725 N 2nd Street, Cherokee IA 51012
Phone: 712-225-2561 * Fax: 712-225-5350

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: _____

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

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OUTPATIENT REHABILITATION
PATIENT INFORMATION AND BRIEF MEDICAL HISTORY

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

Date: _____ Birthdate: _____ OP Med Rec # _____

Patient Name: _____ Patient Phone # _____

Reason For Therapy Referral: _____

Date of Onset/Injury/Surgery _____ Physician: _____

MEDICAL HISTORY:

Do you have/or have you had any of the following:

Diabetes	Yes	No	Sensitivity to heat	Yes	No
High Blood Pressure	Yes	No	Sensitivity to cold (ice)	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 Problem	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

If Yes on any of the above, please explain and give approximate dates

_____

_____

_____

MEDICATIONS:

Are you presently taking medications? Yes No If Yes, please list what medications, dosage and for what condition: Medication Dosage Condition

_____

_____

OTHER INFORMATION: Have you had previous therapy for the present condition for which you are to receive treatment here? Yes No

Is this a work-related injury or condition? Yes No

Has this injury been reported to your employer? Yes No

Careage Hills

Patient Acknowledgement Signature Form

Please **initial** each sections below.

_____ **Financial Responsibility:** I do hereby guarantee payment for therapy services to Careage Hills. 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% 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 suns 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, understanding and agree to its terms and conditions. Responsible party, or other person who sign this agreement on behalf of and in 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 the facility or any employees or agents other than are set forth in this agreement.

_____ **Treatment Consent:** I hereby consent to the evaluation(s) and treatment 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 $25.00 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 that maybe 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.

_____**Assignment 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.

_____ **Assignment 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 evaluation and\or treatment 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 evaluation and\or treatments are rendered all co-pays balances need to be paid. I hereby authorize the institution rending treatment to charge my credit card or process a withdrawal from my bank account for co-pay balances on the day of the treatment unless otherwise paid by other means. Bank account/credit card authorization form must be completed 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's from using or disclosing health information as permitted by law.

____ **Acknowledgement of Patient Rights:** My initials acknowledge that I have received a copy of my Patient Rights.

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

PATIENT AND\OR RESPONSIBLE PARTY BY SIGNING BELOW IS AGREEING TO ALL OF THE ABOVE AND IS ACKNOWLEDING THAT THEY HAVE RECIVED COPIES OF THE ABOVE DOCUMENTS.

These copies were received by: (circle one) Email Paper

_____

Patient or Responsible Parties Name (printed)

_____ _____

Patient or Responsible Parties Signature Date

_____ _____

Facility Witness Signature (if not signed electronically) Date

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FOR OFFICE USE ONLY

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

Patient's Name: _____

Acknowledgement not obtained: _____

Date of attempt to gain acknowledgement: _____

Reason Acknowledgement was not signed:

___ Patient/Responsible Party received all of the above-mentioned notice 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:

(PleaseDescribe)_____

_____

_____

_____

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: _____

OTC Financial Agreement

FACILITY RESPONSIBILITIES

1. The facility shall provide services and materials as described in Section 2 below, in compliance with the orders of the Patient's physician. Administration of treatments shall be ordered by the Patient's physician.
2. Facility shall provide the following prescribed services to Patient (circle all that apply): Occupational Therapy, Physical Therapy, Speech Therapy)
3. Additional services may be provided by Facility upon receipt of subsequent orders from the Patient's physician. Any such services provided by Facility shall be subject to all the terms of conditions and obligations of this Agreement. Facility welcomes all persons without regard to race, color. national origin. religion sex or qualified handicaps.

PATIENT/RESPONSIBLE PARTY RESPONSIBILITIES

1. Patient and Responsible Party agree jointly and severally to assume and be liable for all charges of whatever nature incurred by or on behalf of Patient for the services described herein and to pay such charges as they become due.
2. Patient and Responsible Party further agree that, if any of the services rendered by Facility to Patient, are covered by insurance, or benefits under either Title XVIII or Tile XIX of the Social Security Act (Medicare/Medicaid), is nevertheless the joint and several obligation of Patient and Responsible Party to pay all charges incurred by or on behalf of Patient. Patient and Responsible Party further agree that any co-insurance or deductible obligation under Medicare, Medicaid or private insurance must be paid directly to Facility by Patient and Responsible Party.
3. Patient and Responsible Party further agree that any charges which are not made IN FULL when due or no later than 30 days shall be subject to a late charge of 1.5% monthly, (18%) percent per annum until paid. Should it become necessary for the Facility to refer Patient's delinquent account to an attorney for collection, Patient and Responsible Party agree to pay in addition to all sums due all reasonable attorney's fees, court costs and all other reasonable costs of collection.

PATIENT'S CERTIFICATION

1. Patient certifies and warrants that all information submitted on behalf of Patient for purposes of applying for or receiving benefits under Title XVIII or XIX of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Responsible Party warrants that all information they have supplied to facility is correct and true and further agree to hold harmless and indemnify Facility from and against any and all loss, damage, cost. expenses, or liability resulting from Patient's or Responsible Party's submission of false or incorrect information to Facility.
2. Patient authorizes any health care facility or doctor to furnish the facility and/or or the Social Security Administration. its fiscal intermediary or carrier all requested information from Patient's medical or financial records. Patient further authorizes Facility to disclose all or any part to Patient's medical or financial records to any person or entity which is or may be liable under contract to Facility, to Patient or to a family member or to the employer of Patient to pay all or a portion of the costs or care provided to Patient including, but not limited to, hospital or medical service companies, insurance companies, worker's compensation carrier, welfare fare of Patient's employer. Patient further authorizes Facility to disclose all or any part of Patient's medical or financial records to any independent auditor of Facility.
3. Patient requests and hereby authorizes that payment for any authorized benefits be made directly to Facility on Patients behalf Facility does not make any assurance of any kind whatsoever that Patient's care will or can be covered by Medicare/Medicaid or any private insurance, and the Patient and Responsible Party hereby release Facility, its agents, servants, and employees from any liability or responsibility in connection with the Patient's

and/or Responsible Party's potential claim of coverage under Medicare/Medicaid and/or private insurance program.

RESTRICTIONS AND LIABILITIES

1. Patient and Responsible Party hereby release Facility from any and all harm, liability. injury or loss suffered by Patent while outside the physical confines of the Facility and/or the supervision and contract of Facility's staff.
2. Facility shall have no liability for injuries of any kind suffered by Patient while under its care. except where the injury is caused by the negligence of Facility or its regular staff or as required by law. If Patient discontinues or suspends treatment before the attending physician has so ordered, or if Patient fails to follow a prescribed regimen of activity, treatment or therapy, Patient and Responsible Party agree to assume all responsibility for any result which may follow Patient's action.
3. Facility is not responsible or liable for any injury to Patient caused by Facility visitors attempting to assist to treat Patient in anyway. For the safety of Patient and others, only the Patient and Patient's guardian, if a minor, are permitted into patient treatment areas of the Facility.
4. The Facility is not liable or responsible for any personal belongings brought into and left in Facility by Patient. except as required by law.

MISCELLANEOUS

1. Where Patient is eligible for Medicaid benefits and/or where Facility is precluded under state or federal law in requiring that a Responsible Party act as guarantor for Patient. the term "Responsible Party", as used herein. shall be deemed to mean "Patient Agent". The Patient Agent is responsible for assuring that any of Patient's own funds, over which such Patient Agent exercises any management or control, and which constitutes the Patient's share of costs or liability to Facility, shall be paid to Facility as such liability is incurred.

Therapy Communication Preferences

Patient Name _____ Date _____

SHARING YOUR INFORMATION WITH CAREGIVERS, FAMILY AND OTHER VISITORS: It is our policy not to release confidential medical information regarding your treatment to caregivers, family members (other than the authorized representative), or other visitors unless we can reasonably infer from the circumstances that you do not object to sharing your information (for example, if a family member or other visitor is present while we are providing care, we will assume, unless you object, that the person is entitled to receive information regarding your treatment).

List which caregivers, family members, or other visitors may have limited verbal updates regarding your treatment when you are not present:

_____

_____

Patient Signature _____ Date _____

Therapy Representative _____ Date _____