



**Patient information**

Jupiter Medical Center Outpatient Rehabilitation Center

Phone # 561-263-5775 Fax # 561-263-5776

*Welcome to Jupiter Medical Center's Outpatient Rehabilitation Center. We offer Physical Therapy, Occupational Therapy, and Speech-Language Pathology by appointments. All services are provided by Licensed Therapists. We also require a prescription from a Florida Licensed physician.*

For my appointments:

I  am  am not limited by day(s) of the week: \_\_\_\_\_  
I  am  am not limited by the hour(s) of the day: \_\_\_\_\_

*You are likely to have multiple therapists treating you if:*

- You have multiple therapies, such Physical, Occupational, and/or Speech Language Therapy
- If you receive motor aide transport
- If you are in need of a fixed time and/or day of the week

*You are likely to have different times and/or days of the week if:*

- You request the same therapists

*We will make every effort to accommodate you during your treatment in Outpatient Rehabilitation.*

*Thank you for your patience.*

Please allow 24 hour notice if you need to cancel an appointment. If you miss three consecutive appointments without notifying our department, we will discontinue scheduling and notify your physician. After the initial evaluation, your therapist will discuss your treatment plan, times and dates of future sessions and the number of visits (when known).

**MEDICARE INSURANCE INFORMATION:**

Your will be responsible for meeting your co-payments and annual deductibles. Supplemental insurances will be billed when applicable. **Always check your insurance policy for eligibility and verify your coverage.**

**PRIVATE INSURANCE/HMO's/PPO's/MANAGED CARE:**

Each health policy differs in benefits, coverage and reimbursements. It is important that you know what is covered, your eligibility, benefits, co-payments, deductibles, and visits allowed for the services rendered. The hospital's business office will bill for all services and submit claims. You will be billed for all co-payments and deductibles.

**Any non-covered services rendered will become your financial responsibility!**

**\*Are you CURRENTLY receiving, or have you received within the last 6 months, any HOME HEALTH SERVICES (i.e. nurses, CNA's, therapists) at your residence?\***

Yes  No

**I hereby acknowledge reading and understanding the above information and accept the terms of said information as noted above.**

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_