehab & Wellness May Disclose this information to:

Recipient/Provider:_____

Address: _____

City: _____

State: _____ Zip: _____

Telephone: _____

Fax Number: _____

Email: _____

Purpose: For continuing care

Please Specify the Health Information Needed for Use or Disclosure:

☐ PMH & Current Medications & Most Recent H & P

☐ Medical Records dated from _____ to _____

☐ Hospital Records dated from _____ to _____

☐ Specific Injury/Treatment _____ Dept _____ Dated from _____ to Current

☐ Imaging: Images and/or Films Radiology Reports

☐ Laboratory Results dated from _____ to _____

☐ ENT Notes ☐ ____ Neurology Notes ☐ _____ Cardiology Notes ☐ __ Audiogram

☐ Audiology ☐ _____ Vestibular Test Results

☒ Other (specify): _____

Media Preference: ☐ Paper ☐ Encrypted E-mail **Delivery Preference:** Mail ☐ Pick Up ☐ Fax ☒ Email ☐

Duration: This authorization shall remain in effect for one year from the date of signature unless a different date is specified here: _____.
Revocation: You or your representative can revoke this authorization upon written request. If you revoke, it will not affect information disclosed before the receipt of the written request.
Redisclosure: Once this health information is disclosed, how the recipient further discloses it may no longer be protected under federal privacy law (HIPAA). A copy of this authorization is as valid as an original. I have the right to receive a copy of this authorization.

_____ _____ _____

Date Signature If not patient, print your name & relationship to the patient

Transcend Rehab & Wellness LLC | 2800 1st St South Suite 110 Willmar MN 56201 | T: 320-318-8812 |F: 320-318-8813

Physical Therapy Appointment Cancellation & No-Show Policy

We understand that sometimes schedules can change unexpectedly. At Transcend Rehab & Wellness we do our best to be flexible, but to keep things running smoothly for *everyone,* we've got a few simple guidelines when it comes to missed appointments. Our policy is as follows:

1. **Cancellation Notice**: We request at least **24 hours' notice** if you need to cancel or reschedule an appointment. This allows us to offer your appointment slot to another patient in need of care.
2. **Late Cancellations**: Cancellations made less than 24 hours before the scheduled appointment will incur a **fee of $120**.
3. **No-Shows**: Of course, we hope you are okay (!) but failing to keep your appointment without advance notification will result in a **no-show fee** of **$160**.
4. **Exceptions**: *We understand that illness and emergency circumstances can arise. If you have an emergency or need to cancel due to exceptional circumstances, please contact us as soon as possible, and we will review your case individually.*
5. **Repeated Cancellations/No Shows**: 2 late cancellations and/or no shows will result in restrictions on booking future appointments or dismissal from our practice. Each case will be reviewed by the owner/clinic manager. In most cases, you will be restricted to scheduling same day appointments, as the schedule allows.
6. **Running Late?** If you are more than 15 minutes late, we may need to reschedule your session so it doesn't affect other patients. Call us- we'll do our best to work with you.
7. **Rescheduling**: If you need to reschedule your appointment, please contact us at least 24 hours in advance to avoid late cancellation fees.

Why This Matters
Your appointment time is reserved *just for you.* When missed, it's time that could've gone to someone else on their healing journey. We believe in respecting your time – and ask the same in return.

For any questions or concerns, please call our office at 320-318-8812.

Patient Acknowledgement
I have read and understand Transcend Rehab & Wellness' Appointment Cancellation & No-Show Policy. I agree to the terms outlined above and understand that I may be charged a fee for missed appointments without adequate notice.

_____ _____

Signature Date