OUTPATIENT REHABILITATION
PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical records in this office.

Date: ________________________ Birthdate: __________________ OP Med Rec # ______________

Patient Name: ____ Patient Phone # ______________

Reason For Therapy Referral: ____

Date of Onset/Injury/Surgery ________________________ Physician: ___________________________

MEDICAL HISTORY:

Do you have/or have you had any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold (ice)	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problem	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other Injuries	Yes	No
Are you pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No

If Yes on any of the above, please explain and give approximate dates: ___________________________

____

____

MEDICATIONS:

Yes No Are you presently taking medications?

If Yes, please list what medications, dosage and for what condition:

Medication Dosage Condition

____

____

____

____

____

OTHER INFORMATION:

Yes No Have you had previous therapy for the present condition for which you are to receive treatment here?

Yes No Is this a work related injury or condition?

Yes No Has this injury been reported to your employer?

DATE: ____________________

RESIDENT NAME: ________________________________

PHYSICIAN: ____________________________________

DEAR ____
(Financial Responsible Party)

Before a full evaluation or treatment/s are rendered, approval from the responsible party must be received. It is specifically important to note that according to the Medicare Part B guidelines, 80% of the reasonable therapy costs are covered. In the absence of a qualifying co-insurance, 20% of the therapy services charge is to be covered on a private pay basis. Below is an estimate of the duration, number of therapy treatments in each discipline required to achieve all of the goals designed for/by the resident, and the estimated
20% co-payment dollar amount.

TYPE OF THERAPY	ESTIMATED NUMBER OF TREATMENTS	20% $ AMOUNT
Physical Therapy	__ Evaluation __ Treatment Visits	Not to Exceed $
Occupational Therapy	__ Evaluation __ Treatment Visits	Not to Exceed $
Speech and Language Pathology	__ Evaluation __ Treatment Visits	Not to Exceed $

__ Yes, please provide therapy services as indicated. I understand that I will be responsible for the private pay segment of the therapy bill, which is not covered under the insurance plan.

__ No, I do not wish to cover the private pay segment of the bill and understand that no additional therapy services will be provided.

Signature: ______________________________ Date: ____________________
(Financial Responsible Party)

Print Name: ______________________________

Business Office Approval: ____________________ Date: ____________________

Revised 3/2016

Legend Oaks Healthcare & Rehabilitation – New Braunfels

OUTPATIENT TREATMENT FINANCIAL AGREEMENT

This Agreement is entered into this _______ day of _______________, 20__ by and between **LEGEND OAKS HEALTHCARE & REHABILITATION – NEW BRAUNFELS**, hereinafter referred to as "Facility", and _____________________, hereinafter referred to as Responsible Party.

FACILITY RESPONSIBILITIES

1. The facility shall provide services and materials as described in Section 2 below, in compliance with the orders of the Patient's physician. Administration of medicines and treatments shall be ordered by the Patient's physician.
2. Facility shall provide the following prescribed services to Patient
   ____
   ____
   ____
   Additional services may be provided by Facility upon receipt of subsequent orders from the Patient's physician. Any such services provided by Facility shall be subject to all the terms of, conditions and obligations of this Agreement.
3. Facility welcomes all persons without regard to race, color, national origin, religion, sex or qualified handicaps.

PATIENT/RESPONSIBLE PARTY RESPONSIBILITIES

1. Patient and Responsible Party agree jointly and severally to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient for the services described herein and to pay such charges as they become due.
2. Patient and Responsible Party further agree that, if any of the services rendered by Facility to Patient, are covered by insurance, or benefits under either Title XVIII or Tile XIX of the Social Security Act (Medicare/Medicaid), it is nevertheless the joint and several obligation of Patient and Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Responsible Party further agree that any co-insurance or deductible obligation under Medicare, Medicaid or private insurance must be paid directly to Facility by Patient and Responsible Party.
3. Patient and Responsible Party further agree that any charges which are not made IN FULL when due shall be subject to a late charge of ten (10%) percent per annum until paid. Should it become necessary for the Facility to refer Patient's delinquent account to an attorney for collection, Patient and Responsible Party agree to pay in addition to all sums due all reasonable attorney's fees, court costs and all other reasonable costs of collection.

PATIENT'S CERTIFICATION

1. Patient certifies and warrants that all information submitted on behalf of Patient for purposes of applying for or receiving benefits under Title XVIII or XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Responsible Party warrants that all information they have supplied to facility is correct and true and further agree to hold harmless and indemnify Facility from and against any and all loss, damage, cost, expenses, or liability resulting from Patient's or Responsible Party's submission of false or incorrect information to Facility.
2. Patient authorizes any health care facility or doctor to furnish the facility and/or or the Social Security Administration, its fiscal intermediary or carrier all requested information from Patient's medical or financial records. Patient further authorizes Facility to disclose all or any part to Patient's medical or financial records to any person or entity which is or may be liable under contract to Facility, to Patient or to a family member or to the employer of Patient to pay all or a portion of the costs or care provided to Patient including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carrier, welfare fund of Patient's employer. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any independent auditor of Facility.
3. Patient requests and hereby authorizes that payment for any authorized benefits be made directly to Facility on Patients behalf.
4. Facility does not make any assurance of any kind whatsoever that Patient's care will or can be covered by Medicare/Medicaid or any private insurance, and the Patient and Responsible Party hereby release Facility, its agents, servants, and employees from any liability or responsibility in connection with the Patient's and/or Responsible Party's potential claim of coverage under Medicare/Medicaid and/or private insurance program.

RESTRICTIONS AND LIABILITIES

1. Patient and Responsible Party hereby release Facility from any and all harm, liability, injury or loss suffered by Patent while outside the physical confines of the Facility and/or the supervision and contract of Facility's staff.
2. Facility shall have no liability for injuries of any kind suffered by Patient while under its care, except where the injury is caused by the negligence of Facility or its regular staff, or as required by law. If Patient discontinues or suspends treatment before the attending physician has so ordered, or if Patient fails to follow a prescribed regimen of activity, treatment or therapy. Patient and Responsible Party agree to assume all responsibility for any result which may follow Patient's action.
3. Facility is not responsible or liable for any injury to Patient caused by Facility visitors attempting to assist to treat Patient in anyway. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted into patient treatment areas of the Facility.
4. The Facility is not liable or responsible for any personal belongings brought into and left in Facility by Patient, except as required by law.

MISCELLANEOUS

1. Where Patient is eligible for Medicaid benefits and/or where Facility is precluded under state or federal law in requiring that a Responsible Party act as guarantor for Patient, the term "Responsible Party", as used herein, shall be deemed to mean "Patient Agent". The Patient Agent is responsible for assuring that any of Patient's own funds, over which such Patient Agent exercises any management or control, and which constitutes the Patient's share of costs or liability to Facility, shall be paid to Facility as such liability is incurred.

PATIENT AND RESPONSIBLE PARTY HEREBY CERTIFY THAT EACH HAS READ THIS AGREEMENT IN ITS ENTIRETY, UNDERSTAND AND AGREE TO ITS TERMS AND CONDITIONS. RESPONSIBLE PARTY, OR OTHER PERSON WHO SIGNS THIS AGREEMENT ON BEHALF OF AND IN THE PLACE OF THE PATIENT REPRESENTS THAT HE/SHE IS AUTHORIZED BY PATIENT TO DO SO, AND THE ABOVE NAMED PATIENT AND EACH RESPONSIBLE PARTY SIGNING THIS AGREEMENT AGREES BY SO SIGNING ACCEPTING ALL OF THE TERMS HEREOF AND TO PERFORM ALL OBLIGATIONS HEREUNDER. THERE ARE NO REPRESENTATIONS MADE BY FACILITY OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAN ARE SET FORTH IN THIS AGREEMENT.

______________________________ ______________________________
Patient (or Legal Guardian) Date

______________________________ ______________________________
Responsible Party Date

______________________________ ______________________________
Facility Representative Date

Legend Oaks Healthcare & Rehabilitation – New Braunfels

Outpatient Therapy Insurance Verification

(This section to be completed at time appointment is made)

Patient Name: ______________________ Appointment Date: __________ Time: ________

Address: ____

City: ______________________ State: ______________ Zip: ________

Home Phone: ____________ Employer: ______________ Work Phone: ____________

Social Security #: ______________________ Birth Date: ______________

Primary Insurance Co.: ______________________ ID #: ____________

Subscriber Name: ______________________ Group #: ____________

Address: ______________________ City: __________ State: ____ Zip: ________

Phone #: ______________________

Secondary Insurance Co.: ______________________ ID #: ____________

Subscriber Name: ______________________ Group #: ____________

Address: ______________________ City: __________ State: ____ Zip: ________

Phone #: ______________________

(To be completed prior to first appointment or attached with insurance authorization)

Primary Ins. Co.: ______________________ Date contacted: __________

Name of Contact: ______________________ Policy Effective Date: ______________

Policy in force? Yes No

Annual Deductible: $__________ Already met? Yes No

Co-Payment Due: $__________ # of Visit or CPT codes Authorized: __________

Contract Required? Yes No

Type of Coverage: PT OT ST

In-network: PT Yes No OT Yes No ST Yes No

Authorization Required? Yes No

Authorization #: ______________________ Authorization Through Date: ______________

Continued Authorization Required? Yes No

Date: ________ Contact: ______________ Auth. # ____________ Auth. Thru Date: ____________

Date: ________ Contact: ______________ Auth. # ____________ Auth. Thru Date: ____________

Date: ________ Contact: ______________ Auth. # ____________ Auth. Thru Date: ____________

Outpatient Therapy Insurance Verification

(continued)

Send claims to:

Name: ______

Address: ______

City: ______ State: ______ Zip: ______

Required billing format: ______

Required billing frequency: ______

Required billing attachments: ______

Secondary Ins. Co.: ______ Date contacted: ______

Name of Contact: ______ Policy Effective Date: ______

Policy in force? Yes No

Annual Deductible: $______ Already met? Yes No

Co-Payment Due: $ ______ # of Visits Authorized: ______

Contract Required? Yes No

Type of Coverage: PT OT ST

In-network: PT Yes No OT Yes No ST Yes No

Authorization Required? Yes No

Authorization #: ______ Authorization Through Date: ______

Continued Authorization Required? Yes No

Date: ______ Contact: ______ Auth. # ______ Auth. Thru Date: ______

Date: ______ Contact: ______ Auth. # ______ Auth. Thru Date: ______

Date: ______ Contact: ______ Auth. # ______ Auth. Thru Date: ______

Send claims to:

Name: ______

Address: ______

City: ______ State: ______ Zip: ______

Required billing format: ______

Required billing frequency: ______

Required billing attachments: ______

Legend Oaks Healthcare & Rehabilitation – New Braunfels

Notice of Privacy Practices

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. You have the right to:

- **Get an electronic or paper copy of your medical records**
  - You may ask to see or obtain an electronic or paper copy of your medical records 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 and may charge a reasonable, cost-based fee for doing so
- **Ask us to correct your medical records**
  - You may ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this
  - We may deny your request and will provide you a reason in writing
- **Request confidential communications**
  - You may 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 comply with all reasonable requests
- **Ask us to limit what we use or share**
  - You may ask us **not** to use or share certain health information for treatment, payment or our operations. We may deny your request if we believe it may affect your care
  - If you pay for a service or health care item out of pocket in full, you may ask us not to share that information for the purpose of payment or our operations with your health insurer. We will comply with your request unless a law requires us to share that information
- **Get a list of those with whom we have shared your information**
  - You may request a list (accounting) of the times and to whom we have shared your health information for six (6) years prior to the date you ask.
  - We will include all the disclosures except for those about treatment, payment and healthcare operations, and certain other disclosures (such as any you asked us to make). We will provide one accounting a year for free and may charge a reasonable, cost-based fee if you request additional lists within twelve (12) months.

- **Get a copy of this privacy notice**
  - You may 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 may exercise your rights and make choices about your health information
  - We will verify the person has this authority and may act for you before we take any action
- **File a complaint if you feel your rights have been violated**
  - You may complain if you feel we have violated your right by contacting us using the information below. We will not retaliate against you for filing a complaint.
    - *Our Compliance Hotline at **1-866-256-0955** which is available 24 hours per day, 7 days per week.*
  - You may 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 by visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

YOUR CHOICES

For certain health information, you may 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.

If you are not able to tell us your preference, for example if you are unconscious, we may 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, 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 directory
- **In these cases we may not share your information unless you give us written permission:**
  - Marketing purposes
  - Sale of your information
  - Most psychotherapy notes
- **In the case of fundraising**
  - We may contact you for fundraising efforts, but you may tell us not to contact you again

OUR USES AND DISCLOSURES OF YOUR INFORMATION

We may use or share your health information for treatment, to obtain payment, and/or to operate our business.

- **Treat you**
  - We may 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 may 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 may use and share your health information to bill and receive payment for health plans or other entities
    - *Example: We give information about you to your health insurance plan to obtain payment for your services.*

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

- **Help with public health and safety issues**
  - We may 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 a person's health or safety

- **Do research**
  - We may use or share your information for health research with your written permission

- **Comply with the law**
  - We may share information about you if state or federal laws require it, including with the Department of Health and Human Services (DHHS)

- **Respond to organ and tissue donation requests**
  - We may share health information about you with organ procurement organizations or other entities engaged in the procurement, banking, or transplantation for the purpose of facilitating organ and/or tissue donation

- **Work with a medical examiner or funeral director**
  - We may share health information with coroners, medical examiners, or funeral directors as necessary to carry out their duties

- **Address workers' compensation law enforcement and other government requests**
  - We may 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 may share health information about you in response to a court or administrative orders, or in response to a subpoena

OUR RESPONSIBILITIES

- We are required to maintain the privacy and security of your protected health information
- We are required to notify you promptly in the event your information is compromised
- We must follow the duties and privacy practices described in this notice and give you a copy of it on request
- We will not use or share your information other than 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 visit:

www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html

Changes to the Terms of This Notice

We may 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 and on our website.

Acknowledgment of Receipt of Notice of Privacy Practices

My signature below acknowledges that I received the Facility/Agency's Notice of Privacy Practices (with a revision date of March 1, 2016).

Refusing to sign does not prevent the facility/agency from using or disclosing health information as permitted by law.

Signature: ________________________________ Date: ______________________

If not patient/resident, relationship to patient/resident: __________________________

(Print Name) ____

How was Notice provided to the patient/resident: Circle one

During Admission In Person after Admission By Mail/Email Other: _________________

Please return this acknowledgement to the facility/agency receptionist, admissions coordinator, or the medical records department.

[FOR FACILITY/AGENCY USE ONLY]

If acknowledgement was not obtained, please complete the following:

Patient/resident's Name: ____

Date of attempt to obtain acknowledgment: __________________________________

Reason acknowledgment was not obtained:

☐ Patient/resident/family member received notice but refused to sign acknowledgment
☐ Emergency treatment situation
☐ Patient/resident was incapacitated and no family member was present
☐ Unable to communicate due to language barriers
☐ Other (please describe): ____

Employee Signature: ___________________________ Date: ______________

Legend Oaks Healthcare & Rehabilitation – New Braunfels

Rehabilitation Services
Outpatient Therapy Treatment Agreement

This is a Therapy Treatment Agreement in which the patient consents to treatments upon the provisions hereof and the patient, responsible party, and the facility hereby agree as follows:

Patient Name: ______________________________

Address: ______________________________

City: ____________________ State: __________ Zip: __________

Home Phone: __________ Employer: ______________ Work Phone: __________

Social Security #: ______________ Birth Date: ______________

Sex: M F (circle one)

Primary Insurance Company: ____________________ Group #: __________
Address: ____________________ Phone #: __________
Subscriber Name: ____________________ Co-Pay Amount: __________

Secondary Insurance Company: ____________________ Group #: __________
Address: ____________________ Phone #: __________
Subscriber Name: ____________________ Co-Pay Amount: __________

Physician: ____________________ Phone #: __________
Address: ______________ City: __________ State: ______ Zip: ______

Responsible Party: ____________________ Relationship: __________
Address: ______________ City: __________ State: ______ Zip: ______
Home Phone: ______________ Work Phone: ______________

Emergency Contact: ____________________ Relationship: __________
Address: ______________ City: __________ State: ______ Zip: ______
Home Phone: ______________ Work Phone: ______________

Please initial each section:

_______ **Financial Responsibility:** I do hereby guarantee payment of therapy services to **Legend Oaks Healthcare & Rehabilitation – New Braunfels** (Facility). I understand that I am responsible for payment of my account and the facility does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, the facility will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has been received, is due and payable upon receipt.

Patient Name: ______________________________

Interest of 1.5% monthly (18% per annum) will be added to all accounts 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_______ **Cancellation Policy:** 24-hour notice is required to cancel a therapy appointment. A cancellation fee of $25.00 may be charged to the responsible party if sufficient notice is not provided.

_______ **Treatment Consent:** I hereby consent to the examinations, treatments and medications ordered or recommended by my physician or designated alternate.

_______ **Authorization for Release of Information:** The institution rendering services is hereby authorized to furnish and release, in accordance with the facility's policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third party agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

_______ **Assignments and Authorization to Pay Insurance Benefits:** I hereby assign and authorize payment directly to the facility, herein specified and otherwise payable directly to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for charges not covered or paid by my insurance.

_______ **Assignments and Authorization to Bill Medicare:** I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible for 20% of the Medicare Part B services.

Patient and/or responsible party agree and have received a copy of this Outpatient Therapy Agreement.

Patient: ______________________________ Responsible Party: ______________________________

Date: ______________________________ Date: ______________________________

Facility Witness: ______________________________

Date: ______________________________

FOR CLINIC USE ONLY:

Admission #: ______________________________ Admission Date: ______________________________

__________ Copy of insurance attached