SELECT THERAPY AND REHABILITATION SERVICES

PATIENT INFORMATION

Date ---------------------------

Patient Name: -- Birthdate:-------------------------

Address: -- City:------------- State:---------- Zip:-------------

Telephone: (home)---------------------------------- (work) ---

Martial Status: S M D W (please circle one)

Age: ---------------- Sex: M F Social Sec# : ---

Employer: ---------------------------------- Address: --

City: -------------------------------------- Zip: ---------------- Status: FT PT Student

Spouse/Parent: --- Work Phone: -----------------------

Have you ever been seen in this office ---

Type of injury: Auto Work Other Date of occurrence: --------------------------------------

Emergency contact: -- Phone: --------------------------

INSURANCE INFORMATION

Primary Insurance: --

Address: ------------------------------------- City: ---------------------------- State: --------- Zip: ------

Policy# : -------------------------- Group: ------------------------- Insured: -------------------------

Relationship to the insured: Self Spouse Child Other

Insured's name: --- Date of Birth: -------------------------------

Secondary Insurance: --

Address: --------------------------------- City: ------------------- State: --------- Zip:--------------

Policy#: ------------------------------ Group#: ------------------------ Insured: ----------------------

Do you have any other insurance, other than that listed above? Yes ---------- No -----------

By signing below, I attest that to the best of my knowledge, the above information is true and accurate.

7401 N. UNIVERSITY DR * SUITE 104 * TAMARAC. FLORIDA 33324 * (954) 724-5500 * (954) 724-5131

SELECT THERAPY AND REHABILITATION SERVICES

Consent To Treatment

Patient:______________________________ Date:______________________

1. I hereby authorize Select Therapy and Rehabilitation Services to evaluate and treat my condition(s).

2. Select Therapy and Rehabilitation Services has discussed the following items:
   a. The nature and purpose of the proposed treatment, including my treatment plan.
   b. The risks of the proposed treatment, including the risk that such treatment may not accomplish the desired objective(s).
   c. The possible or likely consequences of the proposed treatment.
   d. All feasible alternative treatments (including the risks, consequences, and probable effectiveness of each).
   e. The prognosis if no treatment is received.

3. I have been given sufficient opportunity to discuss my condition and treatment with Select Therapy and Rehabilitation Services and all of my questions will be answered before any treatment of services are rendered.

______________________________ ______________
Signature of Patient Date

If the patient is incompetent to give consent because of physical condition or age, complete the following:

Patient is a minor________years of age, and is unable to give consent.

Patient is physically/mentally unable because

____

____

______________________________ ______________________
Signature of Legal Guardian or closest available relative Witness

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SELECT THERAPY AND REHABILITATION SERVICES

Patient's Name: ______________________________

Guarantee of Payment

I, the undersigned, do hereby authorize my insurance carrier to pay directly to Select Therapy & Rehabilitation Services for all services and treatment rendered to me. If for any reason my insurance does not pay for services or treatment rendered, I understand that I am fully responsible for payment. I shall also be responsible for all costs of collection, including a reasonable attorney's fee. A late payment charge of 1 1\2% monthly may go into effect, on all bills over 60 days past due (18% annual). This agreement is irrevocable.

If any insurance payment is erroneously sent to me, the patient, it will be forwarded to the Select Therapy & Rehabilitation Services immediately.

Guarantor: ______________________________
signature

Worker's Compensation Patients Only

Charges related to the worker's compensation injury shall be forwarded to the worker's compensation insurance carrier and I will not be held personally responsible for them.

If this claim should be controverted, the responsibility of payment reverts to the patient.

Patient's Name: ______________________________
signature

Authorization to Release Information

I hereby authorize \ do not authorize (circle one) the release of identifiable information except when such release is requested by law.

Patient's Name: ______________________________
(parent\guardian if minor) signature

Medicare Benefits Only
Authorization To Release Information To Physician

I, the undersigned, hereby authorize Select Therapy & Rehabilitation Services to inquire and receive any and all information pertaining to the processing of any and all claims submitted by them on my behalf.

Patient's Name: ______________________________
signature

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SELECT THERAPY AND REHABILITATION SERVICES

Medical History & Physical Condition

Name:____________________ Chief Complaint:______________________

1. Do you now have or have you in the past, had any of the following?

Allergies	YES	NO	Hernia	YES	NO
Balance Problems	YES	NO	High Blood Pressure	YES	NO
Breathing Problems	YES	NO	Kidney Problems	YES	NO
Cancer	YES	NO	Nervous Disorders	YES	NO
Circulatory Problems	YES	NO	Osteoporosis	YES	NO
Diabetes	YES	NO	Pregnancy	YES	NO
Headaches	YES	NO	Seizures	YES	NO
Hearing Problems	YES	NO	Sensitive to Heat /Ice	YES	NO
Heart Disease	YES	NO	Vision Problems	YES	NO
HIV/Aids	YES	NO	Hepatitis	YES	NO

If yes to any of the above, please explain and give approximate dates:__________________

____

____

2. Have you received any of the following services this year for this condition or any other condition?

Physical Therapy/ Occupational & Speech Therapy YES NO

If yes, when____

Home Health Care of <u>Any Type</u> YES NO

If yes, please describe ____________________________________

____

3. Have you had surgery related to this problem? YES NO
If yes, what type of surgery and when? ____________________________

4. Do you have metal implants? YES NO
5. Do you have a pacemaker? YES NO
6. Do you have any transmitable/infectious diseases? YES NO
7. List any medications you are currently taking:____________________________

____

Has your illness/disability caused any of the following?

Financial Problem	YES	NO	Family Problems	YES	NO
Emotional Problems	YES	NO	Other ____________	YES	NO

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SELECT THERAPY AND REHABILITATION SERVICES

FUNCTIONAL INFORMATION

Name______________________________ **Date of injury/surgery**______________

Do you need assistance with any of the following?:

Transportation	Yes	No	Meals	Yes	No
Shopping/Errands	Yes	No	Personal Care	Yes	No
Domestic Chores	Yes	No	Other:__________	Yes	No

Are there people available to provide assistance? Yes No

Please describe current job requirements (e.g. lifting frequency and approximate amount, computer use, phone use, etc.)__________________________________

____

Please check those activities which you are now unable to perform or are having difficulty performing and would like to resume.

		Office use only
Walking	( )	
Running	( )	
Going up/down stairs	( )	
Bending	( )	
Lifting	( )	
Sitting	( )	
Standing	( )	
Throwing	( )	
Overhead lifting/reaching	( )	
Activities of Daily living		
Dressing	( )	
Grooming	( )	
Eating	( )	
Cooking	( )	
Cleaning	( )	
Yardwork	( )	
Getting in/out of chair, bed Car, etc.	( )	
Hobbies (please list)	( )	
____________________		
____________________		
Other: ____________________	( )	

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Select Therapy and Rehabilitation Services

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Select Therapy and Rehabilitation's LEGAL DUTY

Select Therapy and Rehabilitation is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Select Therapy and Rehabilitation uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, **Select Therapy and Rehabilitation** may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Select Therapy and Rehabilitation may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any other situation, **Select Therapy and Rehabilitation's** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Select Therapy and Rehabilitation may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. **Select Therapy and Rehabilitation** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Select Therapy and Rehabilitation** may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on **Select Therapy and Rehabilitation's** health information practices or if you have a complaint, please contact the following person:

Select Therapy and Rehabilitation Services
Lilian Bacchus

7401 N. University Drive • Suite 104 • Tamarac, Florida 33321 • (954) 724-5500 • Fax (954) 724-5131

Select Therapy and Rehabilitation Services

PATIENT INFORMATION CONSENT FORM

I have received and understand **Select Therapy and Rehabilitation's** Notice of Information Practices. I understand that **Select Therapy and Rehabilitation** may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that **Select Therapy and Rehabilitation** will consider requests for restriction on a case by case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Select Therapy and Rehabilitation's** Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

____
Patient Name

____
Signature

____
Date

I also authorize **Select Therapy and Rehabilitation** to use my protected health information for targeted marketing, fund raising, and/or solicitation of participation in research studies. I understand I have the right to copy or inspect any information used for these purposes. I also understand this authorization does not affect my consent to use my protected health information for treatment, billing, or operations related to treatment and billing.

____
Patient Name

____
Signature

____
Date

Office Policies for Select Therapy and Rehabilitation Services

(Please initial each box below indicating you have read the following policies)

☐ **Late Policy "15-minutes"**
Arriving more than 15 minutes late for your appointment **MAY** require you to reschedule your visit. We do not allow appointments to overlap because this undeservedly compromises the care of another patient.

☐ **24-hour Advance Notice Fee**
If you wish to change or cancel an appointment, we require a minimum **24 hour advance notice**. Advance notice allows another patient to take your appointment time. Repeated last minute rescheduling and/or no-shows may result in a $10 fee and a patient only being able to schedule appointments on a daily basis.
Please be courteous and responsible.

☐ **Insurance Billing**
We submit billing to insurance companies as a courtesy to our patients. All co-payments and deductibles are due prior to services being provided. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 90 days, you will be responsible for the full balance. **We are not responsible for any misinformation we are given by your insurance company. We RECOMMEND you call your insurance company to verify the information we give to you.**

☐ **Notice Regarding Federal Government Regulations:**
It is unlawful to avoid paying your copay, deductible, or coinsurance payments. Unless you complete a "Financial Hardship" form and qualify for financial assistance under Federal Standards, you may NOT evade paying your responsibility portions for medical care as outlined in your insurance plan. This includes services deemed as "professional courtesy" and "TWIP's –Take what insurance pays". Failure to comply places you in violation of the following laws: Federal False Claims Act, Federal Anti-Kickback Statute, Federal Insurance Fraud Laws, and State Insurance Fraud Laws. Failure to comply may result in civil money penalties (CMP) in accordance with the new provision section 1128 A (a)(5) of the Health Insurance Portability and Accountability Act of 1996 [section 231(h) of HIPAA]. Exceptional cases do apply. Please see the following contact info for more information. Office of Inspector General, Department of Health and Human Services. Contact by phone: 202-619-1343, by fax: 202-650-8512, by email: paffairs@oig.hhs.gov, by mail: Office of Inspector General, Office of Public Affairs, Department of Health and Human Services, Room 5541 Cohen Building, 333 Independence Avenue, S.W. Washington, D.C. 20201, Joel Schaer, Office of Counsel to the Inspector General 202-619-0089.

We look forward to building a successful relationship with you that lasts a lifetime!