

MEDICARE PATIENT & PAYER INFORMATION FORM

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr. , etc.

Address: Street Apt# City State Zip Code

Phone: () - () - () - () -
Home Mobile Work Emergency

Email: _____
We use an automated reminder system to help reduce missed appointments. (If you choose the phone call, it can take awhile to kick in). What method would you prefer? phone call email text message

(2) Patient Sex: M F Birthdate: ____/____/____
S.S # XXX/XX/____ Last 4 digits Legal Photo ID # _____
(Driver's License, Passport, Other State/Federal Photo ID)
Please tell us how you heard about us: _____

(3) Condition to be treated in Physical Therapy: _____
Did this condition result in surgery? No Yes If Yes, date of surgery ____/____/____
Is this condition due to a work Injury? No Yes If Yes, date of accident ____/____/____
Is this condition due to a non-work accident? No Yes If Yes, date of accident ____/____/____
Have you had PT or Speech Therapy this year? No Yes If Yes, where? _____
Are you currently receiving Home Health? No Yes If Yes, from whom? _____
(i.e. any healthcare worker, aide assisting or doing something to or for you?)
Do you live in a nursing home? No Yes If Yes, what is its name? _____
Are you covered:
a. Under Black Lung Disease? No Yes
b. End Stage Renal Disease? No Yes
c. Large Group Health Insurance? No Yes
d. Veterans Affairs? No Yes

(4) Patient's Doctor: Please list the doctor who referred you to therapy, or your Primary Care doctor.

Dr.'s Name: Last First Initial MD, DO, DDS, Other Office Phone: () -

Address: Street City State Zip Code

(5) Payer Information Primary:

Primary Insurance Company: Traditional Medicare Rail Road Medicare Medicare Advantage (Part C)
Insured's Name: _____ ID # _____ Group # _____

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

MEDICARE PATIENT & PAYER INFORMATION FORM

(6) Payer Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph.# _____

Insured is: ___ Patient ___ Spouse ___ Parent

Patient ID #: _____ Group. # _____ Policy/Plan #: _____

Claims Mailing Address: _____
Street City State Zip Code

Employer Name: _____ Employer Phone # () _____ - _____

Address: _____
Street City State Zip Code

(7) Medications : (This includes prescriptions, over the counter drugs, herbal and nutritional supplements)

Medication/Drug or Supplement Name	Prescription		Dosage	Frequency Per Day				Route of Administration				
	Yes	No		1	2	3	4	Oral	IV	Injection	Patch	Other

(8) Payment Authorization: *(Initials required for all 3 statements)*

Assignment of Insurance Benefits

Initials _____ I authorize that the payment of my insurance benefits be made directly to Rx Rehab for any services that are reimbursable by Medicare or any other insurance company, if I have one.

Guarantee of Payment

Initials _____ I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.

Certification of Information

Initials _____ I certify that the information I have provided Rx Rehab for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(9) Signature/ Date:

Patient or Legal Representative's Signature

Today's Date

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

Informed Consent for Therapy Services

“Informed Consent” is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information and I consent to the evaluation(s) and treatment provide by Rx Rehab Physical Therapy.

Signature

Print name Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Rx Rehab Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Rx Rehab Physical Therapy to release any of my protected healthcare information.

Patient's or Authorized Representative's Printed Name & Date

Patient's or Authorized Representative's Signature

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to Treatment, Payment, Healthcare Operations or if Required by Law or Rules

(1) Patient's Printed Name:

_____ Last _____ First _____ Initial _____ or Other _____

Date of Birth: ____/____/____ Insurance # exactly as on card (including letters) _____

(2) Rx Rehab will only disclose the protected health information you want disclosed.

Check only one box to tell Rx Rehab the specific information you want disclosed/released:

- Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)
- Limited information (complete ALL Sections)
- ALL records regarding my care at Rx Rehab to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination _____ Attendance _____ Correspondence re: your Physical Therapy Services
_____ Past Medical History _____ Treatments _____ Other- _____

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: _____ Attorney: _____
Parent: _____ Employer: _____
Friend: _____ School: _____
Other: _____ General Public _____ Other: _____

(5) Check only one box indicating how long Rx Rehab can use this authorization:

- Disclose my information indefinitely (as long as Rx Rehab has custody of my files)
- Disclose my PHI for the following period beginning ____/____/____ and ending ____/____/____

(6) Please initial all items below indicating that you have read and understand the rights or information below:

- _____ I understand that this authorization does not expire unless I have indicated an expiration date above
- _____ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations
- _____ I understand that if I give authorization I may revoke it at any time by notifying this Rx Rehab in writing
- _____ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession
- _____ I understand that if Rx Rehab requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to
- _____ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it
- _____ Rx Rehab will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

Signature of Patient _____ Date _____ or _____
Signature of Parent or Authorized Representative Date
(Indicate the Relationship)

You May Refuse to Sign this Authorization