REHAB PARTNERS, INC.

AUTHORIZATION FOR:
AUTHORIZATION FOR TREATMENT - ASSIGNMENT OF MEDICAL BENEFITS AND PAYMENT RESPONSIBILITY PT OT LMT

Patient's Name: _____
FACILITY / PROVIDER : REHAB PARTNERS, INC.

1.) **THE UNDERSIGNED**, hereby authorizes therapy at **REHAB PARTNERS, INC**. to render to patient Physical Therapy, Occupational Therapy, Massage Therapy or other related services (collectively, "Therapy Services") that provider or patient's treating physician determines may be necessary or advisable. Patient agrees to cooperate with all reasonable requests by Provider in connection with the Provider's rendition of therapy services.
2.) **THE UNDERSIGNED**, hereby certifies that all information provided to the Provider by the undersigned or patient including any information in connection for applying for payment under title XVIII of the Social Security Act is true, correct and accurate in all respects.
3.) **THE UNDERSIGNED**, hereby authorize Provider to disclose any information furnished to the Provider or obtained by Provider in connection with the patient's treatment (including information concerning a related Medicare claim) to any physician, governmental agency (including the Social Security Administrations or any of its intermediaries or carriers) insurance company or health care facility requesting such information.
4.) **THE UNDERSIGNED**, hereby assign to Provider all Medicare benefits to which the patient may be entitled for any therapy services rendered by the Provider. The undersigned hereby authorize and direct the Provider to apply and file for all such benefits on behalf of the patient in the event the patient is covered by both Medicare and Medicaid. The undersigned acknowledge that the Provider has disclosed to the undersigned that the Provider is a supplemental Medicaid Provider and the Provider is paid directly by Medicaid. In addition, the undersigned approves contact with the appropriate family members for medical or claims management purposes.
5.) **THE UNDERSIGNED**, hereby assign to the Provider all Private Medical Insurance benefits (primary and secondary, including med gap providers) or other benefits to which the patient may be entitled for any therapy services rendered by Provider. The undersigned hereby authorize and direct Provider to apply and file for all such benefits on behalf of the patient.
6.) **THE UNDERSIGNED**, agree that the undersigned shall be jointly and severally financially responsible for any portion of the Providers invoice that is not paid, except in the case of a Medicare denial or Medicaid eligible recipients. The undersigned warrant and represent to the Provider if member is a Medicare participant that patient is not a member of or covered by a Health Maintenance Organization or similar arrangement as their primary insurance coverage. The undersigned shall be liable to Provider for all services rendered by Provider in the event the patient is covered by a Health Maintenance Organization or similar arrangement.
7.) **THE UNDERSIGNED**, and patient if applicable agree to execute any documents and perform any acts that the Provider may reasonably request. The undersigned warrant and represent that attached hereto are originals or certified copies of any Powers of Attorney, Health Care Surrogate or Court Orders appointing the undersigned as the legal guardian of the patient.
8.) **THE UNDERSIGNED**, agree that the provisions hereof shall continue in full force and effect until Provider received written notice of termination by the undersigned: provided however that the provisions in paragraphs 1,2,3,4,5,6, and 7 shall survive any such termination.

WITNESSES:

_____

_____

_____

X _____
PATIENT SIGNATURE / LEGAL REPRESENTATIVE

DATE:_____

_____
FINANCIALLY RESPONSIBLE PARTY IF NOT PATIENT

DATE: _____

HIPAA NOTIFICATION

REHAB PARTNERS, INC. IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF YOUR PERSONAL HEALTH INFORMATION AND TO PROVIDE YOU NOTICE OF OUR LEGAL DUTIES AND PRIVACY PRACTICES AND ADHERE TO THIS NOTICE. WE RESERVE THE RIGHT TO CHANGE OUR PRACTICES AND TO MAKE NEW PROVISIONS EFFECTIVE FOR ALL INDIVIDUALLY INDENTIFIABLE HEALTH INFORMATION THAT WE MAINTAIN. IF WE DO CHANGE OUT INFORMATION PRACTICES, WE WILL POST A NOTICE THAT THE NOTICE HAS CHANGED AND THE EFFECTIVE DATEOF THE CHANGE. COPIES WILL BE MADE AVAILABLE UPON REQUEST.

I UNDERSTAND THAT REHAB PARTNERS, INC. HAD MADE AVAILABLE TO ME A COPY OF THE NOTICE OF PRIVACTY PRACTICES. BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND UNDERSTAND THE NOTICE OF PRIVACY PRACTICES.

PATIENT SIGNATURE: _____

DATE: _____

Because of the nature of this practice, it may be necessary to contact you by telephone for examination results, scheduling, appointments, billing, etc. HIPAA requires that we obtain specific consent from our patients allowing us to speak with others on your behalf should you not be available. Please indicate below the names, relationships, and date of birth of those you will allow us to speak with on your behalf. This would include your SPOUSE, FAMILY MEMBERS, CARE GIVERS, ETC.

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

NAME: _____

RELATIONSHIP: _____

DATE OF BIRTH: _____

If you **DO NOT** want us to speak with anyone with regards to your treatment, appointments, billing, etc. please indicate so by signing below.

NAME: _____

DATE: _____

Rehab Partners, Inc.
Health History Questionnaire Date_____

PLEASE NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

Name: _____ DOB: _____ Age: _____

What medical concerns bring you to our office? _____

How did you hear about our office? ☐ Doctor ☐ Friend/Family ☐ Advertisement ☐ Web ☐ Insurance

If disabled, check here: ☐ Nature of disability: _____

Do you exercise routinely? *(circle)* Yes No If yes, what exercise/how often? _____

Have you used tobacco products one or more times within the last 24 months? (circle) Yes No
If yes, was cessation counseling intervention received? (circle) Yes No

Have you completed Advanced Directives or do you have a Living Will? *(circle)* Yes No Which? _____

Tell us about your home environment: *(e.g. live alone or with family; house or apt; stairs? pets?)*

_____

Have you had 2 or more falls in the past year, or any one fall with injury in the past year? (circle) Yes No

Medical Information:

Allergies: _____

Have you ever been diagnosed with or treated for the following conditions? Check all that apply:

☐ Pacemaker	☐ Heart Attack	☐ High Blood Pressure	☐ Diabetes	☐ Stroke/TIA
☐ High Cholesterol	☐ Osteoporosis	☐ Rheumatoid Disease	☐ Osteoarthritis	☐ Seizures
☐ Asthma	☐ COPD	☐ TB/Lung Disease	☐ Pneumonia	☐ Anemia
☐ Thyroid Disease	☐ Lupus	☐ Multiple Sclerosis	☐ Fibromyalgia	☐ HIV/AIDS
☐ Liver Disease	☐ Kidney Disease	☐ Hepatitis A, B or C	☐ Digestive Disorder	
☐ Depression	☐ Anxiety	☐ Glaucoma	☐ Cataracts	

☐ Cancer (please specify type and year diagnosed):_____

PRESCRIPTION MEDICATION:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
OVER-THE COUNTER MEDICATION:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
HERBAL MEDICATION	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:
VITAMINS/MINERALS/DIETARY SUPPLEMENTS:	DOSAGE:	FREQUENCY:	PURPOSE:	ROUTE OF ADMINISTRATION:

Please list all illnesses, medical conditions and surgeries not discussed above:

_____

_____

_____

Personal Safety: (circle your answer)

Are you under a lot of pressure at work or home? Yes No If yes, which? _____

Do you have any safety concerns? Yes No

Do you have any difficulty obtaining or preparing 2 meals per day? Yes No

****

I certify that I have read and understand the above. I will not hold Rehab Partners, Inc. or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____ _____

Patient's/Guardian's signature (or individual completing form for patient) Date