HOPE REHAB KATY

Physical Therapy, Sports Rehab, Aquatics

Welcome to Hope Rehab Katy!

We recognize that you have a choice of physical therapy providers, and we thank you for choosing Hope Rehab Katy. The following important information will help you during your course of treatment with us.

Your first visit will include an initial evaluation performed by a physical therapist. Please wear proper attire to allow the therapist access to the area being treated. You will have the opportunity to discuss your goals and plan of care with your physical therapist. Your therapist is always available to discuss any issues about your condition during the course of treatment.

Prior to the end of your first visit, our office will verify your insurance benefits and inform you of the expected costs for each visit. Your co-pay is due at each visit. As we state in our insurance authorization form, if the information provided by your insurance company is not accurate or the insurance company pays us differently from what they quoted us, you will be responsible for payment of these services.

Once your plan of care begins, please take note of the following:

1. Physical therapy is very effective in treating many conditions and restoring normal function. The therapist has developed a plan of care that will help achieve your goals. Your responsibility is to work with your therapist and to let your therapist know how you are responding to treatment. Occasionally, soreness is normal after the initial 1-2 visits. If you have increased pain or discomfort, relaying this information to the therapist is important so your treatment or exercise can be adjusted accordingly.

2. Each visit is an important part of your plan of care. Cancelled appointments should be rescheduled for another time during that week. Maximum benefits derived from therapy are always achieved with consistent treatment. Sporadic treatment is usually not effective.

3. You will be given a home exercise program. This is an extremely important part of your recovery and it is essential that you are compliant with your home program. Communicating with your therapist as to how you are progressing is necessary so they can update your home exercises regularly.

When your doctor's referral for therapy expires, usually after 30 days, we will perform a re-evaluation. The purpose of the re-evaluation is to keep you aware of your progress, update your exercises, and to determine the need of whether or not to continue with therapy. Your doctor will review the re-evaluation and determine if continued therapy is necessary. We will then obtain a new referral if the recommendation is to continue with physical therapy.

Your doctor has determined that physical therapy is the best course of action to assist you in regaining your function. Attending therapy on a regular basis is the best way to restore your function quickly and effectively and is often less expensive than other medical procedures. We realize that attending therapy is time consuming and expensive. We want you to know that we value each session with you. We will work diligently with you to see that the goals of your plan of care are attained in a timely manner.

The exercises, strategies and techniques that you learn in physical therapy are able to help you long after you discontinue therapy with us!

Best Wishes,

Hope Rehab Katy
21938 Royal Montreal Drive
Katy, TX 77450
281-944-0001
Fax 844-671-0027

Hope Rehab Grand Parkway
2002 W. Grand Parkway North, Suite 125
Katy, TX 77449
281-710-9001
Fax 844-671-0027

www.hoperehabkaty.com

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***** Accident*****
Patient Acknowledgement of Liability

Are we treating you for an injury due to an accident?

_____ **Yes, before continuing, please speak with the front desk personnel.**
_____ No

When a health insurance company determines that their member has received or will receive reimbursement from another party (car insurance, law suit, etc.) due to an auto accident, they will recover or recoup their payments made to the provider on behalf of that member. Hope Rehab Katy is unwilling to bill your health insurance for injuries received due to an automobile accident. Please speak with front desk personnel regarding self-pay or letter of protection options.

_____
Patient and/or Guardian printed name

_____
Patient and/or Guardian signature Date

Medicare Home Health Services
Patient Acknowledgement of Liability

Have you received any home health services (including nursing, home health aide) in the last 6 months?

_____ **Yes, please speak with the front desk personnel.**
_____ No

Name of home health agency: _____

Medicare regulations prohibit any member from simultaneously receiving outpatient physical therapy and ANY home health service.

Eligibility to receive outpatient physical therapy services at Hope Rehab Katy is dependent upon written documentation from the agency that includes the date of discharge from the home health agency.

In the event that you have been recently seen by a home health agency and cannot provide this documentation, we will have you sign an Advanced Beneficiary Notice stating that you assume financial responsibility for these visits should Medicare deny or recoup payment.

_____
Patient and/or Guardian printed name

_____
Patient and/or Guardian signature **Date**

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ALL COPAYS/ DEDUCTIBLES/ PERCENTAGES ARE DUE AT THE TIME OF SERVICE

PATIENT INFORMATION

Date: _____

MEDICARE PATIENTS ONLY:
Are you currently receiving Home Healthcare services?
_____ YES _____ NO

Have you had any therapy in the last 12 months? _____

If yes, when? _____

Is your injury due to an **automobile** accident?_____

If yes, when? _____ Is there pending litigation? _____

Patient Name: _____ Male / Female Marital Status: M S W D

Date of Birth: _____-_____-_____ Social Security Number: _____-_____-_____

Drivers License #: _____ State: _____ Email: _____

Mailing Address:_____Home #: _____

City: _____State:_____Zip:_____Cell Phone #:_____

Patient Employer:_____Work #: _____

Address: _____Occupation: _____

Emergency Contact: _____ Phone #:_____

BILLING INFORMATION

PRIMARY INS name:_____ Policy #:_____Group #:_____

Ins Phone #:_____ Drivers License #:_____ State:_____

Policyholder:_____ Date of Birth:_____-____-_____ Relation to Patient: _____

Social Security #: _____-_____-_____ Employer Name:_____

SECOND INS:_____ Policy #:_____Group #:_____

Ins Phone #:_____

Policyholder:_____ Date of Birth:_____-_____-_____Relation to Patient: _____

Social Security #: _____-_____-_____

Patient/Guardian Signature:_____**Date**:_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare and/or other insurance benefits be made on my behalf to Hope Rehab Katy for services furnished to me. I authorize any holder of medical information about me to be released to Hope Rehab Katy, Health Care Financing Administration and its agents. In addition I authorize any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payments be made and a photographic copy of this authorization will serve the same purpose as the original. **I understand that the benefit verification form is only an explanation of coverage from my insurance company and it is not a guarantee of coverage**. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of these services. **I understand that I am responsible for the deductible, coinsurance, co-pays and non-covered services**, **including supply charges (99070) that will not be reimbursed by insurance.** Initials:_____

MEDICARE PATIENTS ONLY

All Medicare patients are subject to a limitation or cap on the amount of physical therapy services they are able to receive during the calendar year. Hope Rehab Katy will estimate your Medicare benefits remaining on a weekly basis (or as requested by you) and notify you of the approximate end of your covered services. **In the event that your Medicare cap is exceeded and your secondary insurance (if that coverage exists) refuses to cover those charges, you will be responsible for that amount.**

Medicare allows for billing beyond the cap when, "…the patient's condition is justified by documentation indicating that the beneficiary requires continued skilled therapy, i.e., therapy beyond the amount payable under the therapy cap, to achieve his prior functional status or maximum expected functional status within a reasonable amount of time." In cases where the physical therapist and referring physician determine that additional therapy is medically necessary, then with your permission, Hope Rehab Katy will bill Medicare beyond the cap. **In the event that Medicare disagrees with our medical assessment and refuses to pay for services rendered, you will be responsible for that amount.**

CANCELATION/NO SHOW POLICY

Hope Rehab Katy's no show policy requires a phone call to cancel appointments. An appointment must be cancelled no less than 24 hours in advance of the scheduled appointment time. **There is a $25 charge for appointments that are not cancelled in advance or not attended.** After a second consecutive no show or missed appointment, all future appointments scheduled will be cancelled. **All further scheduling is the patient's responsibility**. Initials:_____

NOTIFICATION OF CHANGES IN ADDRESS OR INSURANCE COVERAGE

The patient and/or guarantor is responsible for informing Hope Rehab Katy of any changes in their insurance coverage or their personal contact information. If the failure to report these changes precludes Hope Rehab Katy from obtaining reimbursement from the patient and/or guarantor's insurance company for services rendered, the patient and/or guarantor will be liable for all unpaid charges that would have been paid by their insurance company.

PAST DUE ACCOUNT LATE FEES

Hope Rehab Katy mails statements every 30 days to patients with a remaining account balance after insurance processes claims. A patient account with a remaining balance will become past due on the 30th day past the statement date. **If your patient account becomes past due, you will be assessed a $15 late fee in addition to all outstanding and unpaid charges.**

Patient/Guardian Signature:_____ **Date**:_____

Hope Rehab Katy Patient History

Name:_____ Age: _____ Ht: _____ Wt: _____ Date:_____
Occupation: _____ Are you currently on work restriction? _____

Do you smoke? _____Do you have a pacemaker? _____Are you pregnant? (Women) _____

How did you hear about us? ___ Doctor ___ Friend ___ Insurance Co. ___ Flyer/Ad ___ Location

Have you RECENTLY noted any of the following (check all that apply)?

□ fatigue	□ numbness or tingling	□ constipation
□ fever/chills/sweats	□ muscle weakness	□ diarrhea
□ nausea/vomiting	□ dizziness/lightheadedness	□ shortness of breath
□ weight loss/gain	□ heartburn/indigestion	□ fainting
□ difficulty maintaining balance while walking	□ difficulty swallowing	□ cough
□ changes in bowel or bladder function	□ falls	□ headaches

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

□ cancer	□ depression	□ thyroid problems
□ heart problems	□ lung problems	□ diabetes
□ chest pain/angina	□ tuberculosis	□ osteoporosis
□ high blood pressure	□ asthma	□ multiple sclerosis
□ circulation problems	□ rheumatoid arthritis	□ epilepsy
□ blood clots	□ other arthritic condition	□ eye problem/infection
□ stroke	□ bladder/urinary tract infection	□ ulcers
□ anemia	□ kidney problem/infection	□ liver problems
□ bone or joint infection	□ sexually transmitted disease/HIV	□ hepatitis
□ chemical dependency (i.e., alcoholism)	□ pelvic inflammatory disease	□ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

□ cancer	□ diabetes	□ tuberculosis
□ heart problems	□ stroke	□ thyroid problems
□ high blood pressure	□ depression	□ blood clots

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Is this something with which you would like help? YES YES, BUT NOT TODAY NO

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? YES NO

5. Have you had surgery? ____ Yes ____ No If so, what type of surgery/dates? _____
_____

6. List all your medications and dosages. _____
_____
_____

Have you ever taken steroid medications for any medical conditions? YES NO When: _____

Have you ever taken blood thinning or anticoagulant medications for any medical conditions? YES NO

7. List all your allergies. (latex, etc.)
_____

Hope Rehab Katy Patient History

Please tell us more about your symptoms:

1. How did your symptoms start? _____

2. Was this due to an accident? ___ Yes ___ No Date of Injury: _____
If Yes, where did it happen? ___ Home ___ Work ___ Auto accident ___ Other _____

3. Have you been hospitalized for this problem? ___ Yes ___ No How long? _____

4. What other treatment have you had for these symptoms? _____

5. My symptoms are currently: □ Getting Better □ Getting Worse □ Staying about the same

6. What tests have you had for these symptoms (MRI, X-rays)? _____

7. Are your symptoms changed by? ___ Sitting ___ Standing ___ Walking ___ Lying
Other: _____

8. How are you currently able to sleep at night due to your symptoms?
□ No problem sleeping □ Difficulty falling asleep □ Awakened by pain □ Sleep only with medication

9. How much of your daily activity are you able to do on a scale of 0 to 100%? _____

10. Are you currently receiving home healthcare services? _____

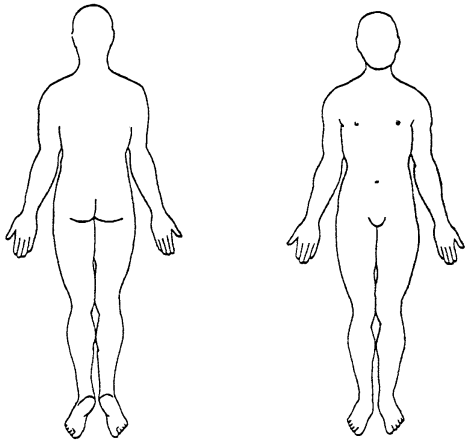
11. Where is most of your pain located?
___ Back ___ Neck ___ Shoulder ___ Elbow ___ Wrist ___ Hand ___ Hip
___ Knee ___ Ankle ___ Foot

12. Circle your level of pain: 0 = Best (no pain), 10 = Worst (unbearable pain) 0 1 2 3 4 5 6 7 8 9 10

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

□ Shooting/sharp pain
□ Dull/aching pain
||| Numbness
= Tingling



My symptoms currently: □ Come and go □ Are Constant □ Are constant, but change with activity

Notice of Privacy Practices

This notice describes how information about you may be used and disclosed and how you can get access to this information.
Please Review Carefully

WHO WILL HAVE ACCESS TO YOUR INFORMATION

We, at Hope Rehab Katy provide physical therapy and other services necessary to provide optimal rehabilitation to you, our patient/client. Because many individuals within the facility need to access to your clinical and billing records we have declared all of our employees as eligible to manage all of your health information. Specifically, this means all clinical staff (employed or contracted), all interning students, volunteers and all off personals (employed or contracted).

Typically, your clinical and billing information would be accessed for treatment and related billing purposes only. However clinical and billing audits are required by professional and regulatory standards. Your records could, therefore, be randomly selected as part of these compliance and quality assurance purposes.

A business associate is a person/entity that provides services or activities to a health care provider or covered entity. Business associates who have access to your information will be strictly limited to those who provide billing and collections, document archiving, copying and disposal services. All of these individuals are under contract and have been educated regarding patient rights and privacy regulations.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We, at Hope Rehab Katy understand that medical information about you and your health is personal. We are strongly committed to protecting your medical information. We simply record in detail the care and services that you receive at our facility, by doing so it also assists us in meeting certain legal requirements. This notice applies to all of the records that are generated by us, whether made by our employees or our contracted personal. Your personal physician may have different politics and notices regarding his/her use and disclosure of your medical information created in his/her office. It is important that you are familiar with and understand how each health care provider handles your health information. This notice will tell you about the ways we may use and disclose health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of health information.

WE ARE REQUIRED BY LAW TO

- Assure that all health information that identifies you is kept private
- Provide you with a "Notice of Privacy Practices" relating our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Privacy Practices Notice provided to you

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe ways that we may use and disclose health information. All of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment:

We may use health information about you to provide you with rehabilitation or related services. We may disclose health information about you to other therapists, doctors (your medical/dental providers), nurses, technicians, clinical students or other clinical or support personal needed to assist in optimal care delivery. This might also include disclosing or using your health information to educate and train a designated family member to assist with home rehabilitation or activities support.

For Payment:

We may use and disclose health information about you so that treatment and services you receive from our staff may be billed to and payment may be collected from your insurance company, third party payor or you. We may need to disclose health information to your health plan/payor about treatment or intervention you are going to have in order to obtain prior approval or to determine whether there is specific coverage for the services to be delivered to you.

Consents, Authorization and Access:

Currently there is not federal regulation that requires your healthcare provider to obtain for treatment, payment or associated healthcare operations. However, all providers are required to adhere to the privacy regulations stipulated in the Health Insurance Portability and Accessibility Act (HIPAA) effective in April 2001. The primary focus of the privacy section of the HIPAA is to require that heath care providers manage all health care information in a confidential and "need to know" basis. This includes paper documents, electronic data and telephonic communications. HIPAA requires that all patients/clients have full access to their health information and that they are given the right to review copy and amend it, as specifically requested. While consents for provider services are unnecessary, authorizations for use of health information outside of treatment, treatment-related operations and/ or payment are required a signed authorization form giving permission to utilize protected health information. Other providers and provider related services noted above must be obtained prior to disclosing or using private health information. The Act clearly states that the health care provider may not restrict access to services or in any way penalize a patient/ client in the event of authorization declination or authorization revocation. (Please sign and date the line below indicating that you have read and understood this form)

_____

Patient's Signature/Date