ZARETT | REHAB | FITNESS

Patient Information

Referred By: _____
Referring Physician: _____

Appointment
Date: _____
Time: _____

Patient Name: _____
Last First Middle Int.

Date of Birth: _____ SS#: _____

Street Address: _____

City/State/Zip: _____

Phone Numbers: Home: _____ Work: _____

Cell: _____ Email: _____

Employer: _____ Address: _____

Emergency Contact: _____ Phone: _____

Type (Circle): Insurance Fitness Work/Comp Personal Injury Auto D/A: _____

Primary Insurance: _____ Phone: _____

ID/Claim #: _____ Group #: _____

Policy Holder Name: _____ DOB (if other than patient): _____

Secondary Insurance: _____ Phone: _____

ID/Claim #: _____ Group #: _____

Policy Holder Name: _____ DOB (if other than patient): _____

Notes: _____

_____

_____

INSURANCE AUTHORIZATION AND ASSIGNMENT OF BENEFITS

I hereby assign to Zarett Rehab & Fitness all payments made by any insurance company for physical therapy services rendered to myself or my dependents. I further hereby assign to Zarett Rehab & Fitness all payments for said physical therapy services are sent promptly and directly to Zarett Rehab. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Signature Date

520 South 19th St. Philadelphia, PA 19146
P. 215.731.1449 F. 215.731.1345 WWW.ZARETTREHAB.COM

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Medical History Intake Sheet

Name _____

Date _____

Please check if you have had any of the following:

__High blood pressure __Heart murmur __Atrial fibrillation

__Heart disease __Heart attack __Circulatory problems

__Migraine headaches __Neurological problems __Cancer

__Lung disease __Broken bones __Metal implants

__Osteoporosis __GI problems __Stroke

__Epilepsy/seizures __Kidney disease __Bowel/bladder changes

__Liver disease __Asthma __Dizziness/Vertigo

__Depression __Anxiety __Other

__Diabetes (__Type 1 or __Type 2)

What test have you had for your current condition? (Please provide images)

__MRI __X-ray __CT Scan __EMG __Myelogram

Have you had any falls in the last year? __Yes, how many? ____ __No

Have you been hospitalized in the last year? __Yes __No

Do you have a pacemaker? __Yes __No

Females: Are you pregnant? __Yes __No If so, how many months? _____

Please list relevant surgeries you have had _____

List any medications you are currently taking _____

Do you know of any allergies you may have?_____

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Patient Injury Information

Patient Name_____ Date of Birth_____

Area of Concern_____

Is this due to accident or injury?_____

Work related injury_____

Auto related injury_____

Sports related injury_____

Other cause of injury_____

Describe how symptoms first occurred (please be specific)

_____

_____

Date of injury_____

Have you ever been treated for the same injury in the past?

_____

If yes, when, where and under which insurance coverage?

_____

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Acknowledgement of Receipt of Privacy Practices

I, _____ have received a copy of Zarett Rehab & Fitness's Notice of Privacy Practices with an effective date of May 1, 2003.

Name of Patient _____

Address of Patient _____

Signature of Patient _____ Date_____

Name of Witness _____

Signature of Witness_____ Date_____

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Authorization/Release of Medical Information

I, hereby authorize the release of any medical information to determine and process insurance benefits payable for services rendered to me and for which claims are submitted for payment to my insurer.

_____ _____

Signature Date

Assignment of Insurance Benefits

I request payment of medical insurance benefits to which I may be entitled (including Medicare or Medicaid) to be made on my behalf to Zarett Rehab & Fitness, to which I hereby assign my rights to payment. This assignment shall remain in effect until revoked by me.

_____ _____

Signature Date

Please review our financial policies in our patient information notice (attached).

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Medicare Reimbursement

Medicare policies allow coverage for outpatient physical therapy up to a limit of $2410. This amount can change by law over time. Medicare pays 80% of amounts up to $2410 Your secondary insurance may cover the 20% which remains. If you have used $2410 of Medicare outpatient physical therapy (which we estimate to equal about 15 visits, but depends on the specific services you receive), you no longer have Medicare coverage and you must pay cash for any additional therapy. We will let you know when your Medicare coverage has been exhausted. In some instances, secondary insurance may continue after Medicare benefits are exhausted.

I have read and understand the Medicare Reimbursement Policy for outpatient physical therapy.

Patient signature_____

Date_____

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Credit Card Authorization On File

If you choose to pay with a credit card, we ask that you provide your credit card information for us to keep on file. We will provide you with a receipt after your credit card has been charged. Please note Zarett Rehab charges a 3% fee for credit card payments.

Your credit card will be charged if:

- A payment is missed at the time of service.
- A payment needs to be made towards your deductible (if applicable).
- A copay or co-insurance payment needs to be made (if applicable).

Please fill out the details as indicated below.

Patient Name: _____ Date of Birth: _____

Cardholder Name: _____

Credit Card Number: _____ Expiration Date: _____

Zip Code: _____ CVV: _____

Cardholder's Signature: _____

I have read and agreed to Zarett Rehabilitation and Fitness' financial policy. I hereby authorize Zarett Rehabilitation to charge the credit card listed above for payment of charges to my account.

This form will be kept on file and will remain in effect until the expiration of the credit card account. Patients may also revoke this form by submitting a written request to the address below.

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Patient Policies and Information

Welcome to Zarett Rehab & Fitness. We strive to provide a professional, caring level of service to our patients. In order to get the most out of your treatment with us, it will be helpful for you to understand our approach to treatment and our policies, including our financial policies.

1. Zarett Rehab and Fitness offers a highly trained staff to deliver a program of treatment which is personalized to your specific needs. The staff and our methods are very standardized so you can be assured of excellent treatment from every person who works with you. Because of our standardization of techniques, any of our staff is able to provide your personal program of treatment. You may be supervised or treated by different people during one session or at different sessions.

2. We schedule appointments based on the availability of staff to work with the multiple patients who may be in the gym or in treatment at any one time. Because people complete their specific treatments at varying rates, when you return to the second floor for manual therapy or other physical therapy, you may have to wait a few minutes for us to be available to provide what you need on that day. We suggest you allow at least 90 minutes for each session.

3. Because we schedule so as to accommodate people in an efficient manner, it is important that you arrive on time to be available for your scheduled slot. If you have to miss an appointment you must cancel no later than twelve hours in advance. You may call Monday-Friday until 7:00PM and Saturdays until 1PM. Failure to cancel at least twelve hours in advance, no matter the reason, will result in a charge. (See below in Financial Policies).

4. We pride ourselves on the quality of the professional services we provide. We encourage good interpersonal relationships between all our patients and all our staff. That said, we have a strict policy against social interactions between staff and patients outside of the facility.

5. We encourage you to ask any questions you may have about your treatment or how you feel in treatment at any time to any staff member. We value knowing how you feel at any time.

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Financial Policies

You have the financial responsibility to pay for all services rendered by Zarett Rehab & Fitness. We accept insurance payment on your behalf for physical therapy services. However, this acceptance does not eliminate all financial responsibility to us.

1. We accept most insurances. We make a good faith effort to verify coverage. However, it is your responsibility to be knowledgeable about your insurance coverage, which can vary widely.

   a. Deductibles. Many insurance programs have a deductible, a specified amount of money you must pay in cash for your treatment, before your insurance benefits become available. We are not permitted to waive deductibles. You must pay them upfront until the specific amount your insurance program requires has been paid.

   b. Co-Pay/ Co-Insurance. Many insurance programs impose some type of cost for patients to use their coverage. These fees go on throughout the benefit coverage period, even after the deductible has been satisfied. The cost sharing may be a fixed amount (e.g., $20 per visit – often called a "co-pay") or it might be a percentage of the fee schedule amount (e.g., 20% of $110 – often called "co-insurance"). We have no control over your insurance coverage and we are obligated to collect all co-pays and co-insurances as established by your insurer.

   c. Exhaustion of Benefits. Many insurers limit the number of treatments you may get with insurance coverage. If you exhaust your benefits, you must pay cash for any additional treatments.

2. Physician Authorization. Insurance coverage requires a physician prescription every 30 days. Without the prescription, your treatment is not covered and you must pay out of pocket if you proceed with treatment. It is your responsibility to make sure your physician's prescription is current when you present for treatment. Treatment without a physician prescription requires cash payment.

3. Appointments Canceled Too Late. Our facility is designed to deliver personal, efficient treatment. We reserve time for you. If you do not notify us 12 hours in advance you will have to pay a fee for the missed appointment. For physical therapy, where more than one member of the staff may be working with you, the charge is $60 for an appointment canceled too late. For fitness appointments and appointments that are longer than an hour, the charge may be higher. For nutrition, massage and acupuncture where the service is one-on-one, if you cancel too late, you must pay the full amount of the service you reserved.

Failure to pay for services rendered which require us to charge late fees for payment, attorney's fees or collection charges are your responsibility.

IF YOU HAVE ANY QUESTIONS ABOUT THESE POLICIES OR ANYTHING ELSE, PLEASE DO NOT HESITATE TO ASK AT THE DESK.

* * * * *

By my signature below I indicate I have read and agree to the patient policies.

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICES

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessments and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by law enforcement official for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death.

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If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for intelligence and national security activities authorized by law. We may disclose your PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may disclose your PROTECTED HEALTH INFORMATION for workers compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying in your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

- The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.

- The right to request an amendment to your PROTECTED HEALTH INFORMATION.

- The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.

- The right to obtain a paper copy of this notice from us upon request.

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We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complain with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

The Privacy Officer
Zarett Rehab & Fitness
520 South 19th Street
Philadelphia, PA 19146
215-731-1449

For more information about HIPAA or to file a complaint:

The U.S. Department or Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)