Rehabilitation Services, Inc.

Physical, Speech-Language, and Occupational Therapy

Laurel Office
14409 Greenview Drive
Suite 102
Laurel, MD 20708
(301) 498-8100
Or (410) 792-7777
Fax: (301) 498-0009

Administrative Address
P.O. Box 500
Brookeville, MD 20833

PATIENT INFORMATION – *COMPLETE ALL INFORMATION*

Name _____ Date _____

Address _____ D.O.B. _____Sex M ____ F ____

_____ Phone (h) (_____)_____- _____

Patient Social Security _____ ____ _____ (w) (_____) _____-_____

(c) (_____) _____-_____

Family Contact _____ Relationship _____

Address _____ Phone (h) (_____) _____-_____

_____ (w) (_____) _____-_____

_____ (c) (_____) _____-_____

Email: _____

Primary Care Physician (PCP) – Name

PCP Phone (_____) _____-_____

_____
Specialist Physician- Name

Specialist Phone (_____) _____-_____

_____

How did you hear about us? _____

Describe your condition / give diagnoses

_____

When did your symptoms begin? (DATE) _____

What caused your symptoms? 1. *Employment related (current or former)?* Yes/No
2. *Auto Accident?* Yes/No
3. *Other accident?* Yes/No (Describe: _____)
4. *Other* (Describe: _____)

Insured's Name _____ **Insured Employed by** _____

Insured's Date of Birth _____ **City, State of Employer** _____
Patient's Relationship to **Insured** (check): Self____ Spouse____ Child____ Other____

Name of person Responsible for payment if not "Self" (Policy Holder) _____
Responsible Party's Address

_____ Phone (h) (_____) _____-_____

_____ (w) (_____) _____-_____

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INFORMATION RELEASE AND INFORMED CONSENT FOR PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND/OR SPEECH-LANGUAGE PATHOLOGY SERVICES

I wish to participate in a physical therapy, occupational therapy, and/or speech-language pathology program as prescribed by my physician. If patient is a minor child, I consent to therapy for that child, and represent myself as a legal guardian authorized to provide consent for that child.

EXPLANATION OF THE THERAPY SESSIONS

The patient will undergo an evaluation of his/her current level of skills, which may involve formal testing procedures and informal assessments. The patient will be asked to perform certain tasks for the evaluation, a medical history will be obtained, and there will be correspondence with your physician(s) for complete details of his/her condition. This evaluation enables the licensed therapist to determine what areas are in need of therapeutic intervention for functional improvement. A therapy program will be developed based on the results of the evaluation. If it is not clear that a therapy program would be helpful, then a trial period of therapy may be suggested.

As with any process that involves rehabilitation, the patient may find the therapy sessions tiring; there may be muscular soreness, fatigue, and adjustments in neuromuscular functioning. The patient may also experience frustrations. There may be behavioral adjustments necessary on the part of the patient. Should the patient observe any adverse signs or symptoms, please report these to the therapist or the referring physician for his/her attention immediately.

CONFIDENTIALITY

The information gathered by Rehabilitation Services, Inc, (RSI) during the evaluation and therapy sessions will be treated as privileged and confidential between RSI, the patient, referring physician, and other relevant medical professionals. We will also disclose information on the patient's behalf to other parties with a signed consent form/release from the patient.

INQUIRIES

We encourage you to ask any questions about any aspect of the program that is unclear to you and/or the patient.

MEDICAL RECORDS RELEASE

I authorize the release of any medical or other information necessary in the planning and implementation of my rehabilitation program, and necessary in processing my medical claims. I understand this information will be released only to appropriate professional personnel, and to the Social Security Administration or its intermediaries, or to other insurance carriers.

I agree to notify RSI immediately if any insurance or demographic information changes. I accepted the responsibility for my payment for the therapy services, or for that portion of the bill not covered by insurance for any reason, including my failure to notify RSI about changes.

_____
Printed Name

_____ _____
Signature Date

_____
Witness

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NOTICE OF PRIVACY PRACTICES

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and our rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect on April, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For information about our privacy practice, or for additional copies of this Notice, please contact us at (301) 498-8100.

USES AND DISCLOSURES OF HEALTH INFORMATION

Treatment: We may use and disclose your health information to a physician or other healthcare providers providing treatment to you. For example: information obtained by a nurse, rehabilitation therapist, social worker, home health aide or member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will record the actions they took and their observations. In that way, all members of your healthcare team will know you are responding to treatment. We will also provide your physician and other healthcare providers involved with your care of various reports that should assist in treating you while you are receiving homecare services. These reports may be communicated to your other healthcare providers by phone, fax, mail, or protected e-mail.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. For example: a bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, services provided and supplies used.

Healthcare Operations: We may disclose your health information in connection with our healthcare operations. Healthcare operations include qualify assessment and improvement activities, competence or qualification reviews of healthcare professionals, practitioner and provider performance evaluations, training programs, accreditation, certification, licensing or credentials activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at anytime. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

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Business Associates: There are some services provided in our organization through contracts with business associates. Examples include outside medical or financial review organizations. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job that we have asked them to do. To protect your health information, we require the business associates to appropriately safeguard your information.

Communication with Family/Care Representatives: We may contact a family member, personal representatives, or another person responsible for your care, to obtain information about your care, location or general condition, Health professionals, using their best judgment, may disclose to a family member/care representative that you identify health information relevant to that person's involvement in your care.

Appointment Reminders: We may contact you to remind you of a scheduled visit, to provide you with treatment alternatives or other health-related benefits and services that may be of interest to you.

Emergency Medical Providers: In an emergency situation, we may disclose health information to emergency medical providers to assist them in carrying out their duties.

Food and Drug Administration (FDA): We may disclose to the FDA health information related to adverse events with respect to food, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacements.

As Required by Law and for Healthcare Oversight: We may disclose medical information about you when required to do so by federal, state, or local law in response to a valid subpoena. We may disclose medical information to investigations, inspections, and licensures. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.

Worker's Compensation: We may disclose medical information to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law that provide benefits for work-related injuries or illnesses without regard to fault.

Public Health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, and disability.

Victims of Abuse, Neglect or Domestic Violence: We may disclose information about suspected abuse, neglect, or domestic violence if required by law, statue or regulation, or if it is determined that reporting is necessary to prevent serious harm to the potential victim(s).

Government Functions: Specialized government functions, such as protection of public officials, for national security Activities that are authorized by the National Security Act, or for reporting various branches of the armed services, that may require use or disclosure of your health information.

State Law: As applicable, we will not use or disclose information regarding drug or alcohol abuse, HIV infections, or psychotherapy without your written consent or authorization as required by State law.

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PRIOR TREATMENT/EVALUATION

Insurance companies differ in their reimbursement for services which may be considered redundant with respect to previous treatments. It is important for us to know whether you have previously received a therapy evaluation or treatment for the condition which brings you to our office today. It is also important that you notify us of any change in your insurance.

For any services, your insurance company may need you to secure pre-authorization for treatment. It is your responsibility to secure this pre-authorization; if you need to get pre-authorization and have not done so, you may be responsible for payment of your treatment or evaluation. In the space below, please indicate any and all treatment and/or evaluation for this condition. If you misrepresent this information, you may be billed in full for any treatment or evaluation performed by RSI and its associates. If you have never received prior treatment or evaluation for your condition, please write ***"NONE"*** in the table and sign below.

Place of prior treatment	Type of prior treatment(PT, OT, Speech) or "*NONE*"	Approximate dates of prior treatment	Insurance company at the time of prior treatment

I agree to notify RSI if any of my demographic or insurance information changes. I agree to assume responsibility for any payment owed due to non-coverage by my insurance. If I agree to be seen for services without authorization or referral required by my insurance, I explicitly waive my benefit for that service and agree to pay for the services.

Your signature here verifies that this information is true and correct.

_____
Printed Name

_____ _____
Signature Date

I acknowledge that I have received a copy of **The Notice of Privacy Practices** from a representative of RSI. The Notice of Privacy Practices relates to my rights and obligations under the Health Insurance Portability and Accountability Act.

_____ _____
Signature Date

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ASSIGNMENT OF BENEFITS

PATIENT: _____

EMPLOYER OF POLICYHOLDER: _____

INSURANCE COMPANY NAME: _____

MEMBER ID NUMBER: _____

CLAIM/GROUP # OF POLICYHOLDER: _____

SOCIAL SECURITY # OF POLICYHOLDER: _____

SOCIAL SECURITY # OF PATIENT: _____

I hereby instruct and direct _____ (list ALL insurance companies or responsible parties) to pay RSI directly:

RSI-Rehabilitation Services, Inc,
P.O. Box 500
Brookville, MD 20833

If my current policy prohibits direct payment to RSI-Rehabilitation Services, Inc., then I hereby instruct and direct the above mentioned insurance company to make the checks payable to me, but mail it directly to RSI-Rehabilitation Services, Inc. at the above address.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY FOR SERVICES RECEIVED.

It is understood that this payment will not exceed my indebtedness to RSI-Rehabilitation services, Inc., and I have agreed to pay, within 30 days of the determination of insurance benefit or within 30 days of the billing from RSI, whichever is sooner, any balance of RSI's charges over and above this insurance payment. I agree that I will be responsible for interest at a rate of 8% (eight percent) per annum for any amount owed by me which is not paid within 30 days of the billing date. Interest will begin to accrue on the date of the first billing. If I do not pay any amount within 60 days, RSI for any and all fees related to collection of my account in addition to the interest.

**I agree to notify RSI immediately if I change insurance. I expressly agree to be liability for 100% of any charges due to my failure to notify RSI of any insurance change. I understand that each insurance may need a different referral or authorization and I agree to waive my insurance coverage if I fail to obtain the appropriate referral or authorization.

A copy of this "Assignment of Benefits" shall be considered as effective and valid as the original.
If I proceed to receive services without the proper authorization or referral required by my insurance, I hereby waive my benefit for the coverage of such service and agree to be held personally liable for payment for any such services.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

_____ _____
Signature of policyholder Date

_____ _____
Signature of claimant, if other than policyholder Date