Beaches Rehabilitation Center

Neptune Beach	Mandarin	Northside	Lake City
700 3rd St #202	10232 San Jose Blvd	2377 Dunn Ave 2-A	404 NW Hall of Fame Dr
Nept. Beach, FL 32266	Jacksonville, FL 32257	Jacksonville, FL 32218	Lake City, FL 32055

Welcome to Beaches Rehabilitation Center

Your therapist will evaluate you and design a specifically individualized treatment program. Your therapist will discuss the course of treatment with you so, as a teal, you will fully benefit from your program. There are some basic policies for you to understand to maintain quality of service both delivered and received.

No Show/Cancellation Policy

Consistent attendance is necessary to get full benefit from your program. Please make every effort to arrive on time for your appointment. If for some reason you must be late, please call the office. Your therapy treatment for that day may be adjusted within the timeframe allotted so that we can maintain the daily schedule. If you are unable to make your appointment, it is imperative that you call the office to cancel at least twenty-four (24) hours prior to your scheduled appointment. Failure to provide adequate notice will result in a fee that must be paid upon arrival of your next appointment. Your therapist is scheduled to be there for your appointment, failure to arrive still results in compensation for their time and effort to fulfill your plan of care.

Child Responsibility Form

Children under the age of twelve (12) who are not patients should not be brought to therapy if at all possible, If your child must come with you to therapy, please bring a responsible adult to care and supervise your child during your therapy treatment. Children are not allowed in the gym for their own safety. The equipment in the gym area poses a hazard for children and is strictly for the use of our patients under the supervision of a therapist. We will not be responsible for any injury which may occur while your child is in the Therapy Department.

Worker's Compensation and Medicare Patients

Patients filing under Worker's Compensation or Medicare Insurance **CANNOT HAVE A PHYSICIAN'S APPOINTMENT AND A PHYSICAL THERAPY APPOINTMENT ON THE SAME DAY.** Your doctor's appointments have priority over therapy appointments. Therefore, if your doctor's and therapy appointments should fall on the same day, YOU MUST KEEP YOUR DOCTOR'S APPOINTMENT AND YOUR THERAPY APPOINTMENT WILL BE RESCHEDULED. We ask that you please keep us informed of your doctor's appointments so that we may have progress reports readily available to update your physician. Medicare patients must come in for a discharge visit or all future visits may be denied by Medicare.

Change of Insurance Plan/Policy

During your therapy treatment, **it is your responsibility to inform us of any changes in your insurance plan.**

I, the undersigned, have read and understand the Rehabilitation Therapy policies at Beaches Rehabilitation Center.

______________________________	______________________________
Patient/Legal Guardian Signature	Date
______________________________	______________________________
Office Representative	Date

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Patient Information Consent

I ______________________________ (Name of Patient) have been informed that the purpose of my participation in therapy provided by this clinic is to promote healing and my sense of well-being by promoting strengthening of my muscles, promoting my coordination and my capacity to use my body effectively, to enhance my breathing capacity and to promote my emotional recovery. I understand that my illness is ______________________________ (Name of Illness/Location of Pain). I understand that my treatment plan will be individualized to my needs and me, and will be created in consultation with my referring physician and the professional personnel of the clinic. This plan will be reviewed every 30 days. I will be invited to attempt that review if I desire, along with my family, close circle of friends or others I may wish to bring with me. I give consent to Beaches Rehabilitation Center to discuss my case with the people I invite to attend these periodic reviews of my case.

There are risks to every choice in life. Given my infirm state, I am at somewhat increased risk of having an accident while undertaking therapy or of having other untoward effects. However, I am informed that the benefit from this therapy is expected to far outweigh the anticipated risks, and that I am advised to proceed with therapy knowing that there is some degree of risk in doing so. Indeed, I may be at more risk by not undergoing this therapy that I do. Alternatives available to me include not undertaking the therapy or modifying the treatment plan. Furthermore, I have the right to withdraw from this therapy for any reason at any time. I have been informed of the nature of the anticipated therapy, as well as the expectations of me to participate in therapy.

I verify that my participation in this therapy is voluntary, and no undue coercion had been used to secure my consent.

I acknowledge that the Clinic Administrator **Anya Johnson**, will make herself readily available to discuss my concerns or questions. I acknowledge that if I have grievance of any kind, I have the right to utilize the Section 504 grievance of any kind, posted in the clinic lobby.

List of people I authorize to attend review meetings or to receive communication from the clinic to progress:

____

____

______________________________ Patient/Legal Guardian Signature

______________________________ Date

______________________________ Office Representative

______________________________ Date

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Rights of Patients

Patients have a right to as equitable and humane treatment as can be reasonable achieved under the circumstances of the patient. All caregivers are obligated to recognize and respect a patient's individuality and dignity and to create and foster relationships based on mutual acceptance and trust. No person should be denied impartial access to treatment or accommodations, which are available and medically indicated on the basis of race, color, creed, national origin or the method of payment selected for care.

Patients in our health care rehabilitation center retain a right to privacy, which will be protected by the staff to the extent reasonably achievable, regardless of the patient's economic status or the source of payment chosen for his or her care. Representatives of agencies unrelated to the rehabilitation center, and who are not involved in the patient's care, should be restricted from interviewing, interrogating or observing patients or otherwise interfering with a patient's care. The facility should be a patient's sanctuary where healing may take place. A patient may consent to interviews or observations, as desired, once the reasons for such observations are provided.

Caregivers should respect the privacy of a patient's body to the greatest extent possible. Examination and treatment areas should be designed to protect a patient's privacy by shielding him or her from the view of others.

A patient's history should be confidential. A private setting should be available in which a patient may disclose in confidence his or her history to a staff member.

A patient has the right to communicate with those responsible for his or her care, and to receive adequate information regarding the nature and extent of his or her medical problem, the planned course of treatment and the prognosis. Patients also have a right to be instructed in self-care. When language barriers arise, an interpreter should be provided. Cultural variations in language, as well, may impede understanding. A staff member or other trained individual should be available to facilitate communication between staff and patients.

A patient also has the right to complete confidentiality of his or her records and files unless previously signed and dated authorization and release forms are completed, to the extent possible under State and Federal laws.

A patient will be assigned a primary contact person in the professional team, along with emergency contact numbers, on the first day of treatment.

Patient/Legal Guardian Signature ______________________ Date ______________________

Office Representative ______________________ Date ______________________

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Assignment of Benefits and Guarantee of Payment

Patient: ____________________________________

Insurance Company: ____________________________________

Member ID/Claim #: ____________________________________

Social Security #: ____________________________________

I hereby instruct and direct ____________________________________ Insurance Company to pay benefits for my therapy services by check made out and mailed to Therapia, Inc., 1015 Atlantic Blvd. #214, Atlantic Beach, FL 32233.

If my policy prohibits direct payment to the provider of services, I hereby instruct and direct that the check be made out to me and mailed to Therapia, Inc., 1015 Atlantic Blvd. #214, Atlantic Beach, FL 32233 for the professional expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above mentioned assignee, and I agree to pay, in a current manner, any balance due for professional service charges over and above this insurance payment.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize Therapia, Inc. to initiate a compliant to the Office of the Insurance Commissioner for any reason on my behalf.

I authorize Therapia, Inc. to deposit checks received from my secondary insurance carrier or the agent, on my Patient Account, when made out payable to me.

A photocopy of this assignment shall be considered as effective and valid as the original.

____________________________________ ____________________________________

Policy Holder Signature Date

____________________________________ ____________________________________

Witness Date

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Records Release/Authorization

I do hereby consent and authorize Beaches Rehabilitation Center to receive and/or release copies of my medical records.

Patient Name: ____________________
Address: ____________________
City, State and Zip Code: ____________________ Phone #: ____________________
Date of Birth: ____________________ Social Security #: ____________________

I authorize release of my healthcare information concerning (*Please check off at least one of the following*):

1. ____ All Physical Therapy Records
2. ____ Treatment of (*Please identify condition*): ____________________
3. ____ Treatment received on the following dates: ____________ to ____________
4. ____ Other (*Please describe*): ____________________

Release:
I authorize Beaches Rehabilitation Center to release my personal health care information **to**:
Name: ____________________ Care of: ____________________
Practice Address: ____________________
City, State and Zip Code: ____________________
Phone #: ____________________ Fax #: ____________________

Request:
I authorize: Name: ____________________
Practice Address: ____________________
City, State and Zip Code: ____________________
Phone #: ____________________ Fax #: ____________________

To release my private health information as identified above to **Beaches Rehabilitation Center**
1015 Atlantic Blvd. #214
Atlantic Beach, FL 32233

Please list the purpose or need of your health information. Please check one:

1. ____ Transfer of Care
2. ____ Moving
3. ____ Seeing referred practitioner
4. ____ Other (*Please describe*): ____________________

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Patient's Authorization to Release Medical Records

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective with Beaches Rehabilitation Center has already relied on the use or disclosure of the health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. To revoke an authorization, write a letter to Beaches Rehabilitation Center's Medical Records Department.

I understand that information used or disclosed pursuant to his authorization may be disclosed by the recipient and may no longer be protected by deferral or state law.

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment or eligibility for benefits) except when (1) my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party, or (3) an authorization is required for health plan eligibility or enrollment or a risk rating determination. Failure to sign an authorization may result in an inability to obtain certain benefits in these cases.

I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree and authorize to release of patient health care information to the above named person or organization.

Signature: ______________________________ Date: ____________________

If this authorization form is signed by a personal representative for the individual patient:

Personal Representatives Name: ______________________ Date: ____________________

Signature: ______________________ Relationship: ______________________

This authorization is valid for one year from date originally signed unless specified below:

Date of Expiration (*If shorter than one year from original signature*): ____________________

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Beaches Rehabilitation Center's Important Reminders

The staff at Beaches Rehabilitation Center is dedicated to providing you with the best care possible. In order to do so, we ask that you read and adhere to the following guidelines:

1. Please be on time for your scheduled appointment. By doing so, we can ensure that you and other patients are afforded the courtesy of individualized care and attention allotted during your scheduled time slot.

Initial ______ Date ______

2. When arriving for a scheduled appointment, we ask that you please sign in, pay any copay, and be seated until your therapist brings you back. Please do not walk into the gym while the therapist is helping others.

Initial ______ Date ______

Cancellation Notice:

3. If you are unable to attend a scheduled appointment, we ask that you provide at least **24 hours' notice. If proper notice is not provided, a fee will added to your account that will need to be collected upon arrival of your next appointment.** Following two cancellations without 24 hours' notice, Beaches Rehab reserves the right to cancel any remaining appointments, discharge your care and notify your physician.

Initial ______ Date ______

4. Your doctor has asked us to follow a plan of care for your time with us. In the event you do need to cancel or reschedule an appointment, please work with your front desk coordinator to make up for any cancellations! For the therapy to work, we do need you to be here for the number of visits per week your plan of care calls for.

Initial ______ Date ______

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HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing the form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by the law.
- The patient has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text message to confirm your appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by:

____
(PRINT NAME PLEASE)

_______________________ _______________________
Patient/Legal Guardian Signature Date

_______________________ _______________________
Office Representative Date

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ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it. I know that I may request a copy of Beaches Rehabilitation Center Notice of Privacy Practices for my own records.

____
(PRINT NAME PLEASE)

______________________________ ______________________________
Patient/Legal Guardian Signature Date

______________________________ ______________________________
Office Representative Date

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