GABRIEL REHABILITATION, INC

PATIENT INFORMATION

Patient's Name: _____ Date of Birth: ____/____/____Age:____
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: _____ Day Phone: _____
Are you currently seeing a chiropractor? Y N
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
Auto Adjuster Name and Phone Number: _____
Attorney Name and Phone number: _____
Is your injury related to a workman's compensation claim: Y N

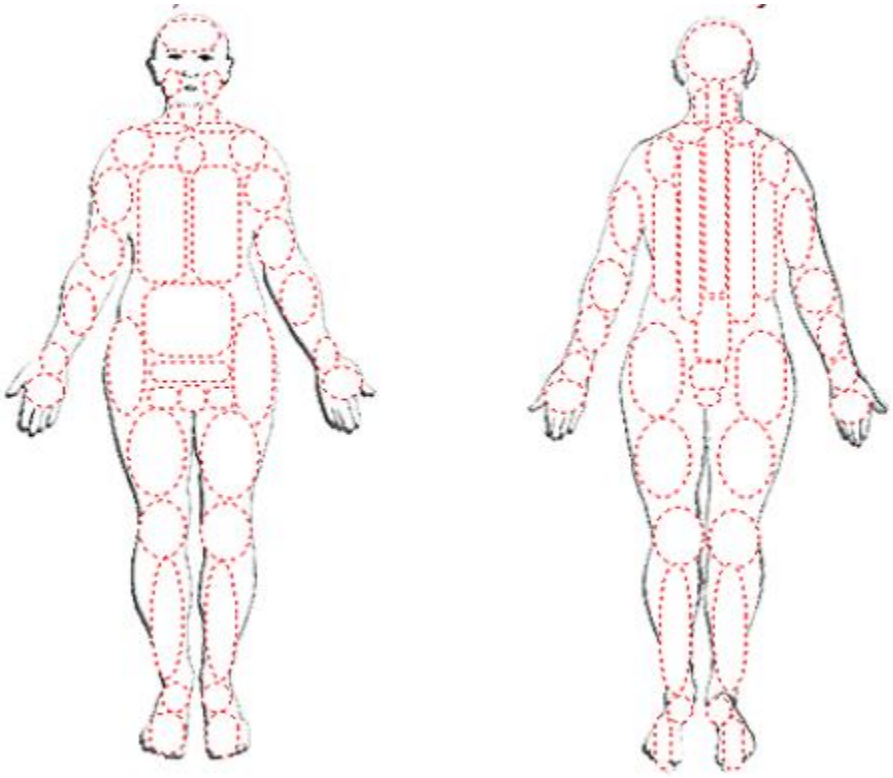
I authorize the release of the above information for treatment, payment, health care operations, and to process insurance claims. I also understand that I am responsible for charges if my insurance company fails to pay for services rendered. I consent to treatment by Gabriel Rehabilitation Inc.

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 Date: _____

Name_____ Height: _____ Weight: _____

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? _____

Have you received physical therapy since January 1, 2019 YES NO

If yes reason for previous therapy: _____

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 2019

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 2019 deductible of $185.00. *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. The benefits in the Part B program have changed. It now specifies that there is a $2040.00 limitation for outpatient physical therapy/speech therapy per calendar year. There is a separate $2040.00 for occupational therapy. This translates to approximately 16 visits. If your condition requires care beyond $2040.00 Medicare may make exceptions for extension of the cap depending upon your diagnosis and medical necessity. Your therapist will go over these exceptions/options 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

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 or at your visit we will call your primary 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.

Missed or Cancelled Appointment Policy

Kindly give 24 hours advance notice if you are unable to keep your scheduled appointment time.

We ask that you make every effort to keep your scheduled appointment and to arrive on time.

Our office requires a minimum of 24 hours notice prior to the cancellation or rescheduling of any appointment to not incur a fee for cancellation. If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. Your consideration is appreciated because the sooner you call us the greater our chances of providing this time to someone else.

If a person fails to show for an appointment and does not provide 24 hour notice prior to cancelling then our office will charge the rate of $25.00 for payment of the missed appointment. These charges will not be billed to your insurance provider.
Your appointment time is allotted to you so we will charge you for failure to call.

This policy applies to all patients for the following missed appointments:
1). The cancellation was not due to a medical emergency.
2). Failure to cancel less than 24 hours before your scheduled appointment.

According to payment policy at the Center for Medicare Management, "CMS's policy is to allow physicians and suppliers to charge Medicare beneficiaries for missed appointments, provided that they do not discriminate against Medicare beneficiaries but also charge non-Medicare patients for missed appointments. The charge for a missed appointment is not a charge for a service itself (to which the assignment and limiting charge provisions apply), but rather is a charge for a missed business opportunity." Therefore, our missed appointment policy applies equally to all patients (Medicare and non-Medicare).

A pattern of missed appointments may result in our office no longer being able to provide care for you.

Thank you for your cooperation in helping us provide the best care possible to you!

Patient or Legal Guardians Signature: _____

Print Name _____ Date: _____

Effective: January 24, 2014

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
790 Juno Ocean Walk, Suite 504C
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