LIFESTYLES
Therapy & Wellness Center
Personalized Solutions for Lasting Results

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Twin Falls, ID 83301
208.735.8563 • 208.735.8564 fax
www.lifestylestherapy.com

Patient's Name _____ Phone # _____
Mailing Address: _____ City _____ ST _____ Zip _____
Patient's Date of Birth _____ Age _____ Male / Female Marital Status _____
Patient's Social Security # _____ Occupation _____
Employer Name & Address _____

Referring Physician _____ Date of next appointment _____
How did you hear about Lifestyles Therapy & Wellness Center? _____
Have you previously had Physical/Occupational/Speech Therapy? ___ ***Yes*** ___ ***No***
If so, location _____ ***Date*** _____
Are you currently under the care of a home health agency? ___ ***Yes*** ___ ***No***

Spouse or Responsible Party:
Name _____ Social Security # _____
Date of Birth _____ Phone # _____ Occupation _____
Mailing Address: _____ City _____ ST _____ ZIP _____

_____ **CANCELLATION POLICY:** If I cancel less than 24 hrs. before my appointment time I understand that I will be charged $25. If I **do not show** or **do not call** I understand that I will be charged $50.

_____ **TREATMENT CONSENT:** I hereby consent to the examinations and treatments ordered or recommended by my attending physician and/or designated alternate.

_____ **FINANCIAL RESPONSIBILITY:** I understand that I am financially responsible for my account regardless of my insurance and for any charges which are either for care not covered by my policy or as result of not following the required procedures of my health plan.

_____ **HIPAA PRIVACY:** I have read the LifeStyles Therapy & Wellness Center, INC (LifeStyles) HIPPA Privacy Disclosure Statement. I understand that a copy is available to me, upon my request.

_____ **AUTHORIZATION & ASSIGNMENT OF BENEFITS:** I authorize the release of all medical information necessary to process this claim and request payment of medical benefits be made directly to this provider unless payment is made in full at the time of service. I also understand that it may be necessary for me to bill my own insurance company directly.

_____ **MEDICARE AUTHORIZATION:** I request that payment of authorized Medicare benefits be made either to me or on my behalf to LifeStyles for any services furnished me by this provider. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other insurance" is indicated in Item 9 of HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, LifeStyles agrees to accept the charge determination of the Medicare carrier or intermediary as the full charge, and that I am responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or intermediary.

_____ _____
Signature of Patient or Guardian **Date**