# REHAB RESOURCES, INC.
# CONSENT FOR TREATMENT
# ASSIGNMENT OF BENEFITS – BILLING AUTHORIZATION
# 0-18 NOT ENROLLED IN A BIRTH TO THREE PROGRAM

Rehab Resources, Inc. is a certified agency that provides outpatient therapy services. Occupational, Physical, and Speech Therapy (OT, PT, and ST) services have been prescribed by Dr. _____ for _____. A review of the patient's medical history and condition by the physician and the therapist indicate that the services are medically reasonable and necessary. **The item checked below is an explanation of the present payment source for the therapy services provided.**

_____ **PRIVATE INSURANCE** Your insurance will be billed for therapy services rendered. You will be responsible for any deductible, co-payments and charges not covered by insurance. If private insurance denies coverage, and you do not have Medicare or Medicaid as a secondary payment source you are financially responsible and will be billed directly for services rendered.

_____ **PRIVATE INSURANCE & MEDICAID** Prior authorization for treatment will be submitted to Medical Assistance (MA) to cover the cost of the insurance deductible and co-payments. Should the MA prior authorization be denied, you may request an appeal hearing. If you choose not to pursue an appeal you will be responsible for covering the cost of any deductible and/or co-payments. If the case is taken to appeal and the decision is not reversed, you are responsible for the cost of the deductible and co-payments. **Rehab Resources MUST be informed of any change in your insurance. Medicaid requires that Rehab Resources, Inc. bill any private insurance prior to submitting any charges to Medicaid. Some insurances require prior authorization. If Rehab Resources, Inc. is not informed of changes in insurance, prior authorization cannot be obtained and Medical Assistance cannot be billed. Failure to report changes in insurance will result in the patient being financially responsible; patient will be billed directly for services rendered.**

_____ **PRIVATE INSURANCE HMO & MEDICAID** If there is an HMO to be billed, our office needs a current referral form from your physician on file before treatment is rendered. In some cases Rehab Resources may not be a participating provider with your HMO. In that event your HMO plan will be reviewed to determine if you must first exhaust your therapy benefits through a participating provider before Rehab Resources can begin treatment and bill Medicaid. Any amounts not paid by insurance remain the patient's responsibility with the exception of any charges covered by Medicare or Wisconsin Medical Assistance Program (Medicaid or Title 19). ). **Rehab Resources MUST be informed of any change in your insurance. Medicaid requires that Rehab Resources, Inc. bill any private insurance prior to submitting any charges to Medicaid. Some insurances require prior authorization. If Rehab Resources, Inc. is not informed of changes in insurance, prior authorization cannot be obtained and Medical Assistance cannot be billed. Failure to report changes in insurance will result in the patient being financially responsible; patient will be billed directly for services rendered.**

_____ **MEDICAID** The cost of OT, PT, ST (circle) services will be billed to the Wisconsin Medical Assistance Program (Medicaid or Title 19) as long as eligibility requirements are met. If there is a Medicaid HMO that is to be billed, our office needs a current referral form from your physician on file before treatment is rendered.

_____ **EVALUATION ONLY** Child will be placed on hold until the approved prior authorization is received. If the MA prior authorization for the evaluation is denied, you may request an appeal hearing. If you choose not pursue an appeal, you are responsible for covering the cost of the evaluation. If the case is taken to appeal and the decision is not reversed, you are responsible for the cost of the evaluation.

_____ **EVALUATION AND TREATMENT** Services will start without an approved MA prior authorization. If the MA prior authorization is denied you may request an appeal hearing. If the case is taken to appeal and the decision is not reversed you are responsible for the cost of the evaluation and treatment.

**Please remember that authorization of treatment by private insurance does not guarantee payment. Rehab Resources, Inc. will make every effort to obtain payment from your insurance company; however, if insurance denies coverage and payment, the patient will be financially responsible for the total amount of services rendered. DISCLAIMER: Benefits are subject to all terms & conditions of the contract in effect on the date services are rendered.**

_____ I have been informed of the Birth to Three program and have made the decision not to participate at this time.

**PLEASE SIGN BELOW:** Your signature indicates that (1) you agree with the provisions of the payment source as described above, (2) you authorize payment of any insurance benefits directly to Rehab Resources, Inc. (3) you authorize medical information to be released to RRI and for RRI to release information for professional claims purposes.

| **Responsible Party** | **Relationship** | **Date** |
|---|---|---|

# REHAB RESOURCES, INC. CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Rehab Resources, Inc. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Rehab Resources, Inc. I understand that the treatment of me by therapists of Rehab Resources, Inc. may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Rehab Resources, Inc. is not required to agree to the restrictions that I may request. However, if Rehab Resources, Inc. agrees to a restriction that I request, the restriction is binding on Rehab Resources, Inc.

I have the right to revoke this consent, in writing, at any time, except to the extent that Rehab Resources, Inc. has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have the right to review Rehab Resources, Inc.'s Notice of Privacy Practices prior to signing this document. The Rehab Resources, Inc.'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Rehab Resources, Inc. The Notice of Privacy Practices for Rehab Resources, Inc. is also provided in the clinic lobby and on the Rehab Resources, Inc. website at www.rehabresourcesinc.com. This Notice of Privacy Practices also describes my rights and Rehab Resources, Inc.'s duties with respect to my protected health information.

Rehab Resources, Inc. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by accessing Rehab Resources, Inc.'s website, calling the office and requesting a revised copy to be sent by mail, or asking for one at the time of my next appointment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

# REHAB RESOURCES, INC.
# AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FORM

**CONSENT PLAN**

In the event emergency medical aid/treatment is required due to illness or injury during the process of receiving services, or while being on property of the agency, I authorize Rehab Resources Inc to:

1. Secure and retain medical treatment and transportation, if needed; and
2. Release client records upon request to the authorized individual or agency involved in the medical emergency treatment.

Client's Name: _____ Home Phone: _____
Cell Phone: _____

In the event I cannot be reached, contact: _____ Phone: _____

contact: _____ Phone: _____

Physicians Name:_____ Physician's Phone: _____

Preferred Medical Facility: _____

Health Insurance Co: _____ Policy #: _____

***Consent Signature***: _____ Date: _____
(client, parent or guardian)

Print Name: _____ Phone: _____

Address: _____

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**NON-CONSENT PLAN**

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of receiving services, or while being on property of the agency. In the event emergency treatment/aid is required, I wish the following procedures to take place:

_____

_____

_____

***Non-consent Signature***: _____ Date: _____
(client, parent or guardian)

Print Name: _____ Phone: _____

Address: _____

## REHAB RESOURCES, INC.

## OUTPATIENT CANCELLATION GUIDELINES

Rehab Resources expects families and caregivers to be responsible for keeping scheduled appointments. Therapists will attempt to be as flexible as possible when scheduling. Parents are expected to notify Rehab Resources as soon as they know that their child will be unable to keep a scheduled appointment.

- Please call the clinic to cancel appointments. If a 24 hour notice is not possible due to illness or emergency, call as soon as possible to notify the office regarding the circumstance.
- If you call outside regular business hours, leave a message on the answering machine in the general mailbox.
- When an appointment is cancelled, the therapist will call and offer to schedule a "make-up" session for the cancelled appointment with themselves or another therapist
- Please be aware that a therapist may not be able to keep your child's slot available when there are frequent cancellations.
- If cancellations have been due to illness or another medical condition, a physician's order stating that it is safe for your child to resume therapy may be required.

## "NO SHOWS" - MISSED APPOINTMENTS

- If you do not cancel your child's appointment prior to the scheduled session, you will be notified. It will be your responsibility to schedule the next appointment.
- If your child misses two (2) scheduled appointments without notice, your therapist will not keep your child's time slot. A recommendation to discontinue services will be discussed with you.
- If Rehab Resources Inc has not heard from you, your child will be discharged from therapy services.

I have reviewed and understand these guidelines.

Signature of Parent/Guardian: _____ Date: _____

If clinic appointment is after 4:00, the parent/guardian must be present for liability purposes.

# MEDICAL HISTORY FORM



**Name:**_____
**Date of Birth:** _____

## *PREGNANCY/BIRTH*

Pregnancy Proceeded: ☐ without complications ☐ with complications

Length of Pregnancy: _____ weeks Complications: _____

Birth Weight: _____ _____

Multiple Birth (twin) ☐ YES ☐ NO _____

Delivery Proceeded: ☐ without complications ☐ with complications

Delivery was: Complications: _____

☐ vaginal ☐ planned C-section ☐ emergency C-section _____

Length of child's hospital stay: _____ _____

## *MEDICATIONS/ALLERGIES/IMMUNIZATIONS*

☐ No Known Allergies ☐ Allergies: _____

☐ No current medications ☐ Current medications and dosage: _____

_____

Other vitamins/minerals/homeopathics: _____

Immunizations up to date? ☐ YES ☐ NO - explain: _____

## *HEALTH HISTORY*

Pediatrician: _____ Pediatricians Office/Phone: _____

Current Medical Diagnoses: _____

Child is aware of these diagnoses/prognosis ☐ YES ☐ NO ☐ N/A

Hearing: ☐ Never tested, no concerns ☐ never tested, have concerns ☐ normal test results ☐ abnormal test results: _____

Hearing tested by:_____ Date:_____ _____

Vision: ☐ Never tested, no concerns ☐ never tested, have concerns ☐ normal test results ☐ abnormal test results: _____

Vision tested by:_____ Date:_____ _____

Current Activity or Feeding Restrictions/Precautions: _____

Has your child ever been hospitalized? ☐ NO ☐ YES - explain: _____

_____

_____

Medical Specialists seen:

| Name of Specialist | Specialty | Reason | Date of last visit/ Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Medical Procedures:

| YES / NO | Date | Results/Explain |
|---|---|---|
| ☐ Y ☐ N Ear Tubes Placed | | |
| ☐ Y ☐ N Blood Work | | |
| ☐ Y ☐ N Biopsy | | |
| ☐ Y ☐ N Imaging (X-ray/MRI/CT) | | |
| ☐ Y ☐ N Swallow Study | | |
| ☐ Y ☐ N Endoscopy | | |
| ☐ Y ☐ N Surgical Procedure | | |
| OTHER: | | |
| OTHER: | | |

Medical conditions: Has your child had any of the following? If yes, please explain below:

| | | | |
|---|---|---|---|
| ☐ Austim | ☐ Constipation | ☐ Laryngomalacia | ☐ shunt |
| ☐ Asthma/ upper respiratory issues | ☐ Colic | ☐ Osteoporosis | ☐ torticollis |
| ☐ Brain Injury | ☐ Diarrhea | ☐ Reflux | ☐ tube feeding |
| ☐ Baclofen Pump | ☐ Diagnosed Syndrome | ☐ Seizures | ☐ vagal nerve stimulator |
| ☐ Chronic Ear infections | ☐ Hip subluxation | ☐ Scoliosis | ☐ Other:_____ |

EXPLAIN: _____

_____

_____

List any adaptive/special equipment, orthotics, etc: _____

_____

## *DEVELOPMENTAL HISTORY*

Favorite Toys and Activities: _____

Current Classes/Sport/Extracurricular Activities: _____

FEEDING: Does your child have any feeding problems: ☐ No ☐ Yes
IF YES : Describe_____

Food likes: _____ Food Dislikes: _____

LANGUAGE/COMMUNICATION: Does your child have any communication problems: ☐ No ☐ Yes
IF YES : Describe_____

Primary Method of Communication: ☐ Crying/vocalizations ☐ Single Words ☐ Phrases ☐ Signs ☐ Gestures ☐ Sentences

How often is your child understood? _____% familiar person _____% unfamiliar person

Does your child: Have speech understood by most people? ☐ Y ☐ N Respond correctly to yes/no questions ☐ Y ☐ N

Follow simple instructions? ☐ Y ☐ N Stutter? ☐ Y ☐ N Respond when name is called ☐ Y ☐ N

SENSORY:

Does your child have sensitivity to: ☐ light ☐ touch ☐ textures ☐ sounds Explain: _____

Does your child have difficulty calming when upset? ☐ Y ☐ N _____

MILESTONES: Age your child began to: Babble _____ Said 1st Word _____ Combined 2 words _____
Rolled _____ Sat independently _____ Creep or crawl forward _____
Took 1st steps _____ Toilet trained _____ Self-dressing _____

## *THERAPY HISTORY*

Has your child received PT / ST/ OT in the past? ☐ NO ☐ YES - explain (type, dates, goals) _____

_____

_____

Does your child receive School Based Therapy Services or Birth to Three Services? ☐ NO ☐ YES - please bring in a copy of IEP / IFSP

Does your child receive behavioral or autism services? ☐ NO ☐ YES - please bring in a copy of service plan

## *OTHER INFORMATION*

Please list or describe any other important information not previously noted or discussed above that you feel is important to note:

_____

_____

## *Release and Assignment*

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my minor/child's medical status.

Private Insurance? Yes / No Name: _____

I hereby authorize Rehab Resources Inc. to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Signature of Parent/Guardian: _____ Date: _____