In-Home Therapy Services	**Revive Rehab Services, LLC** Office Phone: **(484)891-0608** Fax:**(484)379-0650**	

NOTICE OF PATIENT PRIVACY AND FINANCIAL AGREEMENT

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How Medical Information About You May Be Used And Disclosed And How You Can Access This Information

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment. We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask us and we will provide you with a copy. If you have any questions, concerns, or complaints about the Notice or your medical information, please contact Revive Rehab Services, LLC at (484)891-0608

Release Of Medical Information Necessary to Process Claims

I authorize the release of all medical or other information needed to process this medical claim. I also request payment of government benefits to the party who accepts assignment below.

CANCELLATION POLICY

We require 24 hours notice in the event of a cancellation. There is a **$100.00** charge for a cancellation without proper notice. Your insurance will not cover the penalty amount and you will be responsible for this charge. Missed/late canceled appointments prevent other patients the opportunity for an appointment and affect the consistency of your own rehabilitation program. The therapist will not be able to reschedule on short notices and must accommodate for lost work time/travel.

Assignment of Benefits / Consent for Physical / Occupational / Speech Therapy

I, the undersigned due hereby agree and give my consent for Revive Rehab Services, LLC to furnish physical, speech and or occupational therapy to myself or dependent, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition. I assign them all payments for medical services rendered. I acknowledge that they will bill my insurance company on my behalf. In the event medical payments are received directly by me for services rendered that have not been paid for, I promise to immediately sign over and forward those payments along with the Explanation of Benefits to In Home Therapy Services of San Diego. I accept financial responsibility for all charges incurred. I understand that I am to pay any deductibles, co-payments, or other charges not covered by my insurance company. If my account has to be referred for outside collections, I will be charged a $30 service charge. For all returned checks, there is a $20 penalty in addition to the immediate cash payment for services rendered. I also authorize Revive Rehab Services, LLC to furnish any necessary information concerning injury /illness to the insurance carrier involved.

I have read and fully understand the above information.

Patient/Guardian Name: _____

Patient/Guardian Signature:_____ **Date:**_____

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REVIVE REHAB SERVICES LLC

AVISO DE PRIVACIDAD Y FINANZAS DEL PACIENTECONVENIOE

stamos comprometidos a preservar la privacidad de su información médica personal. De hecho, estamos obligados por ley a protegerprivacidad de su información médica y para proporcionarle un Aviso que describa:

Cómo se puede usar y divulgar su información médica y cómo puede acceder a esta información
Podemos requerir su consentimiento por escrito antes de usar o divulgar a otros su información médica con el propósito de proporcionar ohacer arreglos para su atención médica, el pago o reembolso de la atención que le brindamos y los trámites administrativos relacionadosactividades que apoyan su tratamiento. Es posible que ciertas leyes nos exijan o permitan que usemos y divulguemos su información médica. para otros fines sin su consentimiento o autorización.

Como nuestro paciente, usted tiene derechos importantes relacionados con la inspección y copia de su información médica que mantenemos, enmendamos ocorregir esa información, obtener un informe de nuestras divulgaciones de su información médica, solicitar que nos comuniquemoscon usted de manera confidencial, solicitando que restrinjamos ciertos usos y divulgaciones de su información médica, y quejándose si ustedcree que sus derechos han sido violados.

Tenemos disponible un Aviso detallado de prácticas de privacidad que explica detalladamente sus derechos y nuestras obligaciones conforme a la ley. Podemosrevise nuestro Aviso de vez en cuando. Tiene derecho a recibir una copia de nuestro Aviso más actual en vigor. Si aún no lo has hechoreservó una copia de nuestro Aviso actual, consúltenos y le proporcionaremos una copia. Si tiene alguna pregunta, inquietud oquejas sobre el Aviso o su información médica, comuníquese con Revive Rehab Services, LLC al (484)891-0608

Divulgación de información médica necesaria para procesar reclamos

Autorizo la divulgación de toda la información médica o de otro tipo necesaria para procesar este reclamo médico. También solicito el pagode los beneficios del gobierno a la parte que acepta la asignación a continuación.

POLÍTICA DE CANCELACIÓN

,viso de 24 horas en caso de cancelación. Hay un cargo de $ 100.00 por cancelación sin previo aviso. Su seguro no cubrirá el monto ed será responsable de esto cargo. Las citas perdidas o canceladas tarde impiden que otros pacientes tengan la oportunidad de una cita stencia de su propio programa de rehabilitación. El terapeuta no podrá reprogramar el avisos breves y deben adaptarse a la pérdida de o / viajes.

Asignación de beneficios / Consentimiento para fisioterapia / terapia ocupacional / del habla

Yo, el abajo firmante, acepto y doy mi consentimiento para que Revive Rehab Services, LLC proporcione servicios físicos, de habla y / oTerapia ocupacional para mí o para mi dependiente, que se considera necesaria y adecuada para evaluarme y tratarme a mí mismo o al dependiente.por mi / su condición física. Les asigno todos los pagos por los servicios médicos prestados. Reconozco que facturarán a micompañía de seguros en mi nombre. En el caso de que yo reciba pagos médicos directamente por servicios prestados que no hayan sidopagado, prometo firmar inmediatamente y remitir esos pagos junto con la Explicación de beneficios a la terapia en el hogarServicios de San Diego. Acepto la responsabilidad financiera por todos los cargos incurridos. Entiendo que debo pagar los deducibles,copagos u otros cargos no cubiertos por mi compañía de seguros. Si mi cuenta tiene que ser referida para cobros externos, lo harése le cobrará un cargo por servicio de $ 30. Para todos los cheques devueltos, hay una multa de $ 20 además del pago inmediato en efectivo por los servicios.prestados. También autorizo a Revive Rehab Services, LLC a proporcionar cualquier información necesaria sobre lesiones / enfermedades alcompañía de seguros involucrada.
He leído y entiendo completamente la información anterior.

Nombre del paciente / tutor: _____
Firma del paciente / tutor : _____ **Fecha: _____**

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RELEASE OF MEDICAL INFORMATION

I, _____ authorize In-Home Therapy Services to release
(PATIENT NAME)
all of my medical records.

Please send the records listed above to:

M.D. or Facility Name

Name:_____ Name:_____
Address:_____ Address:_____
City: _____ City: _____
State/Zip: _____State/Zip: _____

This authorization shall expire no later than: ____/_____/_____ and may not be valid for greater than one year from the date of signature for or upon termination of my treatment if less than one year. I further understand that this release of information may not be released to any other person or organization without my written consent. I may withdraw my authorization at any time with written notice. A photocopy of this authorization shall be considered valid. I further release the above designated persons or agencies from any liability arising from the release of the information.

_____ _____
Signature of patient (or patient's personal representative) Date

_____
Printed name of patient representative

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"Quality Care with Compassion"

NEW PATIENT INTAKE FORM

PATIENT INFO	DATE OF BIRTH	
First Name		
Middle Initial		
Last Name		
Gender	Female ◯ Male ◯	
Treatment Address:		
Billing Address (if different)		
PATIENT CONTACT		
Telephone		
Mobile		
Alternate		
EMERGENCY CONTACT		
Name		
Telephone		
Power of Attorney		
Telephone		
REFERRING PHYSICIAN (FULL NAME)		
NPI		
Telephone		
Fax		
DIAGNOSES		
MEDICARE INFO		
Medicare Card ID#		
Hospice: Yes or NO		
Home Health Enrolled: Yes or No		
Date of Discharge		
PRIMARY INSURANCE (IF NOT MEDICARE)		
ID# and Group#		
SECONDARY/SUPPLEMENTAL INSURANCE TO MEDICARE		
ID# and Group#		
ADDITIONAL INFO		