



MEDICARE CAP ON THERAPY SERVICES

As of January 1, 2006 the Centers for Medicare and Medicaid Services placed a cap on outpatient physical, speech and occupational therapy.

Physical and Speech Therapy have a combined annual cap of \$1980.00 per beneficiary per **YEAR** while Occupational Therapy has a separate cap of \$1980.00 per beneficiary per **YEAR**.

The patient/beneficiary is responsible for the payment of any deductibles.

It is unfortunate that Medicare limits access of Medicare beneficiaries to therapy services however the caps described above reflect the limit of what Medicare will pay for the services that we provide.

In light of these Medicare limits, it is important that you notify us of any physical or speech therapy that you receive or have received at any other location. Accordingly, please notify your therapist if you have received physical or speech therapy at any other location this calendar year.

OUR MUTUAL AGREEMENTS

Welcome to Evans Rehabilitation Services. Our goal is to make your visit with us a pleasant and rewarding experience. The success of your rehabilitation efforts depends on your personal commitment and participation. Based on your available insurance or the circumstances surrounding the injury that has caused you to seek this treatment, the commitment required of you may be one of both time and finances (Please read carefully our Financial Policy below). We realize that your time and finances are both important however in return for your commitment, we promise to dedicate our time, professional skills, effort, and compassion. We are committed to providing you with excellent professional care and customer service in a caring and professional environment. Communication is at the heart of any successful rehabilitation effort so please be sure to share with us any information that you think may be of assistance with our efforts.

Our commitments to you:

- **Excellent** customer service
- Professionalism
- Flexible scheduling
- Respect for your time-seen within 15 minutes of scheduled appointment time

Our requirements of you:

- Respect for our time-prior day cancellation notice
- Timely arrival for your appointment
- Participation in prescribed home program
- Honest and open communication

We realize that unforeseen events may occur which require you to cancel your appointment on the same day it is scheduled, however we expect that this will be rare.

- 1) A same day cancellation is defined as contacting our office on the day of your appointment in order to cancel or reschedule.
- 2) A No-Show is defined as failure to show up for your appointment without cancelling prior to your appointment time. Contacting us after your appointment time in order to cancel or reschedule the appointment will be considered a No-Show.

In order that we might provide the best possible care to all of our patients, A No-Show or multiple same day cancellations will result in one or both of the following:

- **Discharge from care with a notification letter to your referring physician**
- **A fee of \$25 being assessed to your account**

If we fail in any way to meet your expectations, please notify the clinic manager so that we may correct and resolve your concerns.

I have read and understand the above requirements _____

Signature of Patient/Responsible Party

Patient Information Sheet

Patient Information

Patient Name: _____
Last First Middle Initial

Address: _____
Mailing Address City State Zip Code

Date of Birth: _____ Social Security #: _____

Home Phone: (____) _____ Work Phone: (____) _____

Cell Phone: (____) _____ Emergency Contact Name _____
Emergency Contact #(____) _____

Employer Name & Address: _____

Referring Physician Name: _____ Primary Physician Name: _____

Onset/Date of Injury: _____ Is this due to Motor Vehicle Accident? _____

Within the last 12 months have you received any PT/OT/ST/cardiac rehab? Yes or NO

Within the last 12 months have you received care in your home for any condition, to include; Nursing, Occupational Therapy or Physical Therapy? YES or NO

If yes, please list what agency you used and when your last month of service was: _____

Guarantor/Policy Holder Information (If other than patient)

Name of Guarantor:

_____ Last First Middle initial

Address of Guarantor: _____
Mailing address

_____ Relationship to Patient: _____
City State Zip Code

Date of Birth: _____ Social Security # _____

Home Phone: (____) _____ Work Phone: (____) _____

Thank you for choosing Evans Rehabilitation Services for your Physical Therapy needs. The following is an explanation of our Financial Policy. Please read the following material and if you have any questions about any part of this policy, we have financial specialists on staff that will be happy to explain any aspect of these policies. You will be asked to provide us with a written acknowledgement that you have read and understand these policies prior to receiving any treatment.

Financial Policy

While our main concern is that you receive the proper care and optimal treatment needed to restore your health, financial realities and insurance regulations and contracts require that we fully understand the circumstances that gave rise to your injury so that we may determine what individual or insurer may be responsible for the payment of the charges related to your care.

ULTIMATELY EACH INDIVIDUAL IS RESPONSIBLE FOR THE PAYMENT OF ANY CHARGES RELATED TO THEIR OWN CARE AND TREATMENT. AS A COURTESY WE WILL ASSIST YOU, WHERE APPROPRIATE, BY FILING CLAIMS FOR THE PAYMENT OF YOUR CARE WITH HEALTH INSURERS OR OTHER INDIVIDUALS OR ENTITIES. IN THE EVENT THAT THE CHARGES FOR YOUR CARE ARE NOT COVERED OR PAID FOR BY OTHERS, YOU AGREE TO PAY US IN ACCORDANCE WITH THE FINANCIAL POLICIES SET OUT HEREIN.

HEALTH INSURANCE: We will file your insurance as a courtesy to you. However, you must understand the following:

1. Should your insurance require any pre-certification or authorization, please make sure that you or your referring physician have obtained such pre-clearance prior to beginning any treatment. **THIS IS YOUR RESPONSIBILITY.** If you are unsure whether any such pre-authorization is required for your care, and whether it has been obtained, please make this inquiry as any charges incurred without the proper authorization will be the responsibility of the patient.
2. **Your insurance policy is a contract between you and your insurance company, not Evans Rehabilitation Services.** All charges are ultimately the patient's responsibility. Not all services are a covered benefit, so please know and understand your policy. If your insurer does not pay **ERS**, our charges will be your responsibility.
3. Health Insurance co-payments and deductibles are required to be paid at the time of service.

WORKMEN'S COMPENSATION: If we are treating you for a workers' compensation injury and for any reason your claim is denied or contested by your workers' compensation insurer, you will be responsible for the payment of any charges that are unpaid by such insurer.

MEDICARE: We will file all claims with Medicare and any supplemental or secondary companies that are provided to us. If you do not have a supplemental or secondary insurance, a co-payment of 20% of your charges will be due at the time of service.

THIRD-PARTY LIABILITY: **If your condition is due to a motor vehicle accident or otherwise results from circumstances that give rise to a legal claim against another individual or entity, please see our Coordination of Benefits notice and related financial policy that follows.**

Nearly all health insurance policies contain "Coordination of Benefit" ("COB") language and most governmental payers (Medicare, Medicaid and Tri-Care) have similar program requirements and guidelines. These COB provisions require that health care providers identify instances when the injury they are treating was sustained in such a way that the patient has a claim against some individual or entity

("Third Party") and the claim against such Third Party includes a claim for reimbursement of the cost of the medical treatment being provided (a "Third-Party Claim"). The following language is a sample of actual COB language that exists in contracts that ERS has with insurers:

"Provider...will cooperate with (Insurer) to identify any and all parties, other than (the Insurer), that may be responsible for payment of, or reimbursement for, Covered Services, and for the purpose of coordinating benefits with other payers. When a party other than payer is identified as having primary responsibility for payment of or reimbursement for Covered Services under the coordination of benefits of a Member's Health Benefits Plan, Provider...will bill and make all reasonable efforts to collect from such party for the value of Covered Services."

In addition to these COB plan provisions which require that we attempt to collect our charges from any at fault third parties, most health insurance plans also contain provisions which allow an insurer who has paid us benefits for your care and treatment but then subsequently discovers that the claim was the responsibility of some at fault third party, to request that we refund to them the amount of any such benefits and by contract we are then required to make such refunds. If this occurs, all contractual adjustments would be reversed, and the patient would then be billed the full amount of the charges for such refunded visits. Accordingly, it is imperative that we have accurate and complete information throughout the course of your care and treatment so that we might comply with these legal requirements and avoid having to bill you for this care. **When the injury that we are treating has given rise to a Third-Party Claim, we are generally legally prohibited from billing your insurer without first attempting to collect the cost of your care from the At Fault Third Party.** If these circumstances apply to your claim, please fully complete the following Third Party Liability claims material and notify us if and when you discover that your claim circumstances have changed or you discover other information related to the claim or the identity of the at-fault party so that we might update our records.

To the best of your knowledge, did the injury for which we are treating you give rise to a claim against another individual or their insurance company?

Yes: _____ **No:** _____

If so, are you presently represented by an attorney? (Please provide your attorneys name and contact information as well as, a brief description of the incident, accident or occurrence, and the name of the at fault party and/or their insurance company): _____

PATIENT PAYMENT: If the charges for your care and treatment is not paid for by any health insurance carrier, workers' compensation insurer, governmental payer or the insurer for some At Fault Third Party, payment for your care and treatment is due in full at the time the service is provided unless other payment arrangements are made in advance and in writing.

Our office is designed to provide the highest quality physical therapy and rehabilitation care and treatment available, our office is not designed to be a provider of credit or otherwise designed to provide the financing of patient care and treatment. At the same time, we understand that temporary financial problems or financial hardship associated with an unexpected injury or event may affect the timely payment of your account balance. If this is the case, please communicate this with our business office and we will be happy to attempt to work out a payment arrangement although such arrangements generally will not exceed a time period of six (6) months from the conclusion of our services. We also understand that if the payment of your claim is the responsibility of an at fault third party (Third Party Liability Claim), the resolution of such claims may take time. We have designed a specific payment arrangement for patients whose injury gave rise to a Third Party Liability Claim and whose charges are to be paid by an At Fault Third Party. This plan is designed to attempt to help relieve the financial hardship caused by such circumstances.

For your convenience, we accept VISA, MASTERCARD and DISCOVER. In the event any payment is made on your account by check, draft or money order and such check, draft or money instrument is returned for lack of funds, you will owe, in addition to the amount of such check, a service charge in the amount of thirty dollars (\$30.00) or five percent (5%) of the face amount of the instrument, whichever is greater.

In the event that your account, or any portion thereof, is not paid within thirty (30) days of the billing of the account, finance charges will accrue on such outstanding balance at the rate of twelve percent (12%) per annum. Interest will be computed on the basis of a three hundred sixty (360) day calendar year. In addition to the finance charges, in the event that any account is not paid as and when due, the undersigned agrees to pay, in addition to such finance charges, all costs of collection specifically including, but not limited to the cost of collection associated with referral to a collection agency and an attorney at law. Additional costs will include a collection company fee of, up to, 50% of the original balance with interest and attorney's fees at the maximum allowed by law. We thank you for choosing Evans Rehabilitation Services as your health care provider and we appreciate your trust in us and the opportunity to serve you.

We thank you for choosing **Evans Rehabilitation Services** as your health care provider and we appreciate your trust in us and the opportunity to serve you.

I have read, understand and hereby agree to comply with the financial policies and arrangements described above and I hereby agree to be bound by all of the terms and provisions hereof as regards the payment of my account.

Signature of Patient/Responsible Party

Please print patient's name

Date: _____

PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT
STATE OF GEORGIA AUTHORIZATION

Protected Health Information Acknowledgment Pursuant to the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)

By my signature below, I hereby acknowledge receipt of the Evans Rehabilitation Services’ **Notice of Privacy Practices** related to a list of the specific practices of use and disclosure of Protected Health Information (PHI) by Evans Rehabilitation Services.

Authorization to Receive Therapy

The undersigned grants authority to Evans Rehabilitation Services, LLC and its staff to perform procedures and treatments deemed necessary for this patient and generally are used in the care of patients in this and similar physical therapy facilities. These treatments may include but are not limited to; instruction in therapeutic exercises and activity modification, soft tissue and/or joint mobilization, joint manipulation, application of therapeutic modalities and dry needling techniques. Additionally, the undersigned grants permission for the ERS staff to provide emergency treatment if it is needed, or to transfer this patient to a local hospital for emergency treatment deemed necessary by the hospital medical staff.

Authorization to Release Information

I hereby authorize the release by Evans Rehabilitation Services (“ERS”) of any and all of my medical information or medical records necessary to process any and all insurance claims on my behalf. I further authorize any and all other medical providers and/or holders of medical information about me to release any and all of such records and information to ERS as requested by ERS to determine the eligibility for and process the claims of ERS related to the provision of rehabilitation services to me.

Payment Authorization

The undersigned hereby assigns unto Evans Rehabilitation Services all rights to receive payment from my insurance company for the provision by ERS of Physical Rehabilitation Services and I direct my insurer to pay any and all amounts due for the provision of such services directly to Evans Rehabilitation Services.

I acknowledge having read and hereby agree to each of the above acknowledgment/authorizations.

Signature of Patient/Responsible Party

Date: _____

Authorization to Release Medical Records

(List any office that may request your therapy records. Ex. Attorney, non-referring physician)

I, _____ authorize any release of my **medical records** or information pertaining to health care in the form of written or verbal communication to the following person(s) listed below:

(Name of authorized person or persons)

(Name of authorized person or persons)

Authorization for Release of Appointment/Billing Information

(List any person that may call, on your behalf, to make or change appointments or ask billing questions. Ex. Spouse, child, caregiver)

I, _____ authorize any release of my **appointment** and/or **billing** information to the following person(s) listed below:

(Name of authorized person or persons)

(Name of authorized person or persons)

(Signature of patient)

Date

Medication List

Patient Name: _____

Prescription Meds:

Medication	Dosage	Medication	Dosage

Non-Prescription Meds:

Medication	Dosage