CalvertHealth
Outpatient Rehabilitation

Consent to Care and Treatment

Patient Name: _____ Date of Birth: _____

As a patient, you have the right to be informed about the state of your health and any recommended treatment that will be used in the course of your care at this facility so that you may make informed decisions as to whether or not to undergo any recommended treatment.

If you have been a patient of this practice prior to signing this consent, any medical conditions and/or treatment plans have already been discussed with you and you consent to the ongoing care and treatment that has been defined. If you are a new patient with this practice, no specific treatment plan has yet been recommended.

This consent form gives us your permission to examine you and perform the evaluations necessary to evaluate your health and identify any conditions that may be affecting it. It also gives us your consent to recommend appropriate treatment for any conditions identified during the course of your care and treatment.

By signing this consent, you are giving us your permission to perform reasonable and necessary medical examinations and testing on you or your child in order to assess your/child's health and recommend treatment. You authorize this facility, your assigned therapist/ therapist assistant, and any employee working under the direction of the rendering provider, to provide medical care to you. This medical care may include services and supplies related to your health and may include but not limited to preventative, diagnostic, therapeutic, rehabilitative, maintenance, counseling, assessment, or review of physical function of the body and recommendations for devices, equipment or other items required to treat a medical condition. This consent includes contact and discussion with other health care professionals who may be consulted regarding your care and treatment.

You are also indicating that you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the purpose, potential risks and benefits of any test ordered for you in the course of your treatment plan with your physician or health care provider. If you have any concerns regarding any treatment recommended by your provider, we encourage you to ask questions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient Signature (or Guardian) **Date**

CalvertHealth
Outpatient Rehabilitation

Patient Privacy Notice

Patient Name: _____ **Date of Birth:** _____

The Right to Obtain a Copy of this Notice. You have the right to a paper copy of this notice at any time. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, please ask at registration or contact our Privacy Office at the address or phone number located at the end of this document. You may obtain a copy of this notice on our website, www.CalvertHealthMedicine.org.

Your Rights Regarding Your Protected Health Information. We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and this notice. We reserve the right to make the revised or changed notice effective for your PHI we already have as well as any information we receive in the future. We will post a copy of the current notice. The notice will always contain on the first page, the effective date of the Privacy Notice.

Contact Information

If you require further information about this Notice, have privacy issues or believe that your privacy rights have been violated, please contact:

CalvertHealth Medical Center Attn:
Privacy Officer
100 Hospital Road
Prince Frederick, MD 20678 Phone

Number: (410) 535-8282

By signing this document, I acknowledge that I have read and understood this Privacy Notice and that a copy of CalvertHealth Medical Centers Privacy Notice was offered to me.

_____ _____

Patient Signature (or Guardian) **Date**

CalvertHealth
Outpatient Rehabilitation

Patient Financial Policy

Patient Name: _____ **Date of Birth: _____**

Thank you for choosing CalvertHealth Outpatient Rehabilitation as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Insurance: Please confirm your provider is enrolled with your insurance carrier prior to scheduling your visit. We participate with most insurance plans, including Medicare. If you are not insured by a plan we accept and you choose to submit your claim yourself, payment in full is expected at each visit.

Proof of Insurance: If you have insurance and we submit claims on your behalf, we require a copy of your driver's license or other government-issued photo ID and your current insurance card at each visit. This information must be provided prior to seeing a provider.

Coverage Changes: Please notify us before your scheduled appointment if any of your insurance information has changed. This included changes of employer, insurance provider, address, policy number, covered dependents, etc. Not having up to date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the whole amount of the services provided.

Claims Submission: Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit the claims, we require the patient's name, address, and date of birth, as well as the policy holders name, address, and date of birth. This information must match exactly what your insurance company has on file.

Assignment of Benefits: I hereby authorize and direct any insurance company to pay the proceeds of any benefits due to me for services rendered by CalvertHealth Outpatient Rehabilitation directly to the provider.

Knowledge and Release of Information: I understand the diagnosis of my problem and consent to CalvertHealth Outpatient Rehabilitation to render appropriate treatment as prescribed by my physician. Furthermore, I authorize CalvertHealth Outpatient Rehabilitation to release to my referring physician and insurance company any information including my diagnosis and records of treatment, concerning my medical

history and therapy. I authorize CalvertHealth Outpatient Rehabilitation to file an appeal or grievance on my behalf to contest any adverse decisions by an insurer. I agree to sign an authorization for this purpose, if necessary. CalvertHealth Outpatient Rehabilitation and involved providers are released from liability arising from reliance on this authorization to release Protected Health Information.

Copayments/Co-insurance: If your insurance requires copayment/co-insurance, those payments must be made at the time of service. We collect copays during appointment check in.

Responsibility Agreement: I acknowledge and understand that I am responsible for all the charges for all services rendered to me or a member of my family. Although I have requested that my bill be submitted to my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason a portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill. I also understand that obtaining required authorization for therapy (and/or supplies) is my responsibility. CalvertHealth Outpatient Rehabilitation will initiate authorization and verify insurance benefits as a courtesy to me; however, this is not a guarantee of payment and does not waive my responsibility for payment for services unpaid by my insurer. I waive any right to claim the charges for the services are unreasonable or unnecessary, as to the amount charged or the treatment rendered. I will provide CalvertHealth Outpatient Rehabilitation with any changes in address, employment, insurance, or attorney representation within ten (10) days of any changes.

Minor Patients: Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for payment for all services rendered to the minor child at the time of the appointment.

Personal Injury Claims: CHOR does not bill third party. We will use your PIP. Once exhausted, we will bill the current health insurance for treatment covered by the insurance company. All applicable copays will be collected at the time of service.

Worker's Compensation: Prior authorization is required from your employer before services can be provided. We require the following information for each claim submitted on each date of service: state where the injury occurred and that is covered by the claim. If the claim is denied and you do not have health insurance, the charges will become your responsibility.

Our office is committed to providing the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand, and agree to the terms of this Patient Financial Policy.

_____ _____

Patient Signature (or Guardian) **Date**

CalvertHealth
Outpatient Rehabilitation

No-Show and Late Cancellation/Reschedule Policy

Patient Name: _____ Date of Birth: ___/___/_____

Thank you for choosing CalvertHealth Outpatient Rehabilitation as your healthcare provider. We are committed to building a successful provider-patient relationship with you and your family. We understand there are times when you must miss a scheduled appointment or cannot cancel or reschedule in a timely manner; however, when you do not call to cancel a scheduled appointment **at least 24 hours** before the appointment or miss a scheduled appointment without notice, you may be preventing another patient from getting much-needed treatment. Conversely, the situation may arise when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment block.

To help avoid misunderstandings, we are providing you with our No Show and Late Cancellation/Reschedule Policy. For purposes of this policy, a late cancellation is when a patient cancels or reschedules a scheduled appointment but provides less than **24 hours' notice**. **Late cancellations will be treated as a 'no-show' per CHOR policy.**

The following policies will apply to 'no-shows' and late cancellations/reschedules, combined on a rolling 12-month period.

'No-Shows' and late cancellations/reschedules:

- First offense will prompt a phone call from the office to the patient (Additional calls will be made for post-operative patients to their surgeon and for Workers Compensation patients to their adjuster/nurse case manager.)
- Second offense will prompt another phone call from the office and appointments will be scheduled one week at a time, referring doctor will be notified.
- Third offense will prompt the discharge of the case, and notification to the referring physician. The patient will be required to get a new order from their physician before reestablishing care. Appointment(s) will be scheduled under clinic discretion.

If you arrive after your scheduled appointment time, we will do everything possible to provide treatment. Your treatment time may be abbreviated and/or canceled depending upon the time of your arrival. If you arrive later than 15 minutes after your scheduled appointment, it is up to the discretion of the therapist as to whether treatment will be rendered. Please remember that the treatment time that you are unable to use may be valuable to another patient who needs our services.

_____ _____

Patient Signature (or Guardian) **Date**

CalvertHealth
Outpatient Rehabilitation

Medical Information Release Form

Patient Name: _____ **Date of Birth:** _____

Release of Information

Please choose one of the following:

◯ **I authorize the release of information including diagnosis, records, examination rendered to me and claims information. This information may be released to:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

◯ **I do not want my information to be released to anyone.**

Messages

Please call: ◯ **Home** ◯ **Work** ◯ **Cell Phone** **Number:** _____

If unable to reach me: ◯ **Leave a message asking me to return your call**

◯ **Leave a detailed message**

◯ **Other:** _____

_____ _____

Patient Signature (or Guardian) **Date**

CalvertHealth
Outpatient Rehabilitation

Patient Registration

Last Name: _____ First name: _____ MI: ___

Gender: M F Birth Date: ____/____/_____ SSN_____

Marital Status: Single Married Divorced Widow Student Status: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ Home Phone: _____

Cell Phone: _____ Work Phone: _____

Preferred Contact Method: Home Work Cell Email

Name of Employer: _____ Occupation: _____

Employer's Address: _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone Number: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____Phone: _____

FOR MINOR PATIENTS or if your bill is to be paid by someone other than yourself, please complete this area:

Name: _____

Relationship: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

_____ _____

Patient Signature (or Guardian) **Date**

_____ _____

Name of Guardian **Relationship to patient**

CalvertHealth
Outpatient Rehabilitation

Insurance Information

Patient Name: _____ **Date of Birth:** _____

Primary Medical Insurance Company: _____

Claims Address: _____

Policy Holder Name: _____ Relationship: _____ Birth Date: ___/___/___

Policy Number: _____ Group Number: _____

Secondary Medical Insurance Company: _____

Claims Address: _____

Policy Holder Name: _____ Relationship: _____ Birth Date: ___/___/___

Policy Number: _____ Group Number: _____

Workers Compensation Insurance Company: _____

Date of Injury: _____ Claims Address: _____

City: _____ State: _____ Zip Code: _____

Adjuster/Case Manager: _____ Phone: _____

Fax: _____ Claim Number: _____

Auto (Patient's PIP Insurance) Company: _____

Date of Accident: _____ Claims Address: _____

City: _____ State: _____ Zip Code: _____

Adjuster: _____ Phone: _____

Fax: _____ Claim Number: _____

Insured Drivers Name: _____ Date of Accident: _____

If you are represented by an Attorney:

Attorney's Name: _____ Phone: _____

_____ _____

Patient Signature (or Guardian) **Date**

_____ _____

Name of Guardian **Relationship to patient**

CalvertHealth
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Health History

Patient Name: _____ **Date of Birth:** _____

What is the reason for your visit today? _____

Briefly describe how your condition began: _____

_____

Please list any current medications you are taking: _____

_____

_____

Please list any current medical conditions: _____

_____

Please list any past medical condition: _____

_____

If applicable, please list:

Date of Injury: _____ **Date of Surgery:** _____

Date of Last X-Ray: _____ **Facility:** _____

Is your visit today related to Workers Comp or an Auto Accident? Yes ◯ No ◯

If yes, please circle injury type: Workers Comp ◯ Auto Accident ◯

Date of Injury: _____ **Date of Surgery:** _____

Date of Last X-Ray: _____ **Facility:** _____

Have you been treated in Physical Therapy, Occupational Therapy, or Speech Therapy in the last 12 months?

Circle: Yes ◯ No ◯ **If Yes, which?** _____

Name of Facility: _____ **Last Treatment Date:** _____

_____

Fall Risk Questionnaire

Please circle YES or NO to the following questions:

Are you concerned about falling?	YES ◯ NO ◯	Have you fallen in the last year?	YES ◯ NO ◯
Have you fallen more than two (2) times?	YES ◯ NO ◯	Has any fall resulted in an injury?	YES ◯ NO ◯

_____ _____

Patient Signature (or Guardian) **Date**

_____ _____

Name of Guardian **Relationship to patient**