Office use only:

Appointment Date:_____

Day: _____**Time:** _____

Walk-Over: Yes or No / Splint: Yes or No

Jeter Rehab Services, Inc.
1900 L Street, NW - Suite 607
Washington, DC 20036
Ph. 202-528-7223 / Fax 202-293-2262
Admin@JeterRehabTherapy.com

Demographics

Name: _____ **SSN:** _____ **DOB:** _____ **Age:** _____ **Sex (M/F)** _____

Address: _____ **City**_____ **ST**_____ **Zip** _____

Primary Phone #: (H), (O), (C):_____ **E-Mail:**_____ **/ Reminder: Text or E-Mail**

Emergency Contact: _____ **Phone:** _____

Referring Physician:_____ **Injury:**_____ **Date of Injury/Surgery:** _____

Referring Physician Phone Number:_____ **Referring Physician Fax Number:**_____

Personal / Insurance

What type of work do you do? _____ **Does your injury affect your job activities? Y / N**

Primary Insurance Name:_____ **ID#**_____ **Group#**_____

Secondary Insurance Name:_____ **ID#**_____ **Group#**_____

Effective Date of Insurance (s) : Year_____**Mo.**_____ **Does Insurance renew on January 1st or What other Date:**_____
Do you require Prior or On-going Insurance Authorization / Clinical Submission before being treated for purposes of Reimbursement for Occupational Therapy? : Y or N Describe:_____

If you have not checked your personal insurance plan for any authorizations prior to treatment please read and sign:
I understand Jeter Rehab Services will check on my behalf but cannot guarantee the accuracy of information received and I will ultimately be responsible for any reimbursement to Jeter Rehab Services that is denied due to lack of or timely submittal of authorizations. **Initial:**_____

Worker's Compensation – FOR WORKERS COMP PATIENTS ONLY

Employer: _____ **Occupation:** _____ **Claim #** _____

Employer address:_____

Workers Comp. Insurance Company: _____

Address: _____

WC Claim Administrator _____**Phone:** _____

Acknowledgement and Authorization to Treat

- I certify that the information I have reported with regards to my insurance is correct and further authorize the release of any necessary information, including medical information to my insurance carrier in order to determine benefits to which I am entitled.
- I also authorize Jeter Rehab Services, Inc. to apply for benefits on behalf for services rendered by her, and require payments from my insurance carrier to be made directly to her.
- I understand and agree that I am financially responsible for any portion of a claim that, for any reason, is not covered by my insurance, or is paid directly to me by my insurance company.
- I understand that I will receive a statement for any outstanding balance and agree to make payment within 30 days of the statement date. Furthermore, I understand that any collection costs or attorney's fees are my responsibility to pay.
- I acknowledge by signing the Financial Agreement of Jeter Rehab Services, Inc.I am responsible by abiding by the standard Cancellation/No Show policy and am directly responsible for any charges associated with No Show or Late Cancellations for the scheduled times of my appointments. I acknowledge treatment will not occur until fees are paid.
- Based upon the above and all other information provided to Jeter Rehab, I authorize Jeter Rehab Services, Inc. to treat my condition.

Signature: _____ Date: _____