The Summit Rehab
A HEALTHPRO® HERITAGE COMPANY
EXPERTS IN REHAB, EXCELLING IN SERVICE

Dear Patient or Responsible Party:

The Summit Health & Rehab Services, Inc. provides Physical, Occupational, and Speech therapy services.

Your physician has contracted with us to provide therapy services to their patients. A physician has ordered an evaluation and/or treatment that our therapists will provide. If therapy is indicated, a treatment plan is developed and then reviewed and approved by the physician.

The Summit Health & Rehab Services, Inc., its agents and/or assigns will bill the appropriate insurance carrier for services rendered. If the patient is eligible for Medicare Part B, Medicare will be billed according to the current published physician fee schedule. Medicare Part B typically reimburses 80% of the fee. The remaining 20% will be billed to any co-insurance, if applicable, and then to the patient.

Enclosed are documents that The Summit Health & Rehab Services, Inc. is required to have completed and signed by either the patient or the responsible party overseeing the patient's care.

1. **Billing Information Sheet – Patient Consent/Registration**: allows us to release medical information to Medicare and other insurance companies, and bill and collect for therapy services.
2. **Medicare Secondary Payor Questionnaire (if applicable)**: validates that Medicare is the primary payor.
3. **HIPAA Authorization Form:** authorizes us to disclose or use protected health information regarding the patient's care with the facility, patient, or guardian.

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PATIENT INFORMATION SHEET

PATIENT INFO

Patient's Name: _____ DOB: _____ Age: _____

Mailing Address: _____ Home Phone: _____ Cell: _____

City, State and Zip: _____ SSN#: _____ US Citizen: □ Yes □ No

Marital Status: □ Juvenile □ Never Married □ Married □ Separated □ Divorced □ Widowed Gender: □ Male □ Female

Patient's Employer: _____ Work Phone: _____

Responsible Party: _____ Phone: _____ Relationship: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

PATIENT HISTORY

Was your injury the result of an accident? □ Yes □ No Was injury employment related? □ Yes □ No

If so, what was the date of the injury? _____

List any surgeries (along with dates) that you have had: _____

_____

_____

List any medications that you are taking: _____

_____

_____

Have you or a family member ever had any of the following?

□ Diabetes □ Heart Disease □ High Blood Pressure □ Cancer □ Other

Patient, Parent/Guardian or Power of Attorney Signature: _____ Date: _____

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FINANCIAL RESPONSIBILITY

The Summit Health & Rehab Services. Inc. appreciates the opportunity to provide for your rehabilitative needs. The service(s) you have elected to participate in implies a financial responsibility on your part. This responsibility obligates you to ensure payment for services rendered. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment upon receipt of a bill for any deductible/co insurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full.

☐ I (we) have received this Insurance Verification Determination and **DO** wish to proceed with therapy services. I (we) realize that this is not a guarantee of payment by my insurance company and only the information given at the time of verification. All claims are subject to review and medical necessity by the insurance carrier. In the event these charges are not paid after reasonable attempts to collect them from the insurance carrier, the patient or responsible party is responsible for any outstanding balances.

☐ I(we) DO NOT wish to proceed with therapy services

AUTHORIZATIONS

CONSENT FOR TREATMENT **AUTHORIZATION FOR PAYMENT OF SERVICES FINANCIAL RESPONSIBILITY**

- **I consent to receive rehabilitation services from The Summit Health & Rehab Services, Inc.,**
- **I request payment of authorized benefits, including Medicare, for any services provided to me by The Summit Health & Rehab Services, Inc., to be paid directly to The Summit Health & Rehab Services, Inc., its agents and/or assigns.**
- **I authorize any holder of medical and other information about me, to release to my insurance carrier(s) and/or its agents any information needed to determine the benefits for these related services.**
- **I have read the above policy regarding my financial responsibility to The Summit Health & Rehab Services, Inc. I agree to pay The Summit Health & Rehab Services, Inc. the full and entire amount of all bills incurred after payment has been made by my insurance carrier(s).**
- **I have received a copy of The Summit Health & Rehab Services, Inc.'s Notice of Privacy Practices.**
- **The Summit Health & Rehab Services, Inc. does not discriminate against any person on the basis of race, color, national origin, disability of age.**

_____	_____	_____
Signature of Patient or Responsible Party	**Relationship**	**Date**

THE SUMMIT
Health & Rehab Services, Inc.

Attendance / Cancellation Policy

Your attendance to all scheduled therapy sessions is very important.

Insurers require attendance records for each patient. Payments for services rendered may be denied and precertification requests for future appointments may be significantly reduced or denied altogether secondary to a pattern of frequently missed appointments or cancellations.

When extenuating circumstances prevent attendance for a scheduled appointment, please notify the front office as soon as possible. We will diligently work with you to reschedule so that your continuity of care is not interrupted.

If you have missed more than half of your allotted treatment time for a session, your appointment will be cancelled. You may reschedule within the same week if an appointment is available.

Any patient who does not attend therapy with consistency necessary for benefit from therapeutic interventions may be discharged at therapist recommendation.

WELLNESS / ILLNESS POLICY

Because we care about the welfare of all our patients, do not come to therapy if you or your child has had fever or exhibited the following symptoms in the last 24 hours: Vomiting, Diarrhea, Runny Nose, (Yellow or Green), Rash, Symptoms of any Childhood Diseases, (Measles, Mumps, Chicken Pox, etc.).

APPOINTMENT REMINDERS

I, _____, give The Summit Health & Rehab Services permission to contact me with appointment reminders as follows: (Please select one.)

By Text at (cell phone #) _____

By phone call at (phone #)_____

Signature of Patient, Parent/Guardian, or Responsible Party: _____

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DISCLOSURE AGREEMENT

I authorize ***The Summit Health & Rehab Services, Inc.*** to disclose general medical information and other protected health information to the person(s) and/or entities listed below:

If no one is listed below, protected health information will not be disclosed except in those situations described in the ***Notice of Privacy for The Summit Health & Rehab Services, Inc.***

Name and relationship of the person you wish to allow access to your health information.
For example: your parent(s), spouse, sibling(s), child(ren), grandparent(s), neighbor(s), caretaker(s), or close friend(s).

Name (Including Parents)	Relationship to Patient

I understand that I have the right to revoke this authorization at any time by sending written notification to The Summit Health & Rehab Services, In., 4109 Highway 98W, Summit, MS 39666.

I understand that information used or disclosed pursuant to this authorization may be disclosed by The Summit Health & Rehab Services, Inc. and may no longer be protected by federal or state law.

Signature of Patient, Parent/Guardian, or Power of Attorney

Date

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Authorization for Use or Disclosure of Clinical Information (HIPAA Authorization Form)

Patient Name (First, Last, Middle Initial): Facility: 39059

_____

Treatment Start Date: _____

I, _____ (Patient, Parent/Guardian, or Power of Attorney), hereby authorize The Summit Health & Rehab Services, Inc. to use or disclose the protected health information about _____ (Patient name) in the following manner:

- **Description of the information to be used or disclosed:**
  Clinical Documentation.
- **Authority of the person(s) or entity requesting the information:**
  The patient/guardian or power of attorney listed above is requesting the information.
- **Identification of the person(s) or entity of whom the information is being made available:**
  The patient/guardian or power of attorney has requested the information above be released to the following:
  _____.
- **Use of the information:**
  To provide clinical information regarding the patient's care.
- **Description of expiration event.**
  This authorization will expire upon discontinuation of the use of the information listed in item #1.

I understand that I have the right to revoke my authorization at any time. My revocation will have no effect on an authorization that HealthPRO Heritage has previously relied on and acted upon.

To revoke my authorization, I must complete and sign a "Notice of Revocation of Authorization for Use and Disclosure of Protected Health Information" form and return it to our Privacy Officer or Agency Administrator. A copy of the form may be obtained from our Privacy Officer or Agency Administrator at The Summit Health and Rehab Services, Inc.

I understand that my continued treatment and/or any payment issues may not be conditioned upon my signing this authorization form.

I understand that there is a risk of re-disclosure of my information to yet another person or entity to which I am authorizing the above described use or disclosure.

_____ _____
Signature of Patient/Guardian or Power of Attorney Date

_____
Printed Name of Patient/Guardian or Power of Attorney