West Bend Health and Rehab

Rehabilitation Services
Outpatient Therapy Treatment Agreement

This is a Therapy Treatment Agreement in which the patient consents to treatments upon the provisions hereof and the patient, responsible party, and the facility hereby agree as follows:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Employer: _____ Work Phone: _____

Social Security #: _____ Birth Date: _____

Sex: M F (circle one)

Primary Insurance Company: _____ Group #: _____
Address: _____ Phone #: _____
Subscriber Name: _____ Co-Pay Amount: _____

Secondary Insurance Company: _____ Group #: _____
Address: _____ Phone #: _____
Subscriber Name: _____ Co-Pay Amount: _____

Physician: _____ Phone #: _____
Address: _____ City: _____ State: _____ Zip: _____

Responsible Party: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Emergency Contact: _____ Relationship: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____

Please initial each section:

_____ **Financial Responsibility:** I do hereby guarantee payment of therapy services to West Bend Health and Rehabilitation. 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 $25 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.

_____ **Appointment Time:** I hereby consent to being on time or five minutes early for my therapy session. I understand if I am not on time my therapy appointment will be canceled for the day

_____ **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

Patient and/or responsible party agree and have received a copy of this Outpatient Therapy Agreement.

Patient: _____

Date: _____

Responsible Party: _____

Date: _____

Facility Witness: _____

Date: _____

FOR CLINIC USE ONLY:

Admission #: _____ Admission Date: _____

_____ Copy of insurance attached

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

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

West Bend Health and Rehab

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*

_____

_____

MEDICARE SECONARDY PAYER QUESTIONAIRE

Patient Name: _____ **Medicare ID:** _____

INSTRUCTIONS:
Ask the following questions to Medicare beneficiaries upon **each inpatient** and **outpatient admission**. Answer the questions in sequence. The instructions will direct you to the next appropriate question to determine MSP situations.

PART I

1. Are you receiving Black Lung (BL) Benefits?
   - ☐ Yes. Date began: MM/DD/CCYY _____ **BL IS PRIMARY** ONLY FOR CLAIMS RELATED TO BL
   - ☐ No.

2. Are the services to be paid by a government research program?
   - ☐ Yes. **GOVERNMENT RESEARCH PROGRAM IS PRIMARY**
   - ☐ No.

3. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for your care at this facility?
   - ☐ Yes. **DVA IS PRIMARY**
   - ☐ No.

4. Was the illness/injury due to a work-related accident/condition?
   - ☐ Yes. Date of injury/illness: MM/DD/CCYY _____ GO **to PART III**

If YES,** OBTAIN NAME & ADDRESS OF WC PLAN, POLICY NUMBER, AND NAME & ADDRESS OF YOUR EMPLOYER

WORKERS' COMPENSATION(WC) IS PRIMARY ONLY FOR CLAIMS FOR WORK-RELATED INJURIES OR ILLNESS

- ☐ No. GO **to PART II**

PART II

1. Was illness/injury due to a non-work-related accident?
   - ☐ Yes. Date of accident: MM/DD/CCYY _____
   - ☐ No. GO **to PART III**

2. Is no-fault insurance available? (No-fault insurance is insurance that pays for health care services resulting from injury to you or damage to your property regardless of who is at fault for causing the accident) NO-FAULT INSURER IS PRIMARY for services related to accident.
   - ☐ Yes.
     Name & address of no-fault insurer(s) and no-fault insurance policy owner: _____
     _____
     Insurance claim number(s): _____
   - ☐ No.

3. Is liability insurance available? (Liability insurance is insurance that protects against claims based on negligence, inappropriate action or inaction, which results in injury to someone or damage to property) LIABILITY INSURANCE IS PRIMARY for services related to settlement.
   - ☐ Yes.
     Name & address of liability insurer(s) and responsible party: _____
     _____
     Insurance claim number(s): _____
   - ☐ No.

GO **to PART III**

PART III

Are you entitled to Medicare based on:

- ☐ Age. GO **to PART IV**
- ☐ Disability. GO **to PART V**
- ☐ End-Stage Renal Disease (ESRD). GO **to PART VI**

Note that both **Age** and **ESRD** – OR - **Disability** and **ESRD** may be selected simultaneously. An individual **CANNOT** be entitled to Medicare based on **Age** and **Disability** simultaneously

PART IV – AGE

Are you currently employed?

☐ Yes.

Name & address of your employer: _____

☐ No. If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

2. Do you have a spouse who is currently employed?

☐ Yes.

Name & address of your spouse's employer: _____

☐ No. If applicable, date of retirement: MM/DD/CCYY _____

☐ No. Never Employed.

IF NO TO BOTH 1 AND 2, MEDICARE IS PRIMARY STOP **DO NOT PROCEED FURTHER**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ Yes, both.

☐ Yes, self.

☐ Yes, spouse.

☐ No. STOP **MEDICARE IS PRIMARY**

4. If the GHP coverage is based on **your own** current employment, **your spouse's** current employment - Does the employer that sponsors or contributes to the GHP **employ 20 or more employees**?

☐ Yes. **GHP IS PRIMARY**

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, NAME OF POLICY HOLDER/NAMED INSURED, AND RELATIONSHIP TO PATIENT

☐ No. STOP **MEDICARE IS PRIMARY**

PART V – DISABILITY

1. Are you currently employed?

☐ Yes.

Name & address of your employer: _____

☐ No. If applicable, retirement date: MM/DD/CCYY _____ STOP **MEDICARE IS PRIMARY**

☐ No. Never Employed. STOP **MEDICARE IS PRIMARY**

2. Do you have a spouse who is currently employed?

☐ Yes.

Name & address of your spouse's employer: _____

☐ No. If applicable, retirement date: MM/DD/CCYY _____ STOP **MEDICARE IS PRIMARY**

☐ No. Never Employed. STOP **MEDICARE IS PRIMARY**

3. Do you have group health plan (GHP) coverage based on your own or a spouse's current employment?

☐ Yes, both.

☐ Yes, self.

☐ Yes, spouse.

☐ No. STOP **MEDICARE IS PRIMARY**

4. Are you covered under the GHP of a family member other than your spouse?

☐ Yes.

Name & address of your family member's employer: _____

☐ No. STOP **MEDICARE IS PRIMARY**

5. If you have GHP coverage based on **your own** current employment, **your spouse's** current employment, or **family member's** current employment - Does the employer that sponsors or contributes to the **GHP employ 100 or more employees?**

☐ Yes. **GHP IS PRIMARY**

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, GROUP NUMBER, MEMBER NAME, NAME OF POLICY HOLDER/NAMED INSURED, AND RELATIONSHIP TO PATIENT

☐ No. STOP **MEDICARE IS PRIMARY**

PART VI – ESRD

1. Do you or your spouse have group health plan (GHP) coverage?

☐ Yes.

If YES, OBTAIN NAME & ADDRESS OF GHP, POLICY NUMBER, GROUP NUMBER, MEMBER NAME, NAME OF POLICY HOLDER/NAMED INSURED, RELATIONSHIP TO PATIENT, AND EMPLOYER NAME & ADDRESS (if GHP through spouse)

☐ No. STOP **MEDICARE IS PRIMARY**

2. Have you received a kidney transplant?

☐ Yes. Date of transplant: MM/DD/CCYY _____

☐ No.

3. Have you received maintenance dialysis treatments?

☐ Yes. Date dialysis began: MM/DD/CCYY _____

If you participated in self-dialysis training program, date training started: MM/DD/CCYY _____

☐ No.

4. Are you within the 30-month coordination period that starts MM/DD/CCYY?

☐ Yes.

☐ No. STOP **MEDICARE IS PRIMARY**

5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and disability?

☐ Yes.

☐ No.

6. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on ESRD?

☐ Yes. STOP **GHP CONTINUES TO PAY PRIMARY** DURING THE 30- MONTH COORDINATION PERIOD

☐ No. **INITIAL ENTITLEMENT BASED ON AGE OR DISABILITY**

7. Does the working aged or disability MSP provision apply (is the GHP already primary based on age or disability entitlement)?

☐ Yes. **GHP CONTINUES TO PAY PRIMARY** DURING THE 30-MONTH COORDINATION PERIOD

☐ No. **MEDICARE CONTINUES TO PAY PRIMARY**

Beneficiary/Responsible Party Signature _____

Facility Witness Signature _____

Date: _____