



Patient Privacy Policy & Procedure Statement

3905 Ernestine Drive
Suite B
Marion, IL 62930
Phone: (618)993-6237
Fax: (618)997-3529
www.oprtherapy.com

Dear Patient:

Occupational Performance & Rehab maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment, release medical records to the appropriate entities and those who you designate to provide health care treatment, payment, and daily operations of the facility.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at 618-993-6237.

Occupational Performance & Rehab reserves the right to amend, change, and/or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing our health care facility.

Signature _____

Patient / Guardian

Date _____

ORIGINAL



Confidential Patient Information

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Name _____ DOB _____ - - Age _____

Address _____ Apt _____ Phone _____ - -

City _____ State _____ Zip _____ Gender Male Female

Permanent Address _____ Phone _____ - - - -

City _____ State _____ Zip _____ E-Mail _____

Social Security # - - - - D/L # _____ State _____

Single Married Widowed Divorced Separated

If a minor, parent / guardian name _____

Social Security # - - - - DOB - - - -

Employer _____ Phone _____ - - - -

Address _____ Ext or Dept _____

City _____ State _____ Zip _____ Hours _____

Occupation _____ Supervisor _____

Spouse _____ DOB _____ - - - - Age _____

Social Security # - - - - Phone _____ - - - -

Employer _____ Work _____ - - - -

Address _____

City _____ State _____ Zip _____

Emergency Contact _____ Relationship _____

Address _____ Phone _____ - - - -

City _____ State _____ Zip _____

Referring Physician _____ Next Visit _____

Primary Care Physician _____ Next Visit _____

I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ Date _____



Insurance Verification Form

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Referral Date _____ Rx Date _____

Patient Name _____ Phone _____ Sex M F DOB _____

SS # _____ Cell _____ Work _____

Referring Physician _____ Phone _____ Fax _____

Frequency _____ X per week for _____ weeks Diagnosis _____

Workers Compensation

We are IN / OUT of network _____ (name)

Carrier _____ Employer _____

Claim Number _____ Date of Injury _____ State of Accident _____

Adjuster _____ Phone _____ Ext _____ Fax _____

Nurse Case Mgr. _____ Phone _____ Ext _____ Fax _____

Claims Address _____

Comments _____

Authorization # _____ Date _____ Spoke w/ _____ Verified By _____

We are IN / OUT of network _____ (name) **Commercial** Accepting network benefits? _____

WE ARE A FREESTANDING OUTPATIENT REHABILITATION FACILITY

Insurance Carrier _____ PPO / HMO / POS / Indemnity _____ Phone _____

Subscriber Name(if different than patient) _____ DOB _____ SS # _____

Policy # _____ Group # _____ Pre-Cert Reqd? Y / N Phone _____

Referral or auth needed from PCP? Y / N Phone _____ Fax _____ DOI _____

IN-NETWORK	effective date	OUT OF NETWORK	CLAIMS ADDRESS
Deductible _____	Has met _____	Deductible _____	Has met _____
Co-Pay \$ _____		Co-Pay \$ _____	
Co-Ins _____ % / _____ %		Co-Ins _____ % / _____ %	
Out of Pocket Max \$ _____		Out of Pocket Max \$ _____	

Secondary Insurance.... Crossover to Medicare automatically? YES NO Does it cover MCR Ded? YES NO

If Medicare Primary.... Type of Policy? Supplemental Secondary Carve-Out

If BC/BS NASCO? YES NO If so verify Alpha Prefix example, NCH, GMM

Limitation or restrictions _____

Plan Covers _____ PT _____ OT _____

Comments _____

Authorization # _____ Date _____ Spoke w/ _____ Verified By _____

Auto

Carrier _____ Adjuster _____ Phone _____

Insured _____ Claim / File # _____ Date of Accident _____

PIP \$ _____ Deductible\$ _____ Med Pay\$ _____ State of Accident _____

Claims Address _____

Spoke w/ _____ Date _____ Verified By _____

Comments _____

Attorney _____ Phone _____ Fax _____

Atty Address _____



Authorization Log

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Patient Name _____ **DX** _____

Referring Physician _____

Insurance / Name		Patient Responsibility	
W/C	Auto	Copay	Deductible
PPO	Atty	Co Ins	=Approx
HMO	Self	Restrictions	
Medicare	Supp		
VOC Rehab	LOP		
Indemnity	POS		

Script #	Authorization
Freq && Duration	
Visits	Dates
	CX or NS Reason
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

RX Exp.	_____	Done	_____	Rcvd	_____
Auth Exp.	_____				
POC Date	_____				
MD Date	_____				

Script #	Authorization
Freq && Duration	
Visits	Dates
	CX or NS Reason
1	
2	
3	
4	
5	
6	
7	
8	
9	
10	
11	
12	

RX Exp.	_____	Done	_____	Rcvd	_____
Auth Exp.	_____				
POC Date	_____				
MD Date	_____				



Consent for Care and Treatment

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I, the undersigned, do hereby agree and give my consent for Occupational Performance & Rehab to furnish medical care and treatment to _____ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature _____ Date _____
Patient / Guardian

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, the undersigned, hereby assign all medical benefits, ie.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Occupational Performance & Rehab. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Occupational Performance & Rehab to release all medical information and records necessary to secure payment for services rendered.

Signature _____ Date _____
Patient / Guardian

FINANCIAL POLICY STATEMENT

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the services are rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits or estimated co-insurances as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

All co-insurance percentages paid at time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.

If any payments of medical benefits are made directly to you for services rendered by Occupational Performance & Rehab, you must promptly remit such payment directly to Occupational Performance & Rehab.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for your charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature _____ Date _____
Patient / Guardian



Confidential Medical Information

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Please state current problem(s): _____

Are you currently being treated by:

Another Therapist	Yes	No	Or within the last 12 months	Yes	No
Chiropractor / Osteopath	Yes	No	Or within the last 12 months	Yes	No
Home Health Agency	Yes	No	Or within the last 12 months	Yes	No

Major surgeries since birth: _____

Allergies: _____

List current medications: _____

Check if you currently have or previously had any of the followin

- | | |
|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Circulation Problems | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Other Illnesses |

specify: _____

specify: _____

The above information is true and accurate to the best of my knowledge. I hereby authorize the release of any medical information necessary for processing insurance claims and payment of medical benefits for myself or the party who accepts assignment of benefits.

Signature _____ **Date** _____

PATIENT MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and the gain of your physical abilities is something that everyone in our clinic takes quite seriously.

Because we care so much about you we realize that it would be a disservice to you if we did not emphasize the importance of your own commitment to the care you need to receive and to the actions we ask you to do. Your adherence to the recommended number of treatments is a vital component of your progress with our services; therefore we have certain rules that need to be followed in order to ensure the most optimum results.

Your appointment time is reserved just for you with your therapist. If you must cancel your appointment, it will be necessary for you to give at least 24 hours notice in order for the therapist to have an opportunity to fill that session time.

We expect you to keep all your appointments. Write down the time of your visits so that you do not forget.

With the exception of serious emergencies it is expected that you keep all your appointments. If you need to re-schedule an appointment we require a **24 hours notice**. In such a case, please call our office and arrange for a make-up appointment with our Front Desk Receptionist. The make-up appointment needs to be in the same week, preferably the very next day.

In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, we reserve the right to charge you a **\$25.00 fee which will not be covered by your insurance or Medicare**.

In instances of repeated non-compliance (3 no-shows)with your scheduled visits, we also reserve the right to discontinue care from the entire practice. Your referring physician will be notified of the fact that your service has been discontinued due to non-compliance with the prescribed rehabilitation order. Case Mangers will also be notified of non-compliance and this may adversely affect benefits.

We appreciate you greatly as our patient and strive to accomplish wonderful results and success for you.

I have read and understand this policy: _____ Date: _____

All portions of this form must be completed to constitute a valid authorization to release health information under the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations. If any field is left blank, the authorization will be considered defective.

Patient's Name _____
D.O.B. _____
SSN _____
Telephone _____
Address _____

I authorize the use and disclosure of health information about me as described below:

Facility authorized to release my Health

information:

_____ Agency or individual (s) Authorized to receive my health information

Discharge summary _____
Consultation _____
Operative Report _____
Imaging - X-Ray _____
History and Physical _____
Lab _____
Entire Chart _____

Health information that may be used are limited to the following

treatment dates

Health information identifies you (the patient) by name and includes other demographic information about you. Health information may include, but not limited to: medical records, x-ray films, slides, tracings, strips, etc.

I hereby discharge the releasing facility and employees from any and all liabilities, responsibilities, damages, and claims which might arise from the release of this information authorized herein, to include alcohol, drug abuse, communicable disease including HIV status, and or psychiatric diagnoses compiled during my visit, encounter or hospitalization, or make copies thereof in accordance with the policies of this facility. This authorization will expire in 60 days from the signed date below. Notice to the receiving agency or individual: This information is to be treated in accordance with Health Insurance Portability and Accountability Act (HIPAA) privacy regulations.

Patient's or Authorized Personal Representative's signature _____

Date _____ Time _____

Relationship to Patient _____ Witness _____

Expiration Date or Event _____