Premier Rehab Physical Therapy Office Policies

Thank you for choosing Premier Rehab Physical Therapy and Aquatics. We are honored and committed to providing you and your family with the highest quality of patient care possible!

How did you hear about Premier Rehab? _____

PATIENT NAME_____ Patient Date of Birth_____

Home Address _____

City_____ State_____ Zip Code _____

Phone Number (_____) _____ - _____ Email Address: _____

Please list your health insurance plans:

Primary_____Secondary_____Teritiary_____

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

Consent for Care and Treatment

I give my consent for treatment by the staff at PREMIER REHAB for physical therapy services and necessary treatment considered medically necessary as prescribed by my physician.

I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at PREMIER REHAB.

Signature _____Date_____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to **PREMIER REHAB** for medical benefits to which I am entitled, including Medicare, private insurance, and third-party payers for services performed during the course of my treatment.

I authorize Premier Rehab to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Rehab staff.

Signature _____Date_____

RELEASE OF INFORMATION: ***We are legally required to follow privacy practices. Please list who we have your permission to disclose any of your Medical Information with other than your referring Physician that has ordered your Physical Therapy.***

I hereby authorize Premier Rehab to release and disclose all Medical History to:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I authorize Premier Rehab staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (____) _____-_____and (____) _____-_____

TEXT MESSAGING CONSENT: I consent to receiving text messages from Premier Rehab to wireless number (_____) _____-_____. ***Text messages to the wireless number provided will include appointment reminders.***

EMAIL CONSENT: I consent to receiving email messages from Premier Rehab to the following email address _____@_____. _____ ***Email messages will include appointment reminders.***

I also understand that I have the right to terminate this authorization at any time in writing or verbally.

_____ _____ _____

Patient Name (Printed) Signature Date

Premier Rehab Physical Therapy Office Policies

Have you had any Physical Therapy or Speech Therapy in the current c/year? **Yes** or **No** If **yes**, #visits? ___Staff initial _____

Are you currently employed? YES or NO Are you on disability? YES or NO
Did you sustain an injury while at work? YES or NO Are your injuries related to an accident (i.e. is the patient being treated for an injury for which another party could be liable)? YES or NO

Financial Responsibility

- As a courtesy, every effort will be made by Premier Rehab to verify your Out Patient Physical Therapy Benefits and all services and procedures verified and preauthorized by your health insurance company.
- It is the patient's responsibility to notify Premier Rehab's Billing Department if at any time there is an insurance change.
- Payment is due at each visit as determined by your Insurance plan contractual benefits
- Patient full responsibility will be determined once your claims are processed for payment by your insurance company with an Explanation of Benefits (EOB) mailed out every 30 days and *it can be* a forwarded balance that is *different* from the **estimated** amount collected at each time of service.
- These quoted benefits are not a guarantee of payment and are an estimate provided by your insurance provider.
- If you have a Secondary or Tertiary insurance, we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- Patient is responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage or if deemed medically unnecessary by your insurance provider.
- If you the patient have received any other healthcare interventions/muscle manipulations that utilize any of your Physical Therapy visit limitations that are still pending payment with your insurance carrier, if your insurance contract has changed during treatment/mid-treatment or after you have been discharged while previous claims are still pending with your insurance you will responsible for the balance due for PT services. Other Healthcare Interventions that some insurance providers may bill under PT benefits might include the following but is not limited to: Out Patient/In Patient Physical Therapy • Occupational/Speech Physical Therapy • Chiropractic Services • Arrosti • Home Health Care (See Home Health Care Policy) • Muscular Manipulations
- It is the patient's responsibility to know if an Insurance Authorization is **REQUIRED** prior to receiving treatment and during treatment in order to continue to receiving additional Physical Therapy services and that an authorization is on file with Premier Rehab. HMO and Health Maintenance Insurance plans require that an authorization is approved before a patient can be seen for treatment. Most Authorizations are not placed by Premier Rehab Physical Therapy. Authorizations are placed by a patient's Primary Care Physician whose name will appear on the patients' Insurance card and we work with the physician's office as much as they will allow for us to assist them in this effort on your behalf.
    - If your Insurance Maximum Benefit Limitations have been met/satisfied any time before/during/or after treatment with claims still pending, service amount will reflect in full charges due based on your contracted rate.
    - All past due balances must be paid prior to receiving any treatment.
    - If a payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of $40.00 per check *plus* the original amount of each check.

At Premier Rehab Physical Therapy, we all take great pride in what we do, and we love what we do! It is with this great passion that it is our mission to develop a provider and patient relationship with our patient's best needs in mind. With each patient that we meet, we look forward to them experiencing the Premier Difference!

We look forward to taking great care of YOU on your road to recovery!

By signing below, you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.

_____ _____ _____

Patient Name (Printed) Signature Date

Home Health Care

Are you currently receiving **any** medical treatment by a **Home Health Care Agency** or any **Other Medical Staff** at **Home** including Hospice? **Yes** or **No** Staff Initial____

If your answer above is YES:
Please bring this information to the attention of a Premier Rehab employee and your Treating Physical Therapist, as you may have to rearrange your Physical Therapy treatment.

Home Health Care Services/ Hospice Agency Name: _____
Telephone Number: _____ Last Date of Service at your House: _____

Appointments

- **Our goal is to offer a variety of appointment times to meet the needs of our patients and their busy schedules.** One of our staff members will accommodate you as soon as possible.
- Children under the age of 18 must have a parent or guardian in our office during the Initial Evaluation and then is up to the discretion of the parent, patient and physical therapist if a parent is to be present for follow appts in its entirety.

Cancellation/No Show Policy

Your patient care is very important to us! If you miss or no show an appointment, we will definitely worry about you and want to know if you are Okay! If you need to cancel, change/edit any scheduled appointments please call us at 817-498-8585. We request that you provide us a **24Hr** business hour notice so we can reschedule your appointment within the same work week so you can continue onto your road to recovery, and avoid having to pay your **$25.00 Cancellation/No Show Fee** at your next therapy visit. If you find that you need to call us over a weekend, please leave us a message and team member will follow up with you on the next business day!

We appreciate your recognizing our policy so we can continue to provide Excellent World Class Service to all of our patients!

_____ _____ _____
Patient Name (Printed) Signature Date

PREMIER REHAB PHYSICAL THERAPY
PATIENT RIGHTS AND RESPONSIBILITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

THE PATIENT HAS THE RIGHT TO:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary, cope with death.
- Expect personnel who care for the patient to be friendly, considerate, respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative of other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third-party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time in a respectful manner to appropriate personnel.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.--DELETE
- Have an advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. --DELETE
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

THE PATIENT IS RESPONSIBLE FOR:

- Being friendly, considerate and respectful of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

X_____

Signature Date

Patient Medical History

Patient Name:_____
Referring Physician:_____
Patient Occupation_____
Emergency Contact Name:_____ **Phone: (_____) _____-_____**

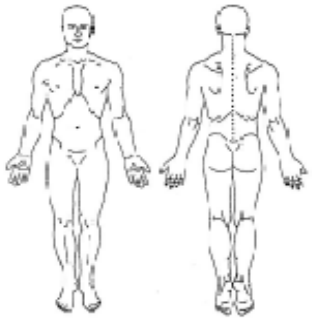
Date of first MD visit for this problem or injury_____ Follow-up MD visit for this problem_____
Is this a work injury? Yes No Is an Attorney involved: Yes No
Date of Injury or onset of symptoms _____
How did your symptoms begin (gradually, suddenly, injury specifics)?_____
_____
Have you had surgery for this problem/Injury: Yes No Type of Surgery_____
Date of Surgery_____

List your current medications. Include prescriptions, over-the-counter, herbs, and vitamins.

Medication	Dosage	frequency & route	Medication	Dosage	frequency & route
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Are you allergic to any medications or latex? If yes please specify_____
Please list symptoms you are currently having (pain, swelling, weakness, etc)_____
_____

Body Chart: Please mark the areas on the chart where you feel pain.



Please Circle your pain level:
0 being no pain & 10 Extreme pain
0 1 2 3 4 5 6 7 8 9 10

What is your main complaint?_____

Check all the activities that you have trouble performing as a result of your present condition.

___Bathing	___Child Care	___Dressing	___Eating
___Homemaking	___Yard work	___Sitting	___Sleeping
___Standing	___Walking	___Working	

How Long can you tolerate the following?

	Less than 30 min	1-2 hours	3-4 hours	No problems
Walking	____	____	____	____
Sitting	____	____	____	____
Standing	____	____	____	____

What treatment have you previously received for this injury/episode?
__ Physical Therapy __ Occupational Therapy __ Chiropractic Care
__ Surgery __ Medications: _____
__ Other _____

Please circle if you have had any of these test done for this injury/episode: Bone Scan X-Ray MRI
CAT Scan EMG- NCV Myelogram Other_____

Do you have or have you had any of the following?

__ No Known Significant PMH to Affect Treatment			
__ Allergies	__ Current Infection	__ Headaches	__ Muscular Disease
__ Alzheimer's	__ Currently Pregnant	__ Hepatitis/ HIV / AIDS	__ Obesity
__ Anemia	__ Depression	__ High Blood Pressure	__ Osteoarthritis
__ Anxiety	__ Diabetes Mellitus Type 1	__ High Cholesterol	__ Osteoporosis
__ Arthritis	__ Diabetes Mellitus Type 2	__ Incontinence/Kidney Problems	__ Other (Please see list of Exmaples)
__ Asthma	__ Dizzy Spells	__ Lupus	__ Parkinsons
__ Autoimmune Disorder	__ Emphysema/Bronchitis	__ Metal Implants	__ Rheumatoid Arthritis
__ Cancer	__ Fibromyalgia	__ MRSA	__ Seizures
__ Cardiac Conditions	__ Fracture or Suspected Fracture	__ Multiple Sclerosis	__ Smoking
__ Cardiac Pacemaker	__ Gallbalder Problems		__ Thyroid Disease
__ Chemical Dependency			
__ Circulation Problems	Other: _____	_____	

What are your expectations/goals during your Physical Therapy program?_____
_____

Patient/Guardian Signature _____ Date _____
Staff Initials: _____ Updated:10/2019

Premier Rehab Physical Therapy and Aquatics

Serving 6 locations

Your Information. Your Rights. Our Responsibilities.
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record
- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice
- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated
- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** We will not retaliate against you for filing a complaint.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice
We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

continued on next page

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory
- Contact you for fundraising efforts

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Example: *A doctor treating you for an injury asks another doctor about your overall health condition.*

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: *We use health information about you to manage your treatment and services.*

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

Example: *We give information about you to your health insurance plan so it will pay for your services.*

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues

- We can share health information about you for certain situations such as:
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety

Do research

- We can use or share your information for health research.

Comply with the law

- We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

- We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

- We can use or share health information about you:
  - For workers' compensation claims
  - For law enforcement purposes or with a law enforcement official
  - With health oversight agencies for activities authorized by law
  - For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

- We can share health information about you in response to a court or administrative order, or in response to a subpoena.

concerns may be emailed to newpatient@premierrehab.org

HIPAA-ACKNOWLEDGEMENT OF RECEIPT Notice of Privacy Practices

Printed Patient Name: _____ Patient Date of Birth :_____

We at Premier Rehab Physical Therapy are required by law to maintain the privacy of and provide individuals with the attached Notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to the Notice, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. If you would like a copy of the Notice, please ask.

I hereby acknowledge that I have received the HIPAA Notice of Privacy Practice document.

_____

Signature of patient or patient's representative/parent Date

_____

Printed name of patient or patient's representative/parent

_____

Relationship to patient

_____