Restore Outpatient Therapy Services

CLIENT INFORMATION FORM

Last Name	First	MI	D.O.B.	S.S.N.	Sex: M/F

Address:	City	ST	Zip	Primary Phone

Marital Status: Single ( ) Married ( ) Other ( )	Circle All That Apply: PT OT ST

Employment Status: Full-Time ( ) Part-Time ( ) Student ( ) Retired ( ) N/A ( )

Employer Name/School Name	Title/Position

EMERGENCY CONTACT OR LEGAL GUARDIAN INFORMATION:

Last Name	First	Primary Phone	Relationship

RESPONSIBLE PARTY OR GUARANTOR INFORMATION:

Last Name	First	Relationship	Primary Phone

Address:	City	ST	Zip	Work/Other Phone

HOW WOULD YOU LIKE TO RECEIVE APPOINTMENT REMINDERS?

Phone:	Preferred Number: _____
Text:	Preferred Number: _____
Email:	Preferred Email: _____

REFERRING PHYSICIAN INFORMATION

Name	City	ST	Phone #

Have you received Home Health services within the last 3 months? Yes ( ) No ( )	If Yes, Agency Name:
Have you been in a SNF facility within the last 3 months? Yes ( ) No ( )	If Yes, SNF Name:
Have you received therapy within the last year? Yes ( ) No ( )	If Yes, when & for what reason:

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Medical History Form:

(The following form is to be completed along with the client and or a family member/sponsor so as to have the most accurate information.)

Client name: _____

Referring Physician: _____

Reason for referral: _____

Restrictions from physician (weight bearing, lifting, ROM, etc.):

_____

_____

Do you currently have any assistive devices such as a cane, walker, wheelchair, etc.?

_____

What is your current activity level? (Please circle)

Very Active Active Not Active

Allergies (i.e. latex, medications etc.):

_____

Do you currently have or have you ever had a defibrillator, spinal stimulator, pacemaker, gastric pacemaker, or any other medical hardware? If yes, please explain.

_____

Self-report of any pertinent medical diagnoses (place a check mark next to all that apply):

	Cancer		Diabetes
	Memory loss		High blood pressure
	Joint replacement/metal implant		Low blood pressure
	Pacemaker or other implanted device		COPD
	Arthritis		Breathing Problems
	Epilepsy or Seizures		Parkinson's Disease
	Joint Swelling		Lymphedema
	Hearing Loss		Stroke
	Numbness/Tingling		Anxiety
	Dementia		Vision Problems

Other medical/surgical history not included above as well as active medical conditions and pregnancy:

_____

_____

_____

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Medical History Form Continued:

Client name: _____

Please list all medications you are currently taking.

Medication	Dosage	Frequency

NOTICE OF PRIVACY PRACTICES

Effective May 1, 2013

"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY."

At Restore Therapy Services Ltd., ("Restore") we respect patient privacy and are committed to responsible practices regarding your health information. Health information includes numerous medical, billing and related records containing information identifying you and describing your health history, symptoms, test results, diagnosis, and treatments. Restore pledges to use your health information only as permitted and required by law.

How Restore is Permitted to Use and Disclose Your Health Information

Treatment: Restore will use your health information in the provision and coordination of your healthcare. We may disclose all or any portion of your health information to your attending physician, consulting physician(s), nurses, technicians, and other health care providers who have a legitimate need for such information regarding your care and continued treatment. Restore may share information about you with other providers in order to coordinate specific services, such as dietary services, durable medical equipment, prescriptions, lab work and x-rays. Restore also may disclose your health information to other healthcare associates and professionals who are involved in your medical care; such as volunteers, family members, clergy, and others used to provide services that contribute to your care. Restore may disclose your health information to a hospital, nursing home, or health care facility to which you may be admitted.

Payment: Restore may release health information about you for determining benefits, billing, claims management, medical data processing, and reimbursement. Your health information may be released to an insurance company, third party payer or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical records, which are necessary for payment of your account. For example, a bill sent to a third party payer may include information that identifies you, your diagnosis, and the services and supplies provided to you.

Routine Healthcare Operations: Restore may use and disclose your health information during routine healthcare operations, including but not limited to, quality assurance, utilization review, medical review, internal auditing, accreditation certification, licensing or credentialing activities of Restore.

Other Individuals Involved in Your Medical Care: Restore may release health information about you to a friend, family member, or others that you tell us are involved in your medical care, or who help pay for it.

Health-Related Benefits and Appointment Reminders: Restore may contact you to remind you of appointments. We may describe treatment options and health-related products or services we provide; inform you of alternative therapies, healthcare providers or settings; and inform you of health-related programs and services the government provides.

Business Associates: Restore may disclose certain health information about you to our business associates. Our business associates include an individual or entity contracted by Restore to perform or assist Restore in a function or activity, which necessitates the use or disclosure of health information. Examples of business associates include, but are not limited to, consultants, accountants, lawyers, medical transcriptionist and third-party billing companies. Restore business associates and any subcontractors of the business associate are required by law to protect the confidentiality of your health information under the same laws and requirements as Restore.

Required by Law: Restore may disclose your health information when required by federal, state, or local law, including abuse or neglect reporting; reporting to a regulatory or healthcare oversight agency, and for specific government functions, such as licensing, audits, investigations and inspections.

Public Health and Safety: As required by law, Restore may disclose your health information to public health authorities charged with preventing or controlling disease, injury or disability, and immunization. This also includes the Federal Drug Administration for monitoring drug reactions and assisting with drug or device recalls. Restore may share information about you to appropriate authorities in a natural disaster or public safety emergency.

Law Enforcement/Litigation: Restore may disclose your health information for law enforcement purposes as required by law or in response to a valid subpoena or court order.

Research: We may disclose your health information to researchers when an institutional review board that has reviewed the research purpose and established protocols to ensure the privacy of your health information has approved their research. Before disclosing, we will verify that the researchers have obtained your consent to participate in the study.

Marketing: Restore is prohibited from disclosing your information for mail, electronic, or telephone marketing communications without your authorization. You may revoke an authorization at any time by writing the Restore Privacy Officer at the address below.

Fundraising: Restore may use limited information to communicate to you about fundraising events, while providing you with the option to remove your contact information from further fundraising communications.

Coroner, Medical Examiner, Funeral Director: Restore may release your health information to a Coroner or Medical Examiner. This may be necessary, for example, to determine a cause of death. Restore may also release your health information to a Funeral Director as necessary to carry out their duties.

Organ Procurement Organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking or transplantation of organs for the purpose of tissue donation and transplant.

Workers Compensation: Restore may release your health information for Workers' Compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Other Uses: Other uses or disclosures of your health information not described in this notice, will be made only with your written authorization. You may revoke a previous authorization at any time by writing the Privacy Officer.

Your Health Information Rights

Although all records relating to the treatment you receive are the property of Restore, the information belongs to you. You have the right to:

- Request additional restrictions on how we use and disclose your health information. Restore may not be required to agree to any and all requested restrictions.
- Inspect and copy your health information that is or may be used to make decisions about your care.
- Request a correction or amendment to your health information. We require that you submit your request in writing and explain your reasons for requesting the correction or amendment. We cannot change information that was not created by Restore, is not maintained in our records, or that is deemed accurate.
- Receive confidential communications about your health information. You may request that we communicate with you about your health information by alternative means (electronic, in writing) or at an alternative location (work address or post office box). Your request must be in writing. We will agree to reasonable requests, whenever possible.
- Obtain an accounting of disclosures of your health information.
- Request restrictions on the release of your health information to a health plan when you have paid in full for your services, out of pocket.
- Receive a copy of this Notice on request.

You may exercise any of these rights by writing and contacting our Privacy Officer at the address listed below.

Our Responsibilities

Restore is legally required to maintain the privacy of your health information, to provide you with this notice regarding our legal obligations and privacy practices with respect to your health information, and to notify you if there is a breach of your unprotected health information. Restore is also required to abide by the terms of this Notice.

Restore reserves the right to change the terms of this Notice and to make revisions to the Notice effective for all your health information that Restore maintains. Should Restore change the terms of this Notice, we will distribute a revised Notice to the address you have on file with us.

If you have questions or would like additional information, or, if you believe your privacy rights have been violated you can contact our **"Privacy Officer"** at the address listed below. You may also send a written complaint to the Department of Health and Human Services. Your quality of care and service is never jeopardized because you file a complaint.

Restore Therapy Services 245 Cahaba Valley Parkway Suite 200, Pelham, AL 35124 (205)942-6820

NOTICE OF GRIEVANCE POLICIES AND PROCEDURES

Complaints: Patient complaints may include, but are not limited to, aspects of care and discrimination based on age, sex, religion or creed, race, disability, or national origin.

Reporting: Report any possible violation of compliance, patient rights, ethical standards, or any possible discrimination laws immediately to the supervisor on duty at outpatient agency. All concerns and possible suspected violations expressed to you by others should also be reported immediately to the supervisor on duty. The complaint should be documented on the compliance log. If immediate supervisor is not available, any concern can be reported to the Director of Outpatient Programs at 1-800-755-3364 ext. 1124, or the corporate compliance office at 1-800-755-3364. You may report orally or in writing with addressing concerns to:

Restore Therapy Services, Compliance Officer
245 Cahaba Valley Parkway, Suite 200
Pelham, Alabama 35124

Reviewing: You should mark documents for review "For Compliance Officer Only". Once received, the Compliance Office/Director of Outpatient Programs, the Administrator and/or designated investigators will attempt to preserve the confidentiality and anonymity of the author/caller to the fullest extent possible. The CO shall determine the most appropriate method and resources required for investigation. An initial report will be provided with 24 hours to the CEO. The Compliance Committee will be responsible for reviewing all reports to the officers. A summary of findings and recommendations shall be submitted to the Board of Directors quarterly. The person filling the grievance may appeal the decision within 15 days of receiving the decision. The Governing Body Board shall make a written decision in response to the appeal no later than 30 days after it is filed.

Department of Health and Human Services: You may report any violation to your rights or can file a complaint with the Department of Health and Human Services without fear of retaliation.

Accommodations: Restore Therapy Outpatient will make appropriate arrangements to ensure that a disabled person is provided other accommodations if needed to participate in this grievance process. Such arrangements may include, but are not limited to, providing interpreters for the deaf, providing taped audio of material for the blind, or assuring a barrier-free location for the proceedings. The Compliance Officer will be responsible for such arrangements.

State of Alabama
Compliance HOTLINE NUMBER
1-800-356-9596

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Informed Consent for Evaluation and Treatment

The information below pertains to your Consent for Treatment

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of treatment have been explained to me. I understand that therapy provides a wide range of services and I will receive information at the **initial visit** concerning the treatment and options available for my condition.

I hereby consent for Restore Therapy Outpatient Services to provide an evaluation and treatment (s) that have been advised or recommended based on my injury, condition, illness, disability and over all wellness. I understand that during my initial visit I will be provided with a proposed treatment plan, benefits and potential risks associated with my treatment and will be afforded at that time the opportunity to ask questions and/or receive additional information. During my initial visit my clinician will also inform me of my diagnosis and prognosis.

I have read the above information and consent to evaluation and treatment.

_____ _____

Signature Date

_____

Name Printed

Assignment of Benefits, Payment and HIPAA Acknowledgment

Assignment of Benefits and Insurance Proceeds

I hereby authorize Restore Therapy Outpatient services to bill my insurance directly on my behalf for payment. I hereby request that payment be made by an assignment of benefits directly to Restore. The completion of the insurance forms and assignment of benefits does not relieve me of the obligation to pay any amounts I owe for my treatment that is not covered by insurance. I agree that a copy of this authorization can be used as the original.

Notice of Privacy Practices Acknowledgement

I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices, which provides a more complete description of how my protected health information may be used or disclosed. I hereby consent to the disclosure of my protected health information in accordance with the Notice of Privacy Practices.

Notice of Grievance Policies and Procedures

I hereby acknowledge that I have been provided with a copy of the Notice of Grievance Policies and Procedures. I acknowledge that I have read or have had this notice explained to me. I understand this notice, and have had the opportunity to ask questions regarding any matters of concern.

Patient Records Release

I hereby authorize the release of all necessary records to my insurance company (s) and/or workers compensation carrier that are necessary for processing and payment of my claims. In addition, I authorize the release of information from or to my physician or any other facility that is necessary for treatment of my condition.

Cancellation Policy In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hours notice so that Restore Outpatient can offer my appointment to patients waiting on the standby list. In the event I do not provide a cancellation notice I could be charged with a $30.00 no show fee.

Designated Individuals Authorization Release

I hereby authorize Restore Therapy Outpatient Services to communicate any Protected Health Information (PHI) regarding my treatment plan, assignment of benefits, payment information or other administrative operations to the following Authorized Designee(s):

Name: _____ Relation: _____

Name: _____ Relation: _____

I hereby acknowledge that I have read and agree to the Patient Records Release, Assignment of benefits and Insurance Proceeds, Cancellation Policy, Notice of Grievance Policies and Procedures, and Notice of Privacy Practices. I have also been given a copy of the Notice of Privacy Practices and the Notice of Grievance Policies and Procedures. I have also had the opportunity to ask questions.

Signature Date

_____ _____

Medicare Secondary Payer (MSP) Questionnaire

Patient Name: _____ **Outpatient Location:** _____

Interviewer Name: _____ **Date:** _____

1. Are you entitled to Medicare based on (Check all that apply):

_____ Age (65 and over)
_____ Disability
_____ End Stage Renal Disease

Do you have group health plan (GHP) coverage? Yes No
Are you within the 30-month coordination period? Yes No

2. Was this injury/illness due to a work related accident/condition? Yes No

If yes: Worker's Comp Carrier: _____
Date of Injury: _____
Phone # _____
Claim # _____

3. Was this injury/illness related to an automobile accident or other accident? Yes No

If yes: Date of Accident: _____
Is the patient's primary diagnosis related to accident? Yes No
If other accident, please list where injury occurred:
a. At a patient's home? Yes No
b. At another location? (Specify):_____

4. Is the illness/injury eligible for coverage under one of the following?

_____ Federal Black Lung Program
_____ Public Health Services
_____ Veterans Affairs benefits
_____ Other Federal Agency (Specify):_____

5. Are you currently employed? Yes No Date of Retirement_____

a. Is your spouse currently employed? Yes No Date of Retirement_____
b. Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current (or former) employment? Yes No
c. Does the employer that sponsors your GHP employee 20 or more employees? Yes No

If you answered yes to questions #3, #4, or #5 above, please complete the following information:

Insurance Co._____
Phone #:_____
Address:_____
Policy/Cert #:_____
Group #:_____
Name of Policy Holder:_____