Florida Institute of Rehabilitation & Sports Training

A Medicare Certified – Outpatient Rehabilitation Facility

Patient Information:

Patient Name_____ **Phone #**_____

Street Address:_____

City:_____ **State:**_____ **Zip Code**_____

SS#_____ - _____ - _____ **Martial Status: S M D W**

Date of Birth: _____/_____/_____ **Age**_____ **Sex: Male / Female**

Referring Physician:_____

Next of Kin:_____ **Contact Phone#:**_____

Relationship:_____ **Address**_____

Employer Name:_____ **Phone#:**_____

- ***Was your injury an Auto Accident / Slip & Fall/ or Work related Yes / No***

Insurance Information:

Primary Insurance_____ **Ins. Card Copied Yes / No**

Policy Holder Name:_____

Secondary Insurance:_____ **Ins. Card Copied Yes / No**

Policy Holder Name:_____ **Policy Holder Date of Birth**_____

1920 Palm Beach Lakes Blvd. • Suite 110 • West Palm Beach • Florida 33409
Tel: (561) 688-7911 • fax: (561) 688-2498

Outpatient Rehabilitation Facility Medical History Form

Last Name _____ First Name _____ M. I. _____ Phone Number _____

Street Address _____ City _____ State _____ Zip Code _____

Date of Birth _____ Male or Female _____ Marital Status _____ Height _____ Weight _____

In Case of Emergency Notify: _____ Relationship _____

Home # _____ Work # _____

Yes No Are you under the care of a physician ? If yes, please state name, address and phone # of physician: _____

_____

Approximately when was your last physical exam. ? _____

Yes No Have you had any serious illness(es), operations, or been hospitalized in the past 5 years? If yes, please describe: _____

_____

Yes No Are you now taking medicine, including non- prescription medication? If yes, what medication(s) (including dosage and frequency) _____

_____

_____

Yes No Do you have any disease or problem not listed below that you feel we should know about? If yes, please explain: _____

_____

Do you have. or have you had, any of the following diseases pr problems?

Yes	No	Diabetes	Yes	No	Hypertension
Yes	No	Alcoholism	Yes	No	Pace- Maker
Yes	No	Allergies	Yes	No	Immune System
Yes	No	Anemia	Yes	No	Liver Disease
Yes	No	Bowel	Yes	No	Mental Illness
Yes	No	Cancer	Yes	No	Renal Disease
Yes	No	Circulatory	Yes	No	Respiratory
Yes	No	Nervousness	Yes	No	Seizures
Yes	No	Depression	Yes	No	Loss of Spouse
Yes	No	Easily Frustrated	Yes	No	Stroke
Yes	No	Drug Abuse	Yes	No	Loss of Socializing Skills
Yes	No	GI Disturbances	Yes	No	Urinary
Yes	No	Hearing Problems	Yes	No	Visual
Yes	No	Heart Disease			

I certify that I have read and understand the above. I acknowledge that my questions if any, about the inquiries set forth have been answered to my satisfaction. I will not hold the program or any of its staff responsible for any errors or omissions that I may have made in the completion of this form.

_____

Patients Signature (or individual completing this form for patient) Date

Insurance Authorization - Release Form

Patient's Name:_____

Patient's Medicare Number: _____ **Date:** _____

Instructions: **Please read this form carefully, check applicable spaces, and sign.**

Insurance Authorization - Patient Release and Authorization:

___ I hereby authorize payment directly to First Rehabilitation for the benefits due to me in my pending claim and / or Major Medical Benefits otherwise payable to me, but not to exceed the physician's and / or the facilities regular charges for therapy for this treatment period.

___ I further authorize the release of any medical information required by my insurance carrier(s).

___ I understand that I am financially responsible for charges not covered by this authorization. A copy of this authorization may be used in lieu of the original.

Medicare Authorization - Patient Release and Authorization

___ I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct.

___ I authorize any holder of medical or other information about me to be released to the Social Security Administration or its intermediaries or carriers of any information to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment.

Notice: **Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.**

Insurance Acknowledgment - Rehabilitation Services Billing and Reimbursement:

___ I am aware that Medicare and / or insurance may not reimburse some costs of my Rehabilitation.

___ I am aware that I will be billed for these non- reimbursed services.

___ I have read the above and understand that I am financially responsible for paying any and all charges incurred in the Rehabilitation Program not reimbursed.

___ However, at this time I am financially unable to pay the balance of the charges for which I am responsible. Please accept this form as a request for Indigence Status which will excuse me from further payment of the remaining balance due for said charges upon approval from First Rehabilitation. If applying for indigence Status the Indigence Information Attachment form must be completed.

Witness: _____ **Patient:**_____

Date: _____ **For Patient:**_____

Primary Payer Questionaire

The questions below are for Beneficiaries age 65 or older, and is used to comply with Medicare regulation #42 CFR 489.20(F)

- **Are you currently working full of part time** **Yes** **No**
- **If married, is your spouse working full or part time?** **Yes** **No**
- **Are you currently under any employers group health plan?** **Yes** **No**
  - **If yes, please provide the following information:**

    Name of insured / Relationship _____ **Name of Employer** _____

    Name of Insurance Carrier _____ **Group / Policy #** _____
- **Are you entitled to Black Lung Benefits ?** **Yes** **No**
- **Is this service for treatment of a Work or Auto related injury ?** **Yes** **No**
  - **If yes, please provide the following information:**

    Name of insured / Relationship _____ **Name of Employer** _____

    Name of Insurance Carrier _____ **Group / Policy #** _____
- **Are benefits for services being submitted to any other party for reimbursement consideration ?** **Yes** **No**

Patient Consent

I have received a copy of the "Notice of Privacy Practices" for FIRST Rehab.

I herby indicate my wish to be a participant in the rehabilitation program offered by FIRST Rehab.

I understand that the purpose of this program is to enhance my recovery from an injury or illness. I further understand that there exists the possibility that certain changes may occur during my treatment.

I will be informed of the procedures and methods of treatment that will be administered to my _____, and I will inquire to the Physical Therapist if I do not understand what is required of me as a patient.

I verify that my participation is fully voluntary, no coercion of any sort has been used to obtain my participation and I may withdraw from treatment at any time.

I understand that the Facility Administrator maintains an open door policy and encourages patients to participate for any reason.

Signature of Patient: _____ *Date:* _____

Printed Name of Patient: _____ *Witness:* _____

FIRST REHABILITATION

Florida Institute of Rehabilitation & Sports Training

Notice of Privacy Practices

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of any testing in physical therapy will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Options: Your health information may be used as necessary to support the day-to-day activities and management of FIRST Rehab. For example, information on the service you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support governmental audits and inspections, to facilitate law-enforcement investigations, and to comply with government-mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Require your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Additional Uses of Information: Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health related products and services that we believe may interest you.

Individual Rights:

You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.

FIRST Rehab Duties:
We are required by law to maintain the privacy of your protected information and to provide you with this notice of privacy practices that are outlined in this notice.

Right to Revise Privacy Practices:
As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in the federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information:
You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulations, we require that requests to inspect or copy protected health information be submitted in writing. We may obtain a form to request access to your records by contacting the Receptionist or the Office Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter to:

Barbara Harden
FIRST Rehab
1920 Palm Beach Lakes Blvd, Suite 110
West Palm Beach, FL 33409
561-688-7911

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person:
The name and address of the person you may contact for further information concerning our privacy practices is:

Barbara Harden
FIRST Rehab
1920 Palm Beach Lakes Blvd, Suite 110
West Palm Beach, FL 33409
561-688-7911

Effective Date:
This notice is effective on or after April 14,2003.