

Longevity Rehab Center
1515 Indian River Boulevard, Suite A135
Vero Beach, FL 32960
Phone (772) 978 9750 Fax (772) 978 9748

Patient Information Sheet

Payer Type (circle one): Medicare Commercial Insurance Private Pay Worker Comp

Patient Name: _____ Date: _____

Local Address: _____ City: _____ State / Zip _____

Permanent Address: _____ City: _____ State / Zip _____

Local Phone # _____ Email Address _____ Can we Email you? Yes _____
No _____

Social Security # _____ DOB _____ Age _____

Sex (circle one) F M Marital Status (circle one): Single Married Divorce Widow

Employer: _____ Address: _____

City: _____ State / Zip: _____ Phone # _____

Referring Physician: _____ Date of last visit? _____

Emergency Contact: _____ Relation: _____ Phone # _____

Responsible Party: Self _____ Spouse _____ Other: _____ (do not write insurance name)

.....
Is Condition Accident Related? Yes ___ No ___ Date of Accident: _____ State: _____

Where did it occur? Home ___ Auto ___ Work ___ Other _____

**ARE YOU RECEIVING ANY HOME HEALTH CARE?
THIS INCLUDES NURSING, PHYSICAL,
OCCUPATIONAL AND SPEECH THERAPY.**

NO _____

YES _____

.....
FOR OFFICE USE ONLY:

Insurance: _____

Authorization Required: ___ Yes ___ No

Deductible: _____ **Oop:** _____

CoPay: _____ **# Visits/Year:** _____

PATIENT MEDICAL HISTORY

Name: _____ Age: _____ Date of next Doctor's appointment: _____

Are you currently receiving any type of home care? _____ Are you pregnant? _____

Are you currently receiving therapy anywhere else? _____

Have you had P.T./O.T./Speech therapy anywhere else **THIS YEAR**? _____

Are you presently working? _____ If Yes: ___Light/moderate duty ___Regular duty

Which area is the problem? _____

How did this problem begin? Briefly describe: _____

Date when injury or problem first occurred: _____

Was the onset ___ Gradual or ___ Sudden?

Have you been hospitalized for this problem? _____ If yes, when? _____

Have you had any testing, x-ray, MRI, CAT scan, etc.? If yes, please specify.

Are you currently seeing any other Doctors? If so, please list. _____

Please list any hospitalizations: _____

Have you ever been diagnosed with or do you have the following? Check if yes:

- | | | |
|--------------------|--------------------------------|------------------------------|
| ___ Cancer | ___ High Blood Pressure | ___ Elevated Cholesterol |
| ___ Tuberculosis | ___ Respiratory Problems | ___ Diabetes |
| ___ Hepatitis | ___ Seizures | ___ Osteoporosis |
| ___ Kidney Disease | ___ Rheumatoid Arthritis | ___ Pace Maker |
| ___ Depression | ___ Other Arthritic conditions | ___ History of heart disease |
| ___ Fibromyalgia | ___ Chemical Dependency | ___ Ortho Surgery |
| | ___ Spinal Stenosis | ___ Do you smoke? |

Other _____ Allergies? (Drug/other) _____

Have you ever had a fracture or dislocation? If yes, please specify. _____

Do you have any metal or plastic in your body? If yes, Please specify. _____

PLEASE LIST ALL MEDICATIONS AND RECENT INJECTIONS: _____

Who can we thank for referring you? _____

PATIENT SIGNATURE: _____ Date: _____

REVIEWED BY THERAPIST: _____ Date : _____

LONGEVITY REHAB CENTER, INC.
PATIENT FINANCIAL POLICY AND AGREEMENT

We are committed to providing you with the best possible care. If you have insurance, we will gladly accept assignment of benefits and file all insurance claims provided verification of your insurance policies allows assigned benefits and coverage for the services rendered.

Please read the following statements carefully. By signing below, you agree that you have read and fully understand all statements contained herein.

I, the undersigned, understand that Longevity Rehab Center, Inc. will bill my insurance carrier for the services rendered upon verification of coverage from my insurance company. I also understand that should my insurance company fail to make payment for services rendered, I am fully responsible for all charges incurred and will pay in full for all services. I understand that I am responsible for payment of any and all deductibles and/or coinsurance amounts. If payment is sent directly to me and the charges incurred are not subject to any fee schedule or reduction made by my insurance carrier, I understand I will pay said monies to Longevity Rehab Center, Inc. for said services rendered. I also understand that if my treatment is due to an injury which results in litigation against a third party, this in no way relieves me of my obligation to pay for the services rendered. I understand that payment of said fees are not contingent upon settlement of a litigation; however, I hereby instruct my attorney to pay Longevity Rehab Center, Inc. in full, directly from the proceeds from any settlement or judgment rendered on my behalf.

EXPLANATION OF MEDICARE BENEFITS: Accepting assignment means that the provider of services agrees to accept the “allowable charges” as determined by Medicare as full payment. However, Medicare pays 80% of the “allowable charge.” Therefore, you are responsible for the 20% balance. In addition to the 20%, you are also responsible for any amounts toward your annual Part B deductible and any non-covered charges.

SUPPLEMENTAL COVERAGE/CO-PAYMENT: Longevity Rehab Center, Inc. has explained to me that under Medicare guidelines, I will be responsible for 20% of the allowable charge. As Longevity Rehab Center, Inc. has agreed to accept assignment of benefits on this portion of the charges, I understand that should the supplemental insurance company fail to pay for these charges within “a reasonable length of time”, or if they send payment directly to me, I will become responsible for payment in full.

WORKERS’ COMPENSATION COVERAGE: Longevity Rehab Center, Inc.. agrees to treat and bill workers’ compensation for preauthorized work related injuries per the Worker’s Compensation Guidelines for the State of Florida. However, if for any reason Worker’s Compensation denies liability for the treatment of the injury I understand I become responsible for full payment of the charges.

ASSIGNMENT OF BENEFITS

The undersigned certifies that the information given by me in applying for payment under the Title XVII of the Social Security act is correct. I, the undersigned, authorize Longevity Rehab Center, Inc. to release information regarding my health care to the Social Security Administration, its intermediaries, or any other insurance carrier, or my attorney needed for this or a related claim. I authorize payment from Medicare to be made directly to Longevity Rehab Center, Inc., on my behalf.

*(SECONDARY INSURANCE IF APPLICABLE)

I hereby instruct and direct that _____
my Supplemental/Commercial Insurance Company make payments directly to:

Longevity Rehab Center
1515 Indian River Boulevard
Vero Beach, FL 32960

for any professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This pay is not to exceed my indebtedness to the above-mentioned assignee. I have agreed to pay any balance of the said professional service charges over and above this insurance payment.

A PHOTOCOPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

X _____
Signature of Policy Holder

Date

Signature of Claimant, If other than Policy Holder

Date

AUTHORIZATION OF TREATMENT

I, the undersigned, hereby consent to such treatment by the authorized personnel of Longevity Rehab Center, Inc., as may be dictated by prudent medical practice of my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

Signature of Patient, Parent or Guardian

Date

Witness

**LONGEVITY REHAB CENTER
1515 INDIAN RIVER BLVD, SUITE A135
VERO BEACH, FL 32960
772-978-9750 772-978-9748**

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ (Patient Initials). I acknowledge that I have received a copy of Longevity Rehab Center Inc., notice of privacy practices with the effective date of 04/01.

MEDICAL EMERGENCY RELEASE

_____ (Patient Initials). I release Longevity Rehab Center to contact my family or responsible party in case of a medical emergency. I also give them permission to send me to Indian River Medical Center Emergency Room for treatment.

CANCELLATION POLICY

_____ (Patient Initials). We ask that you please keep your scheduled appointment times. If you need to cancel your appointment, we ask that you give us twenty-four (24) hours advance notice. We understand emergencies arise without notice. We also want you to understand the importance of keeping your scheduled therapy visits in order to properly reach your rehab goals. However, if it becomes a habit that you are cancelling your appointments without twenty-four (24) hour notice or not showing for appointments \$20.00 charge will be billed to the patient.

By signing below, I understand that I have read the above information.

Signature

Relationship to Patient

Longevity Rehab Center, Inc.
1515 Indian River Boulevard, Suite A135
Vero Beach, FL 32960
Phone: 772-978-9750 Fax: 772-978-9748

NOTICE OF THE USE AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present, or future physical or mental health condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose your Protected Health Information to another physician, such as a specialist, to whom we refer you for medical treatment.
2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for the purposes of their health care operations.
3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) Disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and to determine whether the amount we charge you for medical services are justifiable. (e) Disclosures to determine whether the amount we charge you for medical services are justifiable.
4. Reminders and Treatment Alternatives: We may contact you and provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your Protected Health Information in connection with treatment, payment, or health care operations if we deliver health care products or services to you based on the orders of another health care provider, and we report the

diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable disease, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA- related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; (h) for selected governmental functions, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services (“DHHS”) when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your general condition and your religious affiliation, if any, in our facility’s directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and may not continue the delivery of medical treatment to you until you provide the requested written authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.
2. The right to request in writing and receive confidential communications of your Protected Health Information by alternative means (such as by mail or email) or at alternative locations (such as your office or business workplace).
3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in case where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.
4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.
5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment, payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.
6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Paul R. St. Mary, Owner/Director. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules (c) be filed within 180 days of when you knew or should have known that the act of omission complaint occurred, unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Paul R. St. Mary at 772-978-9750.