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 12021 S. HARLEM, 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 3:30 am and 5:30 pm, 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: _____

INSURANCE VERIFICATION FORM

Patient Name: _____ Date _____
(Last) (First)
Address: _____
(City) (State) (Zip)
Home Phone: _____ Work Phone: _____

Soc-Sec: _____ - _____ - _____ DOB: ____ - ____ - ____ Sex: _____ Marital Status: _____

Please check one:
- ☐ Workman Com. Case
- ☐ Workman Com. with Attorney
- ☐ Auto Accident Case
- ☐ Auto Accident Case with Attorney
- ☐ Health Insurance
- ☐ Self Pay

Insurance company: _____
Insurance Address: _____
City/State/Zip: _____ Phone: _____
Adjuster Name _____ Date of Incident ____ - ____ - ____
Additional Information: _____

Employment Information:

Employer: _____
Address: _____
Phone: _____ Sup Name: _____

Attorney Information:

Name: _____ Date: _____
(Last) (First)
Address: _____
(City) (State) (Zip)
Phone: _____ Fax: _____

File No: _____ Verified by: _____ Date: _____

Please be advised that until we receive information necessary to process the associated medical claim this account will be considered self-pay. Your insurance company should provide you with a letter of financial liability.

Patient Signature: _____

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. _____

9. _____

10. _____

MAXIMUM REHABILITATION SERVICES

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**