MEDICARE

Patient Information Form

Please Print

Name: ______________________________ Date: ______________
Address: __________________ City: __________ State: ____ Zip Code: _____
Home Phone: ______________________ Soc.Sec # ______________
Birth Date: ______________ Age: __________ Marital Status: _________
Occupation: ______________________ Work Phone # ______________

Guarantor/Emergency contact person

Guarantor: __________________________ Relationship: ____________
Address: ____
Phone #: ____________ Employed By: ________ Work Phone: ____________
Employers Address: ______________________________________

Primary Insurance Coverage

Name & Address of Insurance Co.: ______________________________
Insured Name: ________________ Address: ________________________
Employer: ______________ Policy #: ______________ Effective Date: _______

Secondary Insurance Coverage

Name & Address of Insurance Co.: ______________________________
I.D#: __________________________ DOB: ______________________
Eligibility Period: ______________ Through __________ Caseload: _______
Policy #: ____

Release of Insurance Information

I authorize my therapist to furnish to my health insurance company / doctor all information, which said insurance company / doctor may request concerning treatment for my self:

Date: ______________ Signature: ______________________

Assignment of Benefits

I hereby assign to my therapist / agency the medical benefits eligible under my medical insurance plan.

Date: ______________ Signature: ______________________

PATIENT RIGHTS AND RESPONSIBILITIES FORM

Maximum Rehabilitation Services, Ltd. believes our patients have a right to be informed, in advance of service, of their rights and responsibilities related to these rights. The patient's family or guardian may exercise the patient's rights when the patient has been judged incompetent.

PATIENT RIGHTS

YOU HAVE THE RIGHT TO:

1. Competent, considerate, respectful care regardless of age, creed, sex, sexual preference, religion, race color, national origin or source of payment.

2. Receive written notice of your rights prior to receiving service.

3. Have your property treated with respect.

4. Voice grievance regarding your care or the treatment of your property with assurance of no retribution.
5. Have your grievance investigated and to have our staff work with you for resolution.

6. Be informed, in advance, regarding the care to be furnished and of any changes in that care.

7. Be informed, in advance, of the therapists who will provide care, and frequency of services to be provided.

8. Be educated about and participate in planning your care and treatment.

9. Confidentiality of your clinical record maintained by agency, and to advise of agency policies and procedures for disclosure of clinical records.

10. Be advised, before care is initiated of the charges for services and the extent to which payment may be expected from a third party payor and your liability for payment not covered by them.

11. Be informed of changes in our charges and your liability for payment no later than 30 days from the date the agency becomes aware of the change.

12. Receive a reasonable explanation of your total bill for specific services received.

13. Be advised of the Illinois Department of Public Health hot –line phone number, the hour of operation and its purpose.

14. Patient has a right to participate in pain management and to be believed in his/her account of pain

PATIENT RESPONSIBILITIES

YOUR RESPONSIBILITIES ARE TO:

1. Provide accurate and complete information about your health status to the agency.
2. Cooperate with your physician and the agency staffs to follow plan of care.
3. Notify the agency in advance if you will not be available to receive scheduled care. Non-notification may result in a charge to you.
4. Provide accurate health insurance and financial information related to payment of requested service.
5. Accent personal and legal responsibility for your refusal of any treatment or for non-compliance with your plan of care.
6. Sign the service agreement, consent for treatment and release for insurance payment to the agency for care ordered prior to service being initiated.
7. Participate in developing our plan of care asking questions expressing your concerns, and reporting changes in your condition in a timely manner.
8. Treat agency staff with respect and consideration.

To register a complaint with the agency call, (708) 923 – 1768 or write to Maximum Rehabilitation Services, Ltd 12021 S. Harlem Ave, Palos Heights, IL 60463.

To register a complaint or question about the agency with the state call the Illinois Department of public health central complaint Registry at 1-800-252-4343, 24 hours/ day, 7 days/ week. Response will be provided to you between 3:30am and 5:30pm, Monday through Friday.

My Signature below indicates that I have read the above rights and responsibilities and understand their implications for my care.

____________________________ (Patient's Signature)

______________________ (Date)

____________________________ (Legal Guardian's Signature)

______________________ (Relationship)

____

Agency representative Signature:

PATIENT CONSENT AGREEMENT AND AUTHORIZATION

PATIENT NAME: ______________________________________ **DATE OF BIRTH:** ________________

1. **Consent for Service and Treatment**

I hereby consent to the services and treatments as ordered by my Physician and authorize Maximum Rehabilitation Services, Inc. (MRS) to provide such services and treatments. I understand that it is necessary that I remain in the care of my Physician during the prescribed coarse of my health Services.

2. **Release of Medical Information**

I hereby authorize the release of my medical information from my physician and hospital to MRS, Inc. I also authorize MRS to release my medical information to my insurance carrier(s) in order to process any insurance claims. I further authorize the possible review of my clinical record for audit purposes as covered by law. I authorize the release of the plan of treatment and discharge summary from my clinical record should I be transferred to a health care facility or another home health agency.

3. **Assignment of Insurance Benefits**

I hereby authorize my insurance company to make direct payment of my benefits for covered services to MRS in the event that my insurance carrier does not accept "assignment of benefits," I understand that payments for covered services may be sent directly to me, in that event I agree to promptly endorse and send said payment to MRS in payment of my bill for services rendered.

4. **Financial Responsibility**

I understand and agree that I am personally responsible to all charges for services provided to me by MRS I agree that, in the event that my insurance company or other third party payer refuses to pay for services provided to me or delays payment beyond 90 days of my receipt of notification of such event, I shall personally pay MRS bill.

5. **Acknowledgment**

I have been informed about and have received and understand written information regarding patient rights and responsibilities. I have also been informed of the MRS charges for services, payments for services expected from my insurance carrier and an estimate of the charges. I will have to pay for the services I received under this service agreement.

6. **Certification (Title XV111 of Social Security Act)- Medicare Recipients Only**

I certify that the information given by me in applying under title XV111 of Social Security Act is correct and that I am not currently a member of a Health Maintenance Organization. I request that payment of covered and authorized benefits be made in my behalf to MRS.

7. **Advance Directive**

I understand that if I have an Advance Directive, it is my responsibility to provide MRS a copy that will be entered into my medical record. ☐ Yes ☐ No

8. I understand that in the unlikely event of a medical emergency, MRS will contact emergency- Telephone 911 and I will be transported to an acute care facility (Treating facility). I further understand that a copy of my advance directive will be sent with my medical record to the treating facility. It will be the sole responsibility of the treating facility, not MRS to determine the extent of care at that facility.

Signature of Patient or Legal Guardian: ______________________________ Date: ____________

Witness ____ Date: ____________

MEDICARE SCREENING FORM

Patients Name: ______________________________

Address: ______________________________

City: ______________ State: ____________ Zip Code: ____________

Birth Date: ____________ Age: ____________ Martial Status: ____________

Are you currently employed? ☐ Yes ☐ No

If you are retired, what was your retirement date? ____________

Are you covered by an Employee Group Health Plan which is Primary to Medicare?

☐ Yes ☐ No

Do you have another insurance which is Primary Medicare? ☐ Yes ☐ No

If yes, Name of the Policy: ______________________________

Spouse's Name: ______________________________

If your spouse currently employed? ☐ Yes ☐ No

If your spouse is retired, which is His/Her retirement date? ____________

Is your spouse covered by an Employee Group Health Plan which is Primary Medicare?

☐ Yes ☐ No

Are you entitled to Medicare due to disability and covered by a Large Group Health Plan?

☐ Yes ☐ No

Were you involved in an Automobile Motor vehicle accident or an accident involving other liability?

☐ Yes ☐ No

Did you receive injuries in a work related accident and workers compensation is primary?

☐ Yes Date __________ ☐ No

Are you entitled to benefits under Veterans Administration? ☐ Yes ☐ No

Do you have severe kidney disease? ☐ Yes ☐ No

Are you undergoing Dialysis for ESRO? ☐ Yes ☐ No

Are you entitled to Medicare Benefits secondary to Dialysis for more than 12 months?

☐ Yes ☐ No

______________________________ ______________________________

SIGNATURE (Patient or Authorized Representative) Relationship to Patient

______________________________ ______________________________

Witness Date

MEDICARE SECONDARY PAYER SCREENING FORM

1. Is the condition for which you are receiving treatment due to an accident or injury
   No ☐ Proceed to Question #2
   Yes ☐ Respond to the following as applicable:
   A. Motor vehicle:
   Auto Insurance is the Primary payer bill then, Name and address of Automobile insurance.
   ____
   ____
   ____

   B. Work related Specify injury ______________________________
   Workers's Compensation is the Primary Payer, bill them Name and Address of Workers compensation insurer or Employer
   ____
   ____
   ____

   Date of Injury illness: ______________ Case File No ______________
   NOTE: If a Workers's Compensation claim has ever been Med complete IB for Medicare's Records.
   C. Accident (Other than motor vehicle or work related) Give brief description and location of accident.
   ____
   ____
   ____

   If accident occurred at a location other than patients' residence
   Name and address of responsible party or insurance Carrier of responsible party
   Please provide this information even if liability is a question.
   ____
   ____
   ______________ Policy No ______________
   If legal action is involved give name address and telephone number of attorney
   ____
   ____

2. Is this illness covered under the Black Lung Program or are the services provided Authorized by the Veterans Administration?
   No ☐ Proceed to Question # 3
   Yes ☐ Black Lung VA is Primary Payer, Bill them.

3. Is patient 65 years of age or older
   No – Proceed to Question #4
   Yes – If Yes, respond to the following
   If patient is 65 or older and has End Stage Renal Disease, Medicare is Primary Payer proceed to end
   A. Is patient or spouse employed?
      No ☐ Patient's Spouse's date of retirement ______________ ______________
      Yes ☐ Patient employed Complete B if spouse employed complete C

      If Patient and spouse employed Complete B and C.
      EGHP is not primary for:
      1. Employees of employers with lower than 20 Employees.
      2. Self employed individuals with lower than 20 employes.
      3. Individuals entitled to Part B only.
   B. Name and address of patient's EGHP
   ____
   ____
   ____

4. Is patient under 65 years and entitled to Medicare due to a disability other then End Stage Renal D
   No ☐ Proceed to Question #5
   Yes ☐ If the patient is an active member of any Large Group Health Plan (LGHP. The LGHP. The LGHP is primary bill them).
   Name of individual Patient, spouse guardian etc., enrolled in the LGHP ______________
   Name and address of LGHP
   ____
   ____
   ____

5. Is the patient under 65 years of age and entitled to Medicare solely on the basis of End Stage Renal entitled to Medicare due to another disability and undergoing kidney dialysis for less than 12 months entitled to Medicare for less than 9 months?
   No ☐ See the Note Below
   Yes ☐ If the patient covered under an EGHP, EGHP is Primary payer regardless of number of employees then bill them.

   Name and address of EGHP
   ____
   ____

If the answer to all the above question are NO Medicare is the Primary Payer

Patient / Representative Signature ______________________________

MAXIMUM REHABILITATION
SERVICES, LTD.
12021 S. HARLEM AVE.
PALOS HEIGHTS, IL 60463
708-923-1768

HOME HEALTHCARE
PATIENT NOTIFICATION

Please be aware that if you are currently under the care of a Home Healthcare Agency, you can only receive care from that Home Healthcare Agency. Medicare will only reimburse the Home Healthcare Agency for services. Also, if you enter the care of a Home Healthcare Agency while receiving treatment from Maximum Rehabilitation Services, you must notify us immediately and discontinue receiving services from Maximum Rehabilitation Services. Therefore, if you choose to receive services from Maximum Rehabilitation Services while under the care of a Home Healthcare Agency, you will be financially responsible for the services received at Maximum Rehabilitation Services.

This is to certify that I am not currently under the care of a Home Healthcare Agency. I have been informed that if I am currently under the care of a Home Healthcare Agency or if I enter the care of a Home Healthcare Agency and continue to receive treatment from Maximum Rehabilitation, I will be financially responsible for the services I receive from Maximum Rehabilitation Services.

______________________ ______________

Patient Signature Date

Appointment of Representative Form HCFA-1696-U4

Department of
Health and Human Services
Healthcare Financing Administration

Name (Print of Type)	H.I.Claim Number

Section 1 **Appointment of Representative**

I appoint this individual: ______________________________
(Print or type name and address of individual you want to represent you)

to act as my representative in connection with my claim or asserted right under Titles X1, or XV111 of the Social Security Act. I authorize this individual to make or give any request or notice: to present or to elicit evidence: to obtain information: and to receive any notice in connection with my claim wholly in my stead

Signature (Beneficiary)	Address
Telephone Number	Date

Notice of Privacy Practices Acknowledgment

Maximum Rehabilitation Services, Ltd.
12021 S. Harlem Ave, Palos Heights, IL 60463

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment form third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________

Relationship to Patient: ______________________________

Signature: ______________________________

Date: ______________________________

Office use only

I attempted to obtain the patients signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date:	**Initials:**	**Reason:**

LIST OF MEDICATIONS

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

6. ______________________________

7. ______________________________

8. ______________________________

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Please assist us by checking any of the following:

1.) Patient Name______________________________________

2.) How were you referred to Maximum for your therapy?

☐ Doctor/Doctor's Office?______________________________

☐ Hospital? ______________________________________

☐ Insurance Company? _____________________________

☐ Friend? ____

☐ Family Member? __________________________________

☐ Yellow Pages?_____________________________________

☐ Other?____

____

____

Maximum continues to appreciate your business.
We are committed to servicing you toward complete recovery.

TO OUR PATIENTS REGARDING CANCELLATIONS AND NO-SHOWS

We take this subject seriously at our clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or the therapist have prescribed a set frequency of treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you achieve your goals.

The following are our policies regarding Cancellations and No-Shows:

We require 24 hour advance notice in the event of a cancellation. When you call it is your responsibility to have an alternate time in mind that will ensure you get in the full prescribed number of treatments within a week if at all possible.

Patients who do not show up or call to cancel their appointment are considered No-Shows. We do not appreciate this action, as it throws off our schedule and prevents us from having other patients come in that time slot.

PLEASE NOTE: There is a $15.00 charge for any cancellations without proper notice or for No-Shows. This charge will not be covered by your insurance and will be your responsibility.

Patient's who have quite a few cancellations or "no-shows" on their file will be discharged from treatment and their doctor's will be notified.

We understand there are times when it is necessary to cancel an appointment, sometimes at the last minute. However, patients who consistently disregard the courtesy of keeping their appointments or just don't show up, will be charged a fee and/or discharged from treatment.

______________________________ ______________

Signature **Date**

______________________________ ______________

Witness **Date**