Flagship Rehab - *Patient Information Sheet*

Patient Name: _____ **Nickname:** _____
Last First MI

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ **Marital Status:** □ Married □ Single
Home Cell Work □ Divorced □ Widowed □ Separated

Gender: □ M □ F **DOB:** ____/____/_____ **SSN:** _____-____-_____ **Email:** _____

Address: _____
Street City State Zip County

Workers Compensation? □ Y □ N **Employer:** _____ **Date of Injury:** _____/____/_____

Motor Vehicle Accident? □ Y □ N **State:** _____ **Date of Accident:** _____/_____/_____

PRIMARY Insurance Provider: _____ **Relationship to the Policyholder:** _____

Policyholder Name: _____ **DOB:** ____/____/_____ **SSN:** _____-____-_____

Policyholder Address (if different than above): _____
Street City State Zip

Policyholder Phone: (___) ____-_____ **Employer:** _____ **Policy ID#:** _____ **Group #:** _____

SECONDARY Insurance Provider: _____ **Relationship to the Policyholder:** _____

Policyholder Name: _____ **DOB:** ____/____/_____ **SSN:** _____-____-_____

Policyholder Address (if different than above): _____
Street City State Zip

Policyholder Phone: (___) ____-_____ **Employer:** _____ **Policy ID#:** _____ **Group #:** _____

Emergency Contact: _____ **Telephone #:** _____

CO-PAY: $_____ **CO-INSURANCE—PERCENTAGE:** _____% **DEDUCTIBLE: $**_____ □ Met □ Not Met

Due each visit at time of service. You will be billed once insurance payment is received. This amount must be met by the patient before insurance kicks in.

Financial Responsibility: My insurance company has determined these amounts. The above information is what has been communicated to Flagship Rehab by my insurance company. This is not a guarantee. I understand that I am responsible for any charges that are not covered by my insurance carrier. Furthermore, I understand that I am responsible to inform the office of any changes that occur in my insurance coverage. I authorize release of payment directly to Flagship Rehab regardless of participation in or out-of-network. Should I default on my financial responsibility and collection action is necessary, I will be responsible for collection costs incurred. **INITIAL:** _____

Consent to Treat/Privacy Policy: I hereby agree and give my consent to outpatient therapy treatment. It has been explained to me that therapy is not an exact science, and no guarantee has been made as a result of any treatment administered. I authorize release of any medical information needed to process my claim. I acknowledge that I have seen the *Notice of Privacy Practices.* I understand that I may ask questions about the *Notice of Privacy Practices* at any time.

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

Witness Signature: _____ **Date:** _____

Flagship Rehab - *Medical History Form*

Patient Name: _____ **Nickname:** _____
Last First MI

Are you receiving Home Health? __Yes __No **Are you a resident in a Nursing Home?** __Yes __No **Are you receiving Hospice Care?** ___Yes ___No

Please state briefly why you or your physician are requesting therapy services: _____

_____

_____

Are you aware of your diagnosis: □ Yes □ No **Diagnosis as told by doctor:** _____

Are you aware of your chance for recovery: □ Yes □ No **Have you had therapy this year:** □ Yes □ No

Do you have allergies: □ Yes □ No If yes, please list: _____

Are you presently treated or have you ever had any of the following medical conditions? (Check all that apply)

□ Arthritis	□Fainting Spells	□Pacemaker
□Asthma	□Fracture	□Pregnancy
□Bleeding Disorder	□Heart Trouble	□Seizures
□Breathing Problems	□Headaches	□Stroke
□Cancer	□Hepatitis A B C	□Tuberculosis
□Diabetes	□High Blood Pressure	□Other: _____
□Dizzy Spells	□HIV	□Other: _____
□Emphysema	□Implant	□Other: _____

Date of Injury (within 6 months): _____ /_____ /_____

How did the injury occur?: _____

_____

_____

Have you been hospitalized for your condition? □ Yes □ No If yes, date?: _____ /_____ /_____

Have you had surgery for your condition? □ Yes □ No If yes, date?: _____ /_____ /_____

Have you received previous treatment for this condition? □ Yes □ No If yes, date?: _____ /_____ /_____

Describe Treatment Received: _____

_____

_____

Are you receiving any other health, medical or chiropractic services by any other agency organization or individual?

□ Yes □ No If yes, please explain: _____

_____

_____

Last seen by Physician: ____ /____ /_____ **Next Appointment with Physician:** ____ /____ /_____

Are you taking any medications?: □ Yes □ No If yes, please list: _____

_____

_____

For this condition, have you ever had any of the following?: □ EMG □ MRI □ CAT Scan □ X-Ray □ Myelogram **Have you ever received Physical/Occupational Therapy services elsewhere?** □ Yes □ No If yes, where, when and why?:

_____

I believe the above information is true and correct to the best of my knowledge.

_____

Patient Signature **Date**

Form Updated 1/30/14 KK

PRIVACY NOTICE

PLEASE NOTE: WE ARE REQUIRED BY FEDERAL LAW TO PROVIDE YOU WITH A COPY OF OUR PRIVACY POLICY.
PROTECTING YOUR PRIVACY RELATING TO USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION

At Flagship Rehabilitation, we are committed to safeguarding your private health information and maintaining your privacy. Flagship Rehabilitation is providing you this policy notice to help you understand how we handle health information that we collect and may disclose. This notice tells you how you can limit our disclosure of your health information.

Patient Rights for Understanding And Controlling the Utilization of Health Information: Flagship will provide a written explanation of how healthcare provider can use, keep and disclose patient healthcare information (this privacy notice). Flagship will ensure patient access to his/her medical record(s). Flagship will obtain consent before healthcare information is shared for treatments, payment and other healthcare operation purposes. Flagship will provide information for recourse for privacy protection violations. Patients have a right to request electronic copies of their records if their health care provider maintains records in electronic form. Patients also have the right to restrict the disclosure of some of their protected health information to a health plan when the patient has paid out of pocket in full for their care.

Our Policies and Procedures to Protect Your Health Information: At Flagship Rehabilitation, we understand the importance of protecting your health information. That's why we protect the information we collect about you by maintaining, physical, electronic, and procedural safeguards that meet or exceed applicable law. Within Flagship Rehabilitation, we educate our employees about the importance of confidentiality and privacy, and we train them in related policies and procedures. We also take appropriate disciplinary measures whenever necessary to enforce these rules.

Information: Flagship Rehabilitation, is responsible for providing rehabilitation services that enable you to meet your optimal functional level. In order to provide you with the appropriate rehabilitation, Flagship Rehabilitation needs to obtain information that enables us to provide you with responsive, rehabilitation services. Your information comes to us from a variety of sources: You provide some of the information to us at the time of setting your appointment with the evaluating therapist. You provide most of your information to us at the time of your first appointment with us when you are requested to fill out forms giving, but not limited to, information concerning your name, address, social security number, employer, insurance coverage, health history, medications, etc. Your physician provides us with information concerning your treatment diagnosis when s/he orders a therapy evaluation and treatment for your medical condition. Your insurance company provides verification to us of your insurance coverage.

Here is how we put information to use for you: To provide you with the highest quality of rehabilitation services. Health information allows us to provide you with the appropriate rehabilitation services. To communicate with your physician concerning your progress in your rehabilitation program. Health information is shared with your physician to provide comprehensive rehabilitation services to you. To bill your rehabilitation services. Personal and health care information may be shared with your medical insurance company. Flagship Rehabilitation works hard to maintain complete and accurate information about you and your health services. If you ever believe that our records contain inaccurate or incomplete information about you, please let us know immediately, so we may correct any inaccuracies.

Disclosure of Protected Health Information: Patient health information will be used or disclosed for purposes of treatment, payment, and operations. Patient health information will be limited to the minimum necessary for the purpose of disclosure. Authorizations for disclosure of non-routine patient information will meet standards that ensure the authorization is informed and voluntary. Flagship Rehabilitation, may disclose health information without your authorization, including the following: Quality assurance activities, Public Health, Research, Judicial or administrative proceedings, Limited law enforcement activities, Emergency circumstances, Identification of a deceased person or cause of death, Facility patient directories National defense or security.

Marketing: Prior written authorization will be obtained from an individual to use his/ her protected health information for marketing purposes.

HIPAA regulations strengthen the limitations on the use and disclosure of protected health information (PHI) by covered entities and business associates for marketing and fundraising purposes. The new HIPAA regulations also prohibit the sale of PHI by covered entities or business associates without the consent of the patient.

Filing a Complaint: Flagship Rehabilitation will continually assess itself to ensure that patient privacy is respected. To file a privacy complaint, write to: VP Corporate Compliance, Flagship Rehabilitation, 157 Baltimore Street, Suite 100, Cumberland, Maryland 21502 form Updated: 1/30/14 KK

FLAGSHIP

MEDICARE SECONDARY PAYOR (MSP) FORM

Patient Name: _____
Last First
Medicare Number: _____ Admission Date: _____

1. Are you covered by:
   a) Black Lung? ☐ Yes Date benefits began: _____ ☐ No
   b) Government programs such as a research grant? ☐ Yes ☐ No
   c) Department of Veterans Affairs (DVA)? ☐ Yes ☐ No

2. Was your illness or injury due to a work- related accident/condition?
   ☐ Yes - Answer a) ☐ No - go to question 3
   a) Date of your injury or illness: _____

3. Was your illness or injury due to a non-work related accident?
   ☐ Yes - Answer a, b, & c ☐ No - go to question 4
   a) What type of accident caused your illness or injury?
      ☐ Automobile ☐ Non-automobile
   b) Was another party responsible for your accident? ☐ Yes ☐ No
   c) Are you filing or intending to file a liability suit? ☐ Yes ☐ No
   d.) **STOP - Staff will Complete Insurance Verification Form**

4. Are you entitled to Medicare based on:
   ☐ Age **go to question 5** ☐ Disability **go to question 5** ☐ ESRD **go to question 6**

5. Are you currently employed? ☐ Yes ☐ No
   a. Is your spouse currently employed? ☐ Yes ☐ No
   b. Do you have group health plan (GHP) coverage based on your own, or a spouse's current employment? ☐ Yes ☐ No – **STOP Medicare is primary.**
   c. Does the employer that sponsors your GHP employ 20 or more employees?
      ☐ Yes - **Staff willComplete Insurance Verification form**
      ☐ No - **STOP Medicare is primary.**

6. Do you have group health plan (GHP) coverage?
   ☐ Yes ☐ No - **STOP Medicare is primary**
   a) Have you received a kidney transplant?
      ☐ Yes Date of Transplant: _____ ☐ No
   b) Have you received maintenance dialysis treatments?
      ☐ Yes Date dialysis began: _____
   c) If you participated in a self-dialysis-training program, provide date training started _____
   d.) Are you within the 30-month coordination period?
      ☐ Yes ☐ No - **STOP Medicare is primary.**
   e) Are you entitled to Medicare on the basis of either, ESRD and age or ESRD and disability? ☐ Yes
      ☐ No – **STOP** GHP is primary during the 30-month coordination period - **Staff will complete Insurance Verification Form**

f) Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? ☐ Yes - **STOP.** GHP continues to pay primary during the 30-month coordination period – **Staff will Complete Insurance Verification Form**

g) Does the working aged or disability MSP provision apply (i.e., is the GHP primary based on age or disability entitlement)? ☐ Yes - **STOP.** GHP continues to pay primary during the 30-month coordination period – **Staff will Complete Insurance Verification Form**
☐ No -Medicare continues to pay primary.

If the answer is yes to any question 1-6 an Insurance Verification Form will be completed by our staff to indicate the primary insurance coverage.

_____ _____
Patient's Signature Date

_____ _____ _____
Responsible Party Signature (if under 18) Date Relationship

FLAGSHIP
OUTPATIENT SERVICES

Informed Consent

Patient Name: _____ **Medical Record #:** _____

Discipline(s) to become involved with the Patient:

❑ **Physical Therapy** ❑ **Occupational Therapy** ❑ **Speech/Swallowing Therapy**

I, the Undersigned, hereby voluntarily authorize Provider to administer such outpatient therapy treatment(s) to the Patient that in the opinion of the physician and consulting allied health personnel is/are necessary or appropriate. It has been explained to me that therapy is not an exact science and no guarantee has been made as a result of any treatment administered.

I, the Undersigned, understand that the rehabilitation process, by its very nature, involves certain inherent and unavoidable risks, including falls and other similar injuries, and that the only alternative to entirely avoiding these risks would be to forego rehabilitation altogether. I, therefore, acknowledge that falls and other similar injuries are an inherent risk of the rehabilitation process and accept that risk.

I, the Undersigned, hereby certify that all information provided to the Provider by the Undersigned or Patient is true and accurate, including any information in connection with applying for payment under Title XVIII of the Social Security Act.

I, the Undersigned, hereby authorize Provider to disclose any information, furnished to Provider or obtained by Provider in connection with Patient's treatment (including, but not limited to, information concerning a related Medicare claim) to any physician, governmental agency (including, but not limited to, the Social Security Administration, its fiscal intermediaries or carriers), insurance company or health care facility requesting such information.

I, the Undersigned, hereby assign to Provider all Medicare benefits and Medicaid benefits to which Patient may be entitled for any Therapy Services rendered by Provider. I, the Undersigned, hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient.

I, the Undersigned, hereby assign to Provider all private medical insurance benefits (primary and secondary, including Medicare Gap providers) or other benefits to which Patient may be entitled for any Therapy Services rendered by Provider. I, the Undersigned, hereby authorize and direct Provider to apply and file for all such benefits on behalf of Patient.

I, the Undersigned, agree that the discretion of payment for Therapy Services is that of the Insurer not that of the Provider and any services not subject to the Insurer's benefit coverage will be the responsibility of the authorizing parties.

Signed:

_____ _____

❑ Patient ❑ Legal Representative (LR) Signature Date

LR relationship to resident: ❑ *POA* ❑ *Legal Guardian* ❑ *Other:* _____

_____ _____

How would you like to be contacted? ❑ Monthly ❑ *Discharge* __ Email phone etc

Witness Signature Date

Therapy Department Use Only:

Verbal Consent obtained from: _____ (Power of Attorney or Legal Representative) on _____ (Date) at _____ (Time).

Consent obtained by: _____ (Therapy Department Representative) _____ (Date Mailed)