



# Access Rehab Centers

A Waterbury Hospital & Easter Seals Partnership in Physical Rehabilitation

## MEDICAL HISTORY – ADDENDUM

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Patient Act. # \_\_\_\_\_

### MEDICATION PROFILE (CONTINUED FROM PAGE 1)

MEDICATION	DOSAGE	FREQUENCY	COMMENTS
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	
		<input type="checkbox"/> Once Daily <input type="checkbox"/> Twice Daily <input type="checkbox"/> Other:	

### Hospitalizations/Surgeries/Pertinent Procedures (CONTINUED FROM PAGE 1)

**When did this happen?**

6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

\_\_\_\_\_  
Signature of Person Completing Form

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reviewed by

\_\_\_\_\_  
Date

# Access Rehab Centers

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## PATIENT AGREEMENT AND INSURANCE BENEFITS

PATIENT NAME: \_\_\_\_\_ ACCT # \_\_\_\_\_ DATE: \_\_\_\_\_

**PERMISSION FOR GENERAL CARE:** I hereby consent to diagnostic and treatment procedures that may be performed on me during my visit at Access Rehab Centers. These procedures are provided under the direction of my referring physician and other physicians involved in my care. I understand that Access Rehab Centers will occasionally accept students of therapy professions and that these students may be involved in observing or rendering services under the direction of a licensed therapist.

**AUTHORIZATION TO PAY BENEFITS:** I hereby assign benefits to include major medical, private insurance or any other plan to Access Rehab Centers. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of Access Rehab Centers. PLEASE NOTE: BENEFITS, IF VERBALLY QUOTED BY INSURANCE COMPANIES, ARE NOT CONSIDERED A GUARANTEE OF PAYMENT. I HAVE PROVIDED Access Rehab Centers with the following insurances and I understand that the benefits quoted to them may include benefits already used by me. I am responsible for being aware of the benefit limitations of my insurance.

Primary Insurance: \_\_\_\_\_  
Benefit: \_\_\_\_\_ Deductible: \_\_\_\_\_ Met for Year: \_\_\_\_\_  
CoInsurance: \_\_\_\_\_ CoPay: \_\_\_\_\_

Secondary Insurance: \_\_\_\_\_  
Benefit: \_\_\_\_\_ Deductible: \_\_\_\_\_ Met for Year: \_\_\_\_\_  
CoInsurance: \_\_\_\_\_ CoPay: \_\_\_\_\_

- I agree to have Access Rehab Centers bill my insurance and to receive reimbursements/payments.  
 I agree to pay all co-pays on or before the date of service in the amount of \$ \_\_\_\_\_.  
 I will pay \$50 per visit towards my deductible of \$ \_\_\_\_\_.  
 I will pay \$10 per visit if my coinsurance is 10% or \$20 per visit if it is 20%.  
 Any overpayments will be promptly refunded.

**OR**

Authorization to use my Debit/Credit Card for above:  
Name on Credit Card: \_\_\_\_\_ OVV Code: \_\_\_\_\_  
M/C or Visa # \_\_\_\_\_ Exp. Date: \_\_\_\_\_

I authorize Access Rehab Centers to use the above credit card to pay for my charges after billed to insurance, as they are dictated by my insurance company after applicable insurance adjustments. Access Rehab Centers will mail me receipts as charges are made.

**PAYMENT REQUEST FOR MEDICARE/MEDICAID:** I certify that the information given by me in applying for payment under TVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Medicare/Medicaid Program, its intermediaries, or professional review organization, any information needed for this or a related Medicare/Medicaid claim. I authorize payment of benefits be made on my behalf.

**PROTECTED HEALTH INFORMATION:** I consent to the user or disclosure of my protected health information by Access Rehab Centers to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Access Rehab Centers may include HIV/AIDS related information, psychiatric and other behavioral health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which require that I provide specific authorization. I understand that information regarding how Access Rehab Centers will use and disclose my information may be found in Access Rehab Centers' Notice of Privacy Practices. I understand that consent is effective for as long as Access Rehab Centers maintains my protected health information.

**BY SIGNING BELOW, I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:**

- I have read and understand this consent and acknowledgement.
- I am authorized to execute this form and I agree to its terms.
- I have received a copy of the Access Rehab Centers Notice of Privacy Practices today or upon an earlier date of service.

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Representative's Relationship to Patient

\_\_\_\_\_  
Witness (Access Representative)

**FOR ACCESS REHAB CENTERS USE ONLY:** A good faith effort was made to provide the patient with the Access Rehab Centers Notice of Privacy Practices and the information contained in the Patient Agreement, but the patient did not sign/acknowledge receipt because \_\_\_\_\_.

# **Access Rehab Centers**

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## **CANCELLATION AND ATTENDANCE POLICY**

**Should you need to cancel or re-schedule your appointment, please contact us at least 24-hours prior to your scheduled appointment. Missed appointments or cancellations with less than 24-hour notice will result in a \$20.00 charge.**

If you miss two (2) consecutive appointments, or a total of three (3) appointments in total, your name will be taken off the schedule and your physician will be informed. A new referral from your physician will be required for you to continue treatment.

If you are on Worker's Compensation and miss an appointment, your physician and employer will be informed.

If you are late for an appointment, your therapist will see you as the schedule permits.

To receive the most benefit from your therapy, good attendance is essential. The staff at Access Rehab Centers would like to provide you and our other patients with the best possible care.

### **BY SIGNING BELOW, I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:**

I have read and understand this consent and acknowledgement.

---

Signature of Patient or Legally Authorized Representative

---

Today's Date

# Access Rehab Centers

A Waterbury Hospital & Easter Seals Partnership in Physical Rehabilitation

## FINANCIAL & INSURANCE AGREEMENT

PATIENT NAME: \_\_\_\_\_ ACCT # \_\_\_\_\_

Patient's  
Initials

**FINANCIAL AGREEMENT:** In consideration of the services rendered by Access Rehab Centers at my request and directions, I agree to pay in full, within thirty (30) days of the date of billing, any portion of the bill that is deemed to be my responsibility. If it is necessary for Access Rehab Centers to engage in Attorney or Collection Agency to collect the balance due, I agree to pay lawful and reasonable attorneys collection fees and court costs. In addition, I authorize the release of medical records to the collection agency, collection attorney and/or their agents for collection purposes.

Patient's  
Initials

**SELF-PAY:** I do not have medical insurance, have exhausted my benefits, my insurance does not cover my services at Access Rehab or I do not wish to use my insurance. In the case of a high deductible plan, I understand that by not billing my insurance, charges will not be applied to my deductible. If insurance is billed and service is denied, I will pay the rates established by the insurance company.

My services are not related to any type of accident and there is no attorney involved. Discounted fees do not apply to charges that are being billed to an attorney.

I agree to pay at each visit: \$95 for an evaluation; \$75 for each therapy session; \$55 for each Group therapy session.

I agree to be billed: \$100 for an evaluation; \$80 for each therapy session; \$60 for each Group therapy session.

Patient's  
Initials

**AUTO/WORKERS COMP:** I have given Access Rehab Centers information regarding my  Auto Insurance  Workers Comp Insurance.

I,  do not have medical insurance /  do not wish to give Access Rehab this information. I understand that my auto/workers comp. insurance may not pay for my services, in which case I will be responsible to pay for these services.

I understand that my medical insurance carrier may have prior authorization or timely filing requirements and by not providing this information in advance, Access Rehab Centers will be unable to fulfill these requirements. I am instructing Access Rehab Centers to bill my:  Auto insurance  Workers Comp carrier  Own account-I am responsible for paying.

Patient's  
Initials

**LETTER OF PROTECTION:** I have provided Access Rehab Centers with a Letter of Protection from my attorney to replace any other third party carrier. I do NOT have:

Medical Insurance  Auto Insurance  Workers Comp Insurance  I prefer not to use any Insurance

Payment will be made by my attorney when my case is settled. If I withdraw my case or if it is not successful, I will be responsible for payment for my services at Access Rehab Centers. I acknowledge that prior authorization or timely filing limits will not be fulfilled at that time.

### NOTE to the PATIENT:

If you have any questions, please contact our Billing Department at 203-598-3300, during normal business hours, Monday thru Friday. We will work with each and every patient to determine a budget plan to assist you to pay off any and all balances.

**BY SIGNING BELOW, I, UNDERSTAND AND ACKNOWLEDGE THE ABOVE CHECKED ITEMS AND I AM AUTHORIZED TO EXECUTE AND AGREE TO THE TERMS ON THIS FORM.**

\_\_\_\_\_  
Signature of Patient or Legally Authorized Representative

\_\_\_\_\_  
Today's Date

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## CONSENT FORM FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The undersigned patient, consent to have Access Rehab Centers use and disclose my protected health information, including, if applicable, drug/alcohol abuse, HIV and psychiatric information for the purposes of my treatment, healthcare operations and payment by the payer(s) of my health care benefit.

In addition, I consent for Access Rehab Centers to disclose my protected health information to the following for the following:

- Primary Care or referring Physician for follow-up care.
- To other providers for coordination of care.
- To other providers for referral and discharge planning.

I have been provided with Access Rehab Center's Notice of Privacy Practices and understand that I have the right to review this notice before signing this consent. I understand that Access Rehab Centers reserves the right to change its privacy practices, described in its Notice, and that if I wish to receive notification of any changes to the Notice, I may contact Access Rehab Centers' Patient Service Representative at the clinic where I receive care or go to Access Rehab Center's web site at [www.accessrehabcenters.com](http://www.accessrehabcenters.com).

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, Access Rehab Centers may provide me with treatment; however, I will be responsible for charges incurred at the time of service. I understand that treatment required by law, such as emergency care will be provided to me whether or not I sign this consent.

Unless I object, Access Rehab Centers may disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

I have the right to request that Access Rehab Centers restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment and/or conducting health care operations. Access Rehab Centers is not required to agree to any restriction I request. If Access Rehab Centers does decide to agree to my request, Access Rehab Centers must honor the restriction placed on the use and/or disclosure of my health information. I also understand that I have the right to request confidential communications by alternate means or locations. However, Access Rehab Centers may deny the request if it determines that it would be administratively difficult to comply with my request.

I understand that with respect to drug/alcohol abuse, HIV and psychiatric information, this Consent will expire 365 days after the date appearing below or 365 days after my final treatment, whichever is later. I also understand that I have the right to revoke this consent by notifying Access Rehab Center's Patient Service Representative at the clinic where I receive care in writing. I understand that if I revoke my consent, there will be no effect on uses and disclosures already made in reliance on my prior consent.

**I have had the opportunity to have my questions answered regarding Access Rehab Centers' privacy practices. I have read a copy of the Notice of Privacy Practice and consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.**

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Patient or Legal Representative/Witness Date

If signed by the Legal Representative, indicate your relationship to the patient below:

- Parent  Guardian  Conservator  Executor of Estate  Power of Attorney  Other \_\_\_\_\_

If unable to obtain patient's consent, indicate the reason below:

- Emergency treatment situation  
 Required by law to treat the patient and Access Rehab Centers has attempted but is unable to obtain the patient's consent.  
 Substantial barriers to communicating with the patient (i.e., Foreign language) and Access Rehab Centers determines that the patient's consent to receive treatment is inferred from the circumstances.  
 Patient refuses to sign the consent.

\_\_\_\_\_  
Signature of Witness (Person documenting reason)

\_\_\_\_\_  
Date

### NOTICE

**HIV RELATED INFORMATION:** In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

**PSYCHIATRIC INFORMATION:** In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

**DRUG AND ALCOHOL ABUSE RECORDS:** In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.