



**THERAPY SERVICES PATIENT INFORMATION**

Today's Date: \_\_\_\_\_

Name: First \_\_\_\_\_ MI \_\_\_\_\_ Last \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone #: (\_\_\_\_\_) \_\_\_\_\_ Cell Phone #: (\_\_\_\_\_) \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Next Scheduled Appointment: \_\_\_\_\_

**Are you receiving any type of Home Health (HH) Services?    Yes    No**

**If so which HH Agency: \_\_\_\_\_ Date of Discharge from HH: \_\_\_\_\_**

**Have you given us ALL Health Insurance Coverage you have?    Yes    No**

**Have you received any PT, OT or Chiropractor services this year?    Yes    No**

**Are we treating you for a condition as a result of an accident:    Yes    No    Date of Accident or Injury: \_\_\_\_/\_\_\_\_/\_\_\_\_**

If yes, what kind of accident?    Auto Accident    Worker's Compensation    Other \_\_\_\_\_

Briefly describe accident: \_\_\_\_\_

**Medical History Information: Do you suffer from any of the following?**

- |                     |                         |                      |                              |                       |
|---------------------|-------------------------|----------------------|------------------------------|-----------------------|
| Fracture            | Joint Problems/Swelling | Arthritis            | Seizures                     | Communicable Diseases |
| Tuberculosis (TB)   | Weight Loss Surgery     | Osteoporosis         | Visually Impaired            | Kidney Problems       |
| Low Blood Pressure  | Breathing Problems      | Circulatory Problems | Hearing Problems             | Stomach Problems      |
| High Blood Pressure | Numbness                | Diabetes             | Lung Disease                 | Other _____           |
| Tingling            | Metal Implants          | Stroke               | Dizziness                    | _____                 |
| Heart Trouble       | Cardiac Stent           | Heart Valve Problems | Cancer, Type and Year: _____ |                       |

Past Surgeries: \_\_\_\_\_

**Are you allergic to the following?**

- |      |           |            |               |           |          |       |
|------|-----------|------------|---------------|-----------|----------|-------|
| Tape | Cortisone | Gabapentin | Dexamethasone | Lidocaine | Baclofen | Latex |
|------|-----------|------------|---------------|-----------|----------|-------|

Other Allergies: \_\_\_\_\_

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Please circle any of these implanted devices that you have:

None                  Defibrillator                  Spinal Stimulator                  Vagus Nerve Stimulator  
Pacemaker                  Gastric Pacemaker                  Metal Hardware

Have you been hospitalized in the last 12 months? \_\_\_\_\_

If yes, please list dates: \_\_\_\_\_

Have you had any falls in the past year?      Yes      No

If so, how many? \_\_\_\_\_ Any injuries as a result of the fall(s)? \_\_\_\_\_

Do you presently use an assistive device?

No device      Cane      3 or 4 Point Cane      Walker      Wheelchair

Are you receiving rehabilitation due to surgery?      Yes      No

Date of surgery: \_\_\_\_\_ Procedure: \_\_\_\_\_

Is your condition due to an injury?      Yes      No      If yes, date of injury: \_\_\_\_\_

If your condition is not related to injury or surgery, when did the problem start? \_\_\_\_\_

Have you previously participated in any type of rehabilitation?      Yes      No

If so, list when and where \_\_\_\_\_

What is your current activity level?      Very Active      Active      Not Active

What is your current occupation? \_\_\_\_\_

If you are a female, are you pregnant?      Yes      No

Emergency Contact: \_\_\_\_\_ Phone #: \_\_\_\_\_

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

Patient's Name: \_\_\_\_\_

**CONSENT FOR TREATMENT:** I hereby authorize the performance of any medical procedure, which may be advised and/or recommended by my therapist and/or physician.

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby assign payment directly to USA Health for medical benefits otherwise payable to me for their billed services, but not to exceed its charges. Any unpaid deductible and/or estimated co-pay is due and payable at the time of service. I understand that charges not payable by insurance are my responsibility and all charges are due in full within 90 days from the date of service; regardless of any insurance pending.

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS:** Payment for services rendered is to be made as follows: "I request that payment of authorized Medicare benefits be made payable to USA Health on my behalf for any services rendered to me by USA Health. I authorized any holder of medical information about me to release to the Health Care Financing Administration and its agency any information needed to determine these benefits payable for services rendered."

**WORKER'S COMPENSATION PATIENTS:** I authorize the release of all medical information to my Employer, Insurance Adjuster and/or Case Manager assigned to my Worker's Compensation Claim. I further understand that if I am non-compliant with my treatment program and/or appointments that USA Health may notify the above stated individuals.

**RELEASE OF RECORDS:** I authorize USA Health to disclose all or part of my medical and/or patient account records to my insurance company or association as may be necessary for the processing of any outstanding insurance claims, as well as to any treating physician or healthcare providers involved in my, or my child's, medical care to include copies of medical records.

**ACKNOWLEDGEMENT NOTICE OF PRIVACY PRACTICES:** Under federal HIPAA guidelines, all patients are to be provided with the opportunity to review and/or have a copy of our Notice of Privacy Practices which explains how medical information will be used and disclosed. By my signature below I acknowledge having been made aware there is a copy in the waiting room, and I may obtain a copy from USA Health, if desired.

**PAYMENT POLICY:** Standard charges have been established for all services provided by USA Health. The fee for your rehabilitation services will be billed to your insurance company as a courtesy to you. You are required to pay any co-pay and/or unmet deductible amounts at the time of service. You will be sent a statement for any remaining balance after your insurance has processed your claims. At that time, your entire balance for processed dates of service will be due. If payment arrangements need to be made, please contact our regional billing office. Our policy is to have the entire balance on your account with USA Health paid within 90 days from your date of service.

**CREDIT POLICY:** In the event that I do not meet the payment terms above and further action is taken on my account I agree to pay 28% of the unpaid balance for collection costs, or alternatively the maximum lawful fee, at such time my account is placed with a collection agency. I further understand that in the event the account is referred to an attorney for collection, I agree to be liable for such additional reasonable court costs and attorney's fees as may be determined by a court.

**COMMUNICATION CONSENT:** I expressly consent and authorize USA Health to communicate with me for any reason, including reasons related to the services provided by USA Health or services to be provided in the future by USA Health, including collection of amounts owed for said services, via communications at the telephone number or numbers I provide, or that is provided on my behalf, or any phone number, or other forms of communication that USA Health obtains or finds on its own which is not provided by me. Until my accounts are settled, I give my consent to receive communications regarding my account from any servicers and collectors of my accounts through various means such as cell, landline, text, email, auto dialer systems, voicemail messages or other forms of communication.

**I have read and understand the terms of this Statement of Consent and Financial Responsibility.**

Responsible Party's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Responsible Party's Name (please print): \_\_\_\_\_

**PATIENT RIGHTS/GRIEVANCE FORM****Patient utilizing rehabilitation services are entitled to:**

1. Licensed/certified clinicians to evaluate all admissions and if deemed necessary and reasonable, initiate an appropriate plan of treatment under the order of the physician.
2. A clean, safe, healthy environment and proper infection control procedures as determined by clinical guidelines.
3. Assessment of functional levels using appropriate evaluative techniques.
4. Protection of privacy and confidentiality. Photography, video recording or audio recording of any kind, by a patient or USA Health employee, is strictly prohibited within the premises of any USA Health facility without permission of the Facility Director and documented consent of the patient. This policy is in place to protect patient privacy, enhance confidentiality, and maintain security.
5. Patient teaching and/or family education as each individualized treatment process from his/her admission through discharge.
6. Inclusion of the patient and patient's family in the rehabilitation treatment process from his/her admission through discharge.
7. Orientation to rehabilitation services including the physical setting, expectations, outcomes, treatment programs and scheduled therapy services.
8. Be treated with consideration, respect and full recognition of dignity and individuality.
9. Voice grievances regarding treatment or care that is (or fail to be) furnished or regarding the lack of respect by anyone furnishing services and must not be subjected to discrimination or reprisal for doing so. Grievances may be reported to the Clinical Director or the Patient Relation Department. The Patient Relation Department number is (251) 471-7127.

**I have read and fully understand my above patient rights.**

Patient's Name (Printed): \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## No-Show/Cancellation Policy

USA Health's mission is to provide you with the best health care in order to return you to your normal activities as soon as possible. Therefore it is our policy that three (3) consecutive "No Show" visits or a total of six (6) cancellations and/or "No Shows" may result in discontinuation of treatment and patient discharges as well as physician notification of non-compliance.

I also understand that my therapist schedules their appointments to minimize patient wait time. I understand that if I am late for my appointment this may result in my treatment being shortened or may necessitate rescheduling my appointment in order not to affect other patient's appointment time. If I am unable to keep an appointment I will notify the office in order to reschedule my appointment.

I understand if I cannot make my appointment that I need to call at least two hours in advance to cancel. USA Health reserves the right to charge for any non-cancelled appointment. I give you permission to remind me of appointments via call, text or voicemail message.

I agree to schedule my follow-up appointments at the front desk weekly. I also understand the importance of notifying my therapist of any referring physician appointments.

I understand the above policy and agree to comply.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

A. Notifier: USA Health

B. Patient Name:

C. Identification Number:

## Advance Beneficiary Notice of Non-coverage (ABN)

**NOTE:** If Medicare doesn't pay for D. Rehab Services below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the D. Rehab Services below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Any rehabilitation service you receive from USA Health while you are receiving ANY care from a Home Health Agency will prevent Medicare from paying USA Health Rehab for our services rendered. Medicare sometimes initially pays us but, in the future, they recoup their money. Therefore, you will be responsible for payment of all rehab services you receive from USA Health if you are receiving any type of care from a Home Health Agency during the time you are receiving services from USA Health,	Medicare does not pay for out-patient rehabilitation service when a patient is receiving any service from a Home Health Agency.	Medicare allowable amount for services rendered, between \$75.00 to \$175.00 per visit depending upon services performed each visit.

### WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D. rehab service** listed above.

**Note:** If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

### G. OPTIONS: Check only one box. We cannot choose a box for you.

- OPTION 1.** I want the **D. rehab service** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
- OPTION 2.** I want the **D. rehab service** listed above, but **do not bill Medicare**. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.
- OPTION 3.** I **don't want** the **D. rehab service** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

### H. Additional Information:

**This notice gives our opinion, not an official Medicare decision.** If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048).

Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:
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