REHAB PARTNERS, INC.

CONSENT FOR TREATMENT, ASSIGNMENT OF MEDICAL BENEFITS, AND PAYMENT RESPONSIBILITY.

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

1.) **THE UNDERSIGNED**, hereby authorizes therapy at **REHAB PARTNERS, INC**. to render to the 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 authorizes the Provider to disclose any information furnished to the Provider or obtained by the 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 authorizes and directs 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 acknowledges 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 assigns 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 the Provider. The undersigned hereby authorizes and directs the Provider to apply and file for all such benefits on behalf of the patient.
6.) **THE UNDERSIGNED**, agrees that the undersigned shall be jointly and severally financially responsible for any portion of the Provider's 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 the member is a Medicare participant that the 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**, understands that insurance is considered a method of reimbursing the patient for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. I understand it is my responsibility to pay any deductible amount, co-insurance, or any other balance (AFTER THE REQUIRED CONTRACTUAL PROVIDER ADJUSTMENTS) not paid for by my insurance or third payor within a reasonable period of time not to exceed 60 days. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney fees and costs of collection. If this account is assigned to a collection agency, the collection fees of 33% of the total balance will be passed on and payable by the patient.
Patient Initials: _____ Social Security Number: _____
9.) **THE UNDERSIGNED**, agree that the provisions hereof shall continue in full force and effect until Provider receives written notice of termination by the undersigned: provided however that the provisions in paragraphs 1,2,3,4,5,6,7 and 8 shall survive any such termination.

Patient Signature: _____

Patient Name Printed: _____Date: _____

Subscriber Signature (if different from the patient) _____

Name Printed: _____ 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.

PAST FAMILY SOCIAL HISTORY

Date_____

PLEASE NOTE: This is a confidential record of your medical history and will be scanned into your medical record for safety. Information contained here will only be released upon your authorization.

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, 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):_____

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

_____

_____

_____

MEDICATIONS:

****

Prescription Medication:	*Dosage:*	*Frequency:*	*Purpose:*	*Route of Administration:*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Over The Counter Medication:	*Dosage:*	*Frequency:*	*Purpose:*	*Route of Administration:*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Herbal Medication / Vitamins:	*Dosage:*	*Frequency:*	*Purpose:*	*Route of Administration:*
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

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