EVANS REHABILITATION & WELLNESS

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 $2040.00 per beneficiary per **YEAR** while Occupational Therapy has a separate cap of $2040.00 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.

415 Town Park Blvd. – Evans, GA 30809 – www.evansrehab.com
Phone – 706-868-1707 Fax – 706-868-1351

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 Name:

_____
Last First M.I.

Date of Birth: _____ **Email Address:** _____

Home Address:_____

City: _____ **State:** _____ **Zip Code**: _____

Home PH: ( )_____ **Cell PH**: ( )_____

Work PH: ( )_____

Emergency Contact Person: _____**Relation**:_____
Phone: ( ) _____
My condition is related to: □Work □Auto Accident (state_____)
□Other: _____
Onset/Date of Injury: _____ **Primary Care Physician**: _____

Employer Name & Address:

_____

_____

Within the last 12 months have you received care in your home for any condition, to include, Nursing, Occupational Therapy or Physical Therapy? □Yes □ No
If yes, please list what agency you used and when your last month of service was:

_____

How did you hear about us?

_____

Why did you choose this clinic?

_____

Guarantor/Policy Holder Information

Did you obtain health insurance through YOUR employer or otherwise obtained in YOUR name?
□ Yes □ No
If NO, please complete the section below with policy owner information.
Guarantor Name:

_____
Last First M.I.

Guarantor Address:

_____

City: _____ **State**: _____ **Zip Code**: _____ **Gender**: ___M___F

Relationship to patient: _____ **Date of Birth**: _____

Home PH: ( ) _____ Cell PH: ( ) _____

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.

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.

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 the patient responsibility portion of 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 or an attorney at 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.

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

_____ **Date:** _____

Please print patient's name

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. 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 release of my ERS **medical records** written or verbal communication to the following , if requested:

_____
(Name of authorized person / office)

_____
(Name of authorized person / office)

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 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