Spencer Post Acute Rehab Center

Outpatient Therapy Insurance Verification

(This section to be completed at time appointment is made)

Patient Name: _____ Appointment Date: _____ Time: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____

Primary Insurance Co.: _____ ID #: _____

Subscriber Name: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

Secondary Insurance Co.: _____ ID #: _____

Subscriber Name: _____ Group #: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____

(To be completed prior to first appointment or attached with insurance authorization)

Primary Ins. Co.: _____ Date contacted: _____

Name of Contact: _____ Policy Effective Date: _____

Policy in force? Yes No

Annual Deductible: $_____ Already met? Yes No

Co-Payment Due: $ _____ # of Visit or CPT codes Authorized: _____

Contract Required? Yes No _____

Type of Coverage: PT OT ST

In-network: PT Yes No OT Yes No ST Yes No

Authorization Required? Yes No

Authorization #: _____ Authorization Through Date: _____

Continued Authorization Required? Yes No

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Outpatient Therapy Insurance Verification
(continued)

Send claims to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Required billing format: _____

Required billing frequency: _____

Required billing attachments: _____

Secondary Ins. Co.: _____ Date contacted: _____

Name of Contact: _____ Policy Effective Date: _____

Policy in force? Yes No

Annual Deductible: $_____ Already met? Yes No

Co-Payment Due: $ _____ # of Visits Authorized: _____

Contract Required? Yes No

Type of Coverage: PT OT ST

In-network: PT Yes No OT Yes No ST Yes No

Authorization Required? Yes No

Authorization #: _____ Authorization Through Date: _____

Continued Authorization Required? Yes No

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Date: _____ Contact: _____ Auth. # _____ Auth. Thru Date: _____

Send claims to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Required billing format: _____

Required billing frequency: _____

Required billing attachments: _____

Spencer Post Acute Rehabilitation Center

Outpatient Patient Information

Patient Name: _____ Sex: M F

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

DOB: _____ Social Security #: _____

Code Status: Full Code / DNR (please circle one)

Insurance Information

Primary Insurance: _____ Insurance Phone #: _____

Medicare #/ID #: _____ Group #_____

Subscriber Name (if different from self): _____

Subscriber DOB: _____

Secondary Insurance: _____ Insurance Phone #: _____

ID#: _____ Group #: _____

Subscriber name (if different from self): _____

Subscriber DOB: _____

Emergency Contact

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____

Physician Information

Referring Physician: _____ Physician Phone #: _____

Patient Signature:_____ Date:_____

Spencer Post Acute Rehabilitation Center

OUTPATIENT REHABILITATION

PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

Federal and State Regulations require a medical history must be included in the patient's medical record.

Patient Name:_____ Date:_____

DOB:_____ Reason For Therapy Referral:_____

Date of Onset of Injury/Condition:_____ Have you had previous therapy for this injury/condition?_____ Is this injury/condition work related? _____ If so, has it been reported to your employer? _____

Medical History:

Do you have currently or have you had in the past any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold	Yes	No
Circulatory Disorders	Yes	No	Dizziness	Yes	No
Heart Disease	Yes	No	Seizures	Yes	No
Heart Attack	Yes	No	Headaches	Yes	No
Stroke/TIA	Yes	No	Cancer	Yes	No
Pacemaker	Yes	No	Visual Problems	Yes	No
Metal Implants	Yes	No	Allergies	Yes	No
Kidney Problems	Yes	No	Previous Surgeries	Yes	No
Hernia	Yes	No	Back Injuries	Yes	No
Nervous Disorders	Yes	No	Other injuries	Yes	No
Are you Pregnant?	Yes	No	Other Illnesses	Yes	No
Breathing Difficulties	Yes	No	Difficulty Sleeping	Yes	No
Osteoporosis	Yes	No	Neurological Problems	Yes	No
Weight Loss	Yes	No	DVT/Pulmonary Embolism	Yes	No
COVID-19	Yes	No	COVID-19 Vaccine	Yes	No

If you answered **YES** to any of the above, please explain and give appropriate dates:

_____

_____

_____

Medications:

Are you currently taking any medications? _____If **YES**, please let the medications, dosage and for what condition.

Medication Name *Dosage* *Condition*

_____

_____

_____

_____

Spencer Post Acute Rehabilitation Center

Patient Acknowledgements Signature Form

Please **initial** each section below:

Financial Responsibility: I do hereby guarantee payment of therapy services to Spencer Post Acute Rehab I understand that I am responsible for payment of my account and the facility does not accept responsibility for negotiating a settlement on a disputed claim. As a courtesy, the facility will bill my insurance. I understand that co-payments are due when services are rendered. Any balances, after initial insurance payment has been received, is due and payable upon receipt.
Interest of 1.5% monthly (18% per annum) will be added to all accounts 30 days past due. In the event this account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney's fees, legal expenses and lawful collection costs in addition to all other sums due hereunder.

_____

Financial Agreement Acknowledgement: I have received a copy of the financial agreement. Patient and responsible party hereby certify that each has read this agreement in its entirety, understand and agree to its terms and conditions. Responsible party, or other person who signs this agreement on behalf of and in the place of the patient represents that he/she is authorized by patient to do so, and the above-named patient and each responsible party signing this agreement agrees by so signing accepting all of the terms hereof and to perform all obligations hereunder. There are no representations made by facility or any of its employees or agents other than are set forth in this agreement.

_____

Treatment Consent: I hereby consent to the evaluation(s) and treatments ordered or recommended by my physician or designated alternate.

_____

Cancellation Policy: 24-hour notice is required to cancel a therapy appointment. A cancellation fee of $[redacted] may be charged to the responsible party if sufficient notice is not provided.

_____

Authorization for Release of Information: The institution rendering services is hereby authorized to furnish and release, in accordance with the facility's policy, such professional and clinical information as may be necessary for the completion of my medical claims by valid third-party agents or agencies from the medical records compiled during treatment. The facility is hereby released from all legal liability that may arise from the release of said information.

_____

Assignments and Authorization to Pay Insurance Benefits: I hereby assign and authorize payment directly to the facility, herein specified and otherwise payable directly to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am responsible to the facility for charges not covered or paid by my insurance.

_____

Assignments and Authorization to Bill Medicare: I hereby assign and authorize payment directly to this facility, herein specified and otherwise payable to me, but not to exceed the facility's regular charges for this period of treatment. I understand I am financially responsible for 20% of the Medicare Part B services.

_____

Telehealth Acknowledgement: I understand and give approval for the use of telehealth services for evaluations and/or treatments as determined by my clinician. I understand that services rendered using telehealth are billed following the insurance providers requirements.

_____

Co-pays and Authorization to charge credit card or bank account on file: Before evaluations and/or treatments are rendered all co-pay balances need to be paid. I hereby authorize the institution rendering treatment to charge my credit card or process a withdrawal from my bank account for co-pay balances on the day of treatment unless otherwise paid by other means. *Bank account/credit card authorization form must be completed in order to utilize this form of payment.*

_____

Acknowledgement of Receipt of Notice of Privacy Practices: My signature below acknowledges that I received a copy of the Facility/Agency's Notice of Privacy Practices (with a revision date of March 1, 2016). Refusing to sign does not prevent the facility/agency from using or disclosing health information as permitted by law.

_____

Acknowledgement of Patient Rights: My initials below acknowledge that I have been informed of the OTC policy on patient rights, received a copy of my patient rights and have been informed of the complaint process.

_____

Acknowledgement of Advanced Directives: My initials below acknowledge that I have been made aware and have been offered a copy of the facilities policy on advanced directives.

_____

***If a copy of your advanced directives is provided, both patient and OTC representative initial below.

_____ _____

Home Health Service Agreement: I am currently not receiving Home Health Services. I understand that I cannot participate in outpatient therapy at while I am receiving Home Health Services and will be accountable for payment if both are being received at the same time.

_____

PATIENT AND/OR RESPONSIBLE PARTY BY SIGNING BELOW IS AGREEING TO ALL OF THE ABOVEAND IS ACKNOWLEDGING THAT HAVE RECEIVED COPIES OF THE ABOVE DOCUMENTS

These copies were received by: Email Paper

Patient or Responsible Parties** Name (Printed):

**If form is completed by responsible party/POA, a copy of POA paperwork is given to the OTC.

_____ _____ YES _____OTC employee initials

Patient or Responsible Parties** Signature:

_____

Date: _____

OTC Representative (if not signed electronically) and verification that all pages of this form have been completed:

_____

Date: _____

FOR OFFICE USE ONLY

If any of the above agreements and acknowledgements are not obtained, please complete the following:

Spencer Post Acute Rehabilitation Center

Patient's Name: _____

Acknowledgments not obtained: _____

Date of attempt to gain acknowledgement: _____

Reason Acknowledgement was not signed:

_____ Patient/Responsible Party received all of the above-mentioned notices but refused to sign

_____ Emergency treatment situation

_____ Patient was incapacitated and there was no Responsible Party present

_____ Unable to communicate secondary to language barrier

_____ Other: (Please describe) _____

Spencer Post Acute Rehabilitation Center

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Name of Beneficiary: _____ HIC #:: _____

Date(s) of Service: _____ Provider #: _____

SECTION I (Employment)

A. Are you currently working? ☐ Yes ☐ No ☐ No, Never Employed
Date of Retirement, if applicable: _____
Employer: _____ Insurance Co: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

B. Are you covered by an Employer Group Health Plan? ☐ Yes ☐ No
Employer: _____ Insurance Co: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

C. Is your spouse currently working? ☐ Yes ☐ No ☐ No, Never Employed
Date of Retirement, if applicable: _____
Employer: _____ Insurance Co: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

D. Are you covered under an employed spouse or family member: ☐ Yes ☐ No
Employer: _____ Insurance Co: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

SECTION II (Disability)

A. Are you entitled to Medicare Benefits SOLELY because of a disability? ☐ Yes ☐ No
If yes, date of disability: _____ Describe Disability: _____

SECTION III (Accident/Injury)

A. Was your illness/accident related to a WORK injury, past or present? ☐ Yes ☐ No
Employer: _____ Insurance Co: _____ Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____
Name of Workers Compensation Carrier: _____ Attorney: _____

B. Was your illness/injury related to an AUTOMOBILE accident? ☐ Yes ☐ No
Date of accident: _____ Location: _____
How did accident occur: _____
Automobile medical or no-fault insurance: _____ Claim/Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

C. Was your illness/injury related to an accident, OTHER than an automobile accident? ☐ Yes ☐ No
Date of accident: _____ Location: _____
How did accident occur: _____
Automobile medical or no-fault insurance: _____ Claim/Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____
Can payment be made by third party liability insurance: ☐ Yes ☐ No
Third party liability or attorney: _____
Address: _____ City: _____ State: _____ Zip: _____

SECTION IV (VA/Black Lung)

A. Are you entitled to any Veteran's Administration Benefits for a service related illness or injury? ☐ Yes ☐ No
VA Plan Name: _____ Claim/Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

B. Are you entitled to any Black Lung Benefits? ☐ Yes ☐ No
Black Lung Policy Name: _____ Claim/Policy #: _____
Address: _____ City: _____ State: _____ Zip: _____

SECTION V (End Stage Renal Disease (ESRD))

A. Are you entitled to Medicare ONLY because of End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If yes, did you have self dialysis training or a kidney transplant 3 months prior to Medicare Entitlement?
☐ Yes ☐ No
Date of first dialysis or kidney transplant: _____

B. Are the services to be paid by a program such as a government research grant? ☐ Yes ☐ No

OBTAIN BENEFICIARY OR OTHER REPRESENTATIVES' SIGNATURE IF POSSIBLE. IF UNABLE TO OBTAIN A SIGNATURE, PLEASE INDICATE HOW THE INFORMATION WAS OBTAINED.

Beneficiary/Resp. Party Signature (Optional): _____ **Date:** _____

Facility Witness Signature: _____ **Date:** _____