

GABRIEL REHABILITATION, INC

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: ____/____/____
Patient's Address (No., Street): _____
City/State/Zip: _____
Social Security Number: ____-____-____ Patient Status: Single Married Other
Home Phone: _____ Cell Phone: _____
Place of Work: _____ Work Phone: _____
Email Address: _____
Referring Physician: _____
Primary Care Physician: _____
Secondary Residence (If applicable): _____
City/State/Zip: _____
Home Phone: _____ Cell Phone #: _____
Emergency contact: _____
Relationship to patient: _____ Home Phone: _____ Work Phone: _____
Are you currently seeing a chiropractor? Y N
Have you received physical therapy since January 1, 2012? Y N
Reason for previous physical therapy: _____
Have you received home health care within the last 4 months? Y N
How did you hear about us? _____

INSURANCE INFORMATION:

Insurance Plan Name: _____ ID Number: _____
Policy Group Number: _____
Name of Policyholder: _____ DOB: _____
Address of Insured: _____ Relationship: _____

Is your injury related to an auto accident? Y N

If yes do you have an attorney? Y N

Is your injury related to a workman's compensation claim: Y N

I authorize the release of the above information for treatment, payment, health care operations, and to process insurance claims. I also understand that I am responsible for charges if my insurance company fails to pay for services rendered. I consent to treatment by Gabriel Rehabilitation Inc.

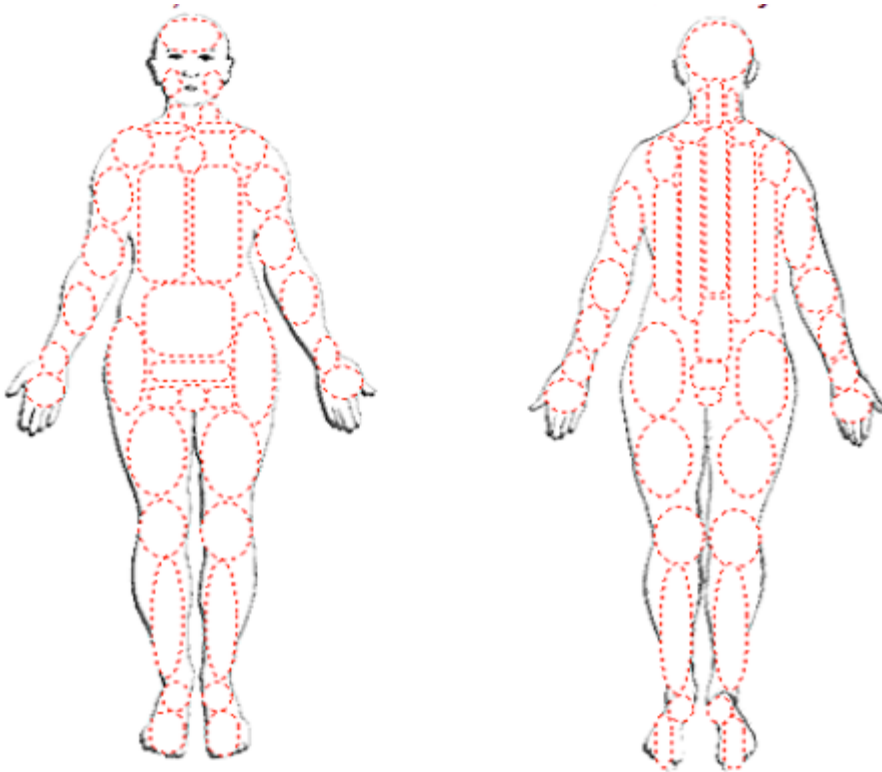
Signature: _____ Date: _____

GABRIEL REHABILITATION, INC.

Name: _____

Date: _____

Please indicate where your pain is located and what
Type of pain you feel at the present time.



Please circle the type of pain you are experiencing:

Ache Burning Numbness Pins & Needles Stabbing Other

What is your main complaint? _____

What was the date & nature of your injury? _____

Please rate your **current** level of pain on a 0-10 scale (0 indicates no pain & 10 maximal pain). _____

Place rate your **average** level of pain on a 0-10 scale (0 indicates no pain & 10 maximal pain). _____

Please rate your **worst** level of pain on a 0-10 scale (0 indicates no pain & 10 maximal pain). _____

GABRIEL REHABILITATION INC.

Health Questionnaire

Name _____ Date _____

- 1. **Yes No** Do you have a pacemaker or a spinal stimulator?
- 2. **Yes No** Do you have high blood pressure?
- 3. **Yes No** Do you have heart problems?
- 4. **Yes No** Do you experience heart palpitations?
- 5. **Yes No** Do you have angina (chest pain)?
- 6. **Yes No** Do you have a heart murmur?
- 7. **Yes No** Do you experience angina with exertion?
- 8. **Yes No** Do you have shortness of breath?
- 9. **Yes No** Do you have asthma, emphysema or allergies?
- 10. **Yes No** Do you have lung problems?
- 11. **Yes No** Do you smoke?
- 12. **Yes No** Are you or could you be pregnant?
- 13. **Yes No** Have you experienced recent weight loss/gain?
- 14. **Yes No** Have you experienced recent loss of appetite?
- 15. **Yes No** Do you have any bladder or bowel problems (constipation, diarrhea, urgency, retention)?
- 16. **Yes No** Do you have diabetes or thyroid problems?
- 17. **Yes No** Do you have or have you ever had cancer?
- 18. **Yes No** Do you have osteoporosis or rheumatoid arthritis??
- 19. **Yes No** Do you have headaches?
- 20. **Yes No** Do you have frequent joint sprains, muscle strain?
- 21. **Yes No** Do you have unusual joint pain and swelling?
- 22. **Yes No** Do you have or have had any orthopedic injuries?
- 23. **Yes No** Do you have a history of back/neck pain?
- 24. **Yes No** Do you have a history of trauma?
- 25. **Yes No** Do you have multiple sclerosis, epilepsy, or gout?
- 26. **Yes No** Do you experience seizures?

Symptoms

- 1. **Yes No** Do your arms or legs fatigue easily?
- 2. **Yes No** Do you have any numbness or tingling?
- 3. **Yes No** Do you have any weakness in your arms or legs?
- 4. **Yes No** Do you have any difficulty walking or coordination problems?
- 5. **Yes No** Do you experience dizziness with a change in position (e.g. from lying down to standing)?
- 6. **Yes No** Do you experience vertigo (feeling of spinning) or frequently lose your balance?
- 7. **Yes No** Have you fallen down?
- 8. **Yes No** Do you have episodes of blurred or double vision?
- 9. **Yes No** Do you wear contact lenses or glasses?
- 10. **Yes No** Do you have ringing or fullness in your ears?
- 11. **Yes No** Do you have difficulty swallowing or experience hoarseness?

What medical intervention have you received since the onset of your problem? _____

Please list all prescription & over the counter medications you are presently using: _____

Please list all surgeries and dates: _____

Please list any & all allergies: _____

Please use this space to explain anything else in your history that you feel may be beneficial _____

Signature: _____

GABRIEL REHABILITATION, INC.

PATIENT’S RIGHTS AND CONSENT TO TREAT

All patients have the right to equitable and humane treatment at all times. No person will be denied access to treatment or accommodations that are available, medically necessary and indicated, on the basis of color, race, creed, sex, national origin or the nature of the source of payment of his care. All patients within the facility have the right to privacy. This pertains to personal privacy while being treated, as well as privacy and non-disclosure of patient’s economic status, source of payment for care and medical information relating to one’s condition. All information pertaining to the patient is, by law, confidential. Release of medical information will require a signed “authorization to release medical information” form, with the exceptions of individuals/facilities associated with the case and listed on the admitting forms. These include but are not limited to the following:

- 1) Patients Family Physician, Primary Care Physician, and/or Referring Physician.
- 2) Patients Attorney.
- 3) Insurance Companies contractually involved in the case.
- 4) Any Rehabilitation Nurse or Coordinator assigned to the case by the patients insurance company.
- 5) Patient’s employer as listed on the Intake Form.
- 6) Any Case Manager or Social Worker assigned to the patients case.
- 7) Any Law Enforcement Agency requests.
- 8) Discharge records from any previous Home Health Agency.
- 9) Evaluation of the quality of services provided, and any administrative operations related to the treatment or payment.

The patient has the right to communicate at all times, his wants, needs and any questions. Treatment may be stopped at any time on the request of the patient. The patient has the right to consent to or refuse any treatment within the facility.

I understand my right as a patient and consent to treatment. I also understand that I may at any time refuse treatment at my own discretion.

Signature (Patient or Guardian)

Date

Witness

Date

GABRIEL REHABILITATION, INC

TO OUR MEDICARE PATIENTS:

JANUARY 2012

Please be advised that we are a Medicare Part B participating provider. What this means is that we accept Medicare's fee schedule as payment for our services. About 30 days after we submit your bills, First Coast/Medicare will reimburse us directly for 80% of their fee schedule. You are responsible for the remaining 20% plus your 2012 deductible of \$ 140.00. *Under no circumstance do we waive your deductible or copayment as it is considered by the federal government as fraud.*

If your secondary carrier is a participant of Medicare's Medigap program, Medicare will automatically file your secondary insurance. If your secondary insurance is not a Medigap plan we will as a courtesy to you file your secondary insurance, but you will be responsible for the 20% Medicare coinsurance if they do not reimburse us the full amount.

Remember for Medicare to pay for your treatments, you have to meet the following criteria:

1. Your present treatment plan ***must have nothing to do with an automobile accident, legal case or be covered by your employer's medical policy.***
2. ***You must be discharged from any home health care services*** prior to initiating outpatient physical therapy. Medicare will not pay for both home health and outpatient care at the same time.
3. If you initiated physical therapy with an out of state prescription, you must present this office with a Florida Physician prescription within 21 days of your first visit in order to be in compliance with our Florida Physical Therapy License.
4. The benefits in the Part B program have changed. It now specifies that there is an \$1880.00 limitation for outpatient physical therapy/speech therapy per calendar year in all settings except hospital rehabilitation departments. There is a separate \$1880.00 for occupational therapy. This translates to approximately 16 visits. If your condition requires care beyond \$1880.00, Medicare may makes exceptions for extension of the cap depending upon your diagnosis and medical necessity; your therapist will go over these exceptions if your treatment here will exceed the cap.

*I acknowledge that I have read the above policy, and I understand that I am responsible for my 20% copayment, and any deductible not met and for notifying **Gabriel Rehabilitation** if I have not met the above-mentioned criteria.*

Signature of Patient

Date

NOTICE OF PATIENT INFORMATION PRACTICES

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

GABRIEL REHABILITATION, INC.'S LEGAL DUTY

GABRIEL REHABILITATION, INC. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

GABRIEL REHABILITATION, INC. uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

GABRIEL REHABILITATION, INC. may also use or disclose your personal health information without prior authorization for emergencies, research studies, auditing purposes, and public health/statistical purposes. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

GABRIEL REHABILITATION, INC. may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. GABRIEL REHABILITATION, INC. will consider all such requests on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that we may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on our health information practices or if you have a complaint, please contact the following person:

GABRIEL REHABILITATION, INC.
Attn: Privacy Officer
13205 US HIGHWAY 1
JUNO BEACH, FL 33408

GABRIEL REHABILITATION, INC.
Financial Policy

Thank you for choosing Gabriel Rehabilitation, Inc. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

- All necessary documentation must be completed prior to receiving any treatment.
- We submit billing to insurance companies as a courtesy to our patient. We will make every effort possible to obtain our fees from your insurance company so as to minimize your out of pocket expense. Your insurance policy is a contract between you and your insurance company. If your insurance company has not paid your account in full within 60 days, you will be responsible for the full balance.
- You are responsible for any co-pays, deductibles and coinsurance. We cannot, by law, reduce these fees. With regard to insurance plans where we are a participating provider, all co-pays and deductibles are due at the time of visit. Prior to your visit we will call your insurance to verify your eligibility & benefits. We are not responsible for any misinformation we are given by your insurance company. We recommend you call your insurance company to verify the information we give to you.
- Your signature below acts as “Signature on File”, irrevocably assigning and transferring insurance and/or Medicare benefits to our facility, and authorizes Gabriel Rehabilitation to file claims with and submit necessary documentation to your insurance company on your behalf.
- Please be aware that some of the services provided may not be covered under the Medicare program and/or other medical insurances. You will be responsible for full payment of these services.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company’s arbitrary determination of usual and customary rates.
- The adult, parent and/or guardian accompanying a minor are responsible for full payment.
- If it is necessary to start collections proceedings in the event of non-payment of a bill, you will be responsible for any additional costs for attorneys and/or collection agency fees incurred.

I have read the Financial Policy. I understand and agree to the Financial Policy. I hereby assign benefits from my insurance company, for services rendered to me, to Gabriel Rehabilitation.

X _____ DATE _____
Signature of patient or responsible party

GABRIEL REHABILITATION, INC.

CONCERNS AND COMPLAINTS

If you are concerned that Gabriel Rehabilitation may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our office manager at the address listed below:

Gabriel Rehabilitation
13205 U.S. 1, Suite 109
Juno Beach, FL 33408

You may also send a written complaint to the U.S. Department of Health and Human Services:

PATIENT INFORMATION ACKNOWLEDGEMENT FORM

I have read and fully understand Gabriel Rehabilitation's Provider Notice of Information Practices. I understand that Gabriel Rehabilitation may use or disclose my personal health information for the purpose of carrying out treatment, obtaining payment, evaluation the quality of services provided, and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that Gabriel Rehabilitation will consider request for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for the purposes as noted in Gabriel Rehabilitation's Provider Notice of information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

Patient Name

Signature (Patient or Guardian)

Date