



**REHAB RESOURCES, INC.
 CONSENT FOR TREATMENT
 ASSIGNMENT OF BENEFITS – BILLING AUTHORIZATION
 ADULT (18 years and over)**

Rehab Resources, Inc. is a certified agency that provides outpatient therapy services. Occupational, Physical, and Speech Therapy (OT, PT, 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 and co-payments. 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** A MA prior authorization for treatment will be submitted 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 your in insurance, Medicaid requires that Rehab Resources, Inc. must bill any private insurance prior to submitting any charges to Medicaid. Some insurance's require prior authorization, if Rehab Resources, Inc. does not get the change of insurance information from you allowing us to obtain the prior authorization Medicaid cannot be billed.**

_____ **PRIVATE INSURANCE HMO & MEDICAID** If there is an HMO that is 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 within your HMO. In which case your HMO plan must 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 Title 19 (Medicaid) Program. **Rehab Resources MUST be informed of any change in your insurance, Medicaid requires that Rehab Resources, Inc. must bill any private insurance prior to submitting any charges to the Medicaid Some insurance's require prior authorization, if Rehab Resources, Inc. does not get the change of insurance information from you allowing us to obtain the prior authorization Medicaid cannot be billed.**

_____ **MEDICAID** The cost of OT, PT, ST (circle) services will be billed to the Wisconsin Title 19 (Medicaid) program 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. Any amounts not paid by insurance remain the patient's responsibility.

_____ **MEDICARE** The cost of the OT, PT, ST (circle) services will be billed to the Federal Medicare program; Medicare Part B (medical insurance) reimburses services at 80%. If you have supplemental Medicare insurance the remaining 20% will be billed to your supplemental insurance company. Any supplies, equipment or services not covered by Medicare will be your responsibility and will be billed to you by Rehab Resources. As of 9/1/03 Medicare coverage has been changed to a maximum of \$1590.00 per year for occupational therapy and \$1590.00 per year for physical and speech therapy combined. If your treatment exceeds this limit of \$1590.00 there are options available. Additional information is available upon request.

_____ **WORKMAN'S COMP** The cost of the OT, PT, ST (circle) services will be billed to the workman's comp insurance company if our office is supplied with the appropriate insurance information. Any amounts not paid by the insurance company remain the patient's responsibility.

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.**

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
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**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: _____

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.



REHAB RESOURCES, INC.
MEDICAL HISTORY

FACILITY: _____

Name: _____ Birth Date: _____

Address: _____

A. Have you ever been treated for or ever had any known indication of: (For each category checked "yes", please explain in the space provided)

	<u>YES</u>	<u>NO</u>	<u>COMMENTS</u>
1. Dizziness, fainting, convulsions, headache; speech defect, paralysis or stroke; mental or nervous disorder, multiple sclerosis or epilepsy?	_____	_____	_____
2. Shortness of breath, persistent hoarseness or cough, blood spitting; bronchitis, pleurisy, asthma, emphysema, tuberculosis, or chronic respiratory disorder?	_____	_____	_____
3. Chest pain, palpitation, high blood pressure, rheumatic fever, heart murmur, heart attack, or other disorder of the heart or blood vessels?	_____	_____	_____
4. Diabetes, thyroid, or other endocrine disorders?	_____	_____	_____
5. Neuritis, sciatica, rheumatism, arthritis, gout, or disorder of the muscles or bones, including the spine, back or joints?	_____	_____	_____
6. Deformity, lameness, or amputation?	_____	_____	_____
7. Disorder of skin, lymph glands, cyst, tumor, or cancer?	_____	_____	_____
8. Please list all surgeries and dates: _____			

B. Have you had any other major illnesses or medical conditions not listed in question #1? If so, please explain: _____

1. Do you smoke? Yes ___ No ___ Have you ever smoked? Yes ___ No ___ If so, when did you quit? _____

2. If female, are you pregnant? Yes ___ No ___

3. Please list any medications you are currently taking: _____

4. Please list any allergies: _____

C. Current Condition Referred to: Physical Therapy Occupational Therapy Speech Therapy .

1. For what condition have you been referred? _____

2. When did the injury take place or condition begin? _____

3. Have you had any recent x-rays? If so, what were the findings? _____

4. Have you had any prior Physical Therapy Occupational Therapy Speech Therapy ? If yes, what type of treatment have you received? _____

5. Have any "special" tests been done for this condition? If so, what were the results? _____

I certify that all the statements and answers to the above questions are complete and true to the best of my knowledge.

Patients/Guardian Signature: _____ Date: _____