HENRY FORD
MACOMB HOSPITALS

INSTRUCTIONS FOR COMPLETING ADULT OUTPATIENT REHABILITATION DOCUMENTS

We are required by Henry Ford Health System to obtain the information on the following documents and share with you specific information about the Health System and our therapy services. Please complete these forms, to the best of your ability and bring them with you to your first visit.

1. **Registration information:** Demographic information to admit you into the system. The information also assists the hospital in addressing the needs of the families we serve.
2. **Adult medical history summary:** Medical History information required to ensure your safe care.
3. **Attendance policy:** Information concerning your attendance expectations and our ability to justify ongoing therapy care.
4. **Medicare secondary payer questionnaire (Medicare patients only):** Medicare requires us to obtain the information on this form before we can submit a claim. The form may be difficult to understand and we will be happy to assist you in completing it if needed. If you are entitled to Medicare benefits based on your age, disability or renal disease (ESRD) and you and your spouse are not currently employed – answer "NO" to questions 9, 10, 11, 12, 13, 15, 17 and 18.
5. **Consent for treatment:** This form acknowledges your consent to allow us to treat you as a patient.
6. **Notice of privacy practices acknowledgement:** By signing this form it acknowledges that we have shared with you our Health Systems Privacy Practices Summary which describes our commitment to your privacy and how we may share your personal information. It will be posted in our office and you welcome to request a copy.

Thank you for your patience and understanding in completing these forms. Please call us if you have any questions or concerns. We look forward to working with you during your rehab recovery.

HENRY FORD MACOMB OUTPATIENT REHABILITATION SERVICES

Clinton Twp Hospital Campus
16301 19 Mile Road (at the corner of Commons, West of Garfield)
Phone: (586) 263-2480
Fax: (586) 263-2574

Warren Hospital Campus
13355 East 10 Mile
(at the corner of Schoenherr)
Medical Office East bldg.
attached to hospital
Phone: (586) 759-7474
Fax: (586) 759-7476

Warren Orthopedics
25625 Schoenherr
(1/2 mile North of 10 Mile)
Phone: (586) 759-4700
Fax: (586) 759-5569

Bruce Township Health Center
80650 Van Dyke Road
(North of 37 Mile Road)
Phone: (810) 798-6470
Fax: (810) 798-6476

Chesterfield Health Center
30795 23 Mile Road
(1/2 mile east of I-94)
Phone: (586) 421-3030
Fax: (586) 421-3031

Fraser Health Center
15717 15 Mile Road
(West of Utica Road)
Phone: (586) 285-3884
Fax: (586) 285-3920

Richmond Health Center
31505 32 Mile Road
(East of Haven Ridge Road)
Phone: (586) 727-4530
Fax: (586) 727-9485

Shelby Family Medicine
49310 Van Dyke
(North of 22 Mile Road)
Phone: (586) 731-5253
Fax: (586) 731-5218

Washington Twp Health Center
12150 30 Mile Road
(between Van Dyke and M-53)
Phone: (586) 336-2480
Fax: (586) 336-2481

Henry Ford Health System

HENRY FORD MACOMB HOSPITALS

Patient Label

REGISTRATION INFORMATION

Patient Name: _____ Social Security Number: _____

Religion: _____ Parish/Church: _____ Ethnicity: _____ Language: _____
(Please print)

Race: ❑ African American ❑ Hispanic ❑ White ❑ Asian ❑ Other: _____

Marital Status: ❑ Married ❑ Divorced ❑ Separated ❑ Single ❑ Widowed ❑ Minor (under 17 years.)

Employment: ❑ Full-time ❑ Part-time ❑ Self Employed ❑ Retired ❑ Not Employed ❑ Disabled

Occupation: _____ Employer: _____

Employer's Phone Number: _____

Emergency Contact Information

Nearest Relative: _____ Relationship: _____

Phone Number: _____ Cell Phone Number: _____

Alternate Contact Person: _____ Relationship: _____

Phone Number: _____ Cell Phone Number: _____

Pediatric Patients (0 – 16 years old)

Mother's Name: _____ Father's Name: _____

Legal Guardian: _____ Relationship: _____ Phone: _____

Child lives with: _____ Child's Primary Caretaker: _____

What language is spoken in the home: _____ School: _____

PROTECTION OF PRIVACY

Some of your treatment may take place in our gym area near other patients. The open format of a gym is beneficial to the rehabilitation process. If you have any concerns regarding privacy during your therapy, please let us know immediately. We will make every effort to accommodate your needs.

CUSTOMER SATISFACTION

Our mission is to ensure that you have the best possible experience during your rehabilitation with us. We value your opinion and appreciate open communication. In an effort to assure high quality care, you may receive a survey asking you to rate your experience with our Rehabilitation Services Department, either during your course of treatment or after you are discharged from therapy. It is our goal that every patient we treat will feel confident in scoring us as a "5" out of "5". Anything less than "Very Good" is unacceptable to our Rehabilitation staff.

YOUR THERAPY GOALS

To obtain maximum benefit from therapy, it is necessary for you to take part in setting achievable goals. The therapist will work closely with you to ensure that your personal goals are addressed and incorporate them into your treatment plan.
Please write down what you hope to achieve through therapy:

_____

_____

* Patient Signature: _____ Date: _____

Henry Ford Health System
HENRY FORD MACOMB HOSPITALS

Patient Label

ADULT MEDICAL HISTORY SUMMARY

Patient Name:_____

Acute/Chronic Medical Conditions		Onset Date	Surgical/Invasive Procedure (You may attach a list if necessary)	Date
❑ Yes ❑ No	Pregnant	NA		
❑ Yes ❑ No	Heart Problems: _____			
❑ Yes ❑ No	Pacemaker or Defibrillator			
❑ Yes ❑ No	Blood Clots			
❑ Yes ❑ No	Stroke			
❑ Yes ❑ No	Cancer Site: _____		**Current Medications** (You may attach a list if necessary)	
❑ Yes ❑ No	High Blood Pressure			
❑ Yes ❑ No	Low Blood Pressure			
❑ Yes ❑ No	Seizures			
❑ Yes ❑ No	Hepatitis/Liver Disease			
❑ Yes ❑ No	Kidney Disease			
❑ Yes ❑ No	Osteoporosis			
❑ Yes ❑ No	Glaucoma/Cataracts			
❑ Yes ❑ No	Arthritis: _____			
❑ Yes ❑ No	Diabetes (Sugar) Do you take insulin? _____		**Allergies** (drug, food, latex, bee stings, etc)	
❑ Yes ❑ No	High Cholesterol			
❑ Yes ❑ No	Ulcers/Hiatal Hernia			
❑ Yes ❑ No	Eating Disorder			
❑ Yes ❑ No	Medication Port			
❑ Yes ❑ No	Thyroid/Hormonal Problems			
❑ Yes ❑ No	Do you smoke?			
❑ Yes ❑ No	Recent weight loss or gain?			
❑ Yes ❑ No	Psychological Problems Specifics: _____			

Other medical problems or diagnoses: _____
_____

* Signature of person completing this form: _____ Date: _____

* Relationship to patient: _____

Signature of therapist acknowledging review: _____ Date: _____ Time: _____

* Patients actively involved in outpatient therapy will have their medical history reviewed at least once every 10 visits or 30 days.

Review Date	Time	Therapist signature	Changes

HENRY FORD
MACOMB HOSPITALS

Patient Label

ATTENDANCE POLICY

Dear Patient:

Thank you for selecting Henry Ford Macomb Hospital Outpatient Rehab Services. We care about you and your progress in therapy. There are two very important policies that we want you to be aware of:

ATTENDANCE

Consistent attendance is necessary for effective therapeutic results and insurance carriers see inconsistent attendance as a reason for rejecting a claim. We have therefore adopted a policy of removing patients from the Outpatient Therapy Schedule after their second missed appointment or after failing to show during a one-week period. We ask that you please make every effort to keep your therapy appointments. If you are discharged your physician will be notified and you will be required to obtain a new prescription in order to resume therapy. If you must cancel, please notify our office prior to your scheduled appointment time. We may reschedule you as the schedule permits. If you are calling during non-business hours please leave a message and we will retrieve your message the next working day. Punctuality is also very important, yours and ours. Please arrive on time for your scheduled appointment. Tardiness may necessitate alteration in the treatment program for that day.

JUSTIFICATION FOR ONGOING THERAPY VISITS

Recently, insurance companies have adopted more stringent guidelines regarding coverage of therapy visits. Insurance companies will not cover therapy for purposes of supervision or maintenance so it is important for us to be able to document ongoing progress and skilled care. Your progress will be formally assessed within your first 8-10 visits or 30 calendar days, whichever comes first. If your therapy goals have been achieved, or we are unable to show continued progress, the therapist will recommend to your physician that you be discharged to a home maintenance program. A formal reassessment may also be performed at any point in time when needed for a doctor's appointment.

We are pleased you chose Henry Ford Macomb Outpatient Therapy and hope you are equally pleased with the services provided.

Sincerely,

Henry Ford Macomb Rehabilitation Services

* Patient Signature: _____ Date: _____

Henry Ford Health System

HENRY FORD MACOMB HOSPITALS

Patient Label

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Who is completing this questionnaire? ❑ Patient ❑ Other: _____

1. Are the services today covered by Black Lung Disease Benefits?	❑ Yes	❑ No
2. Are your services covered by government research program?	❑ Yes	❑ No
3. Are you a veteran and are today's services covered by approved veteran benefits?	❑ Yes	❑ No
4. Are the services the result of a work related accident/condition?	❑ Yes	❑ No
5. Are today's services due to non-work/auto related accident and is another party responsible?	❑ Yes	❑ No
6. Is no-fault insurance available?	❑ Yes	❑ No
7. Is Liability Insurance available?	❑ Yes	❑ No
8. Are you entitled to Medicare based on Age, Disability, or Early Stage Renal Disease (ESRD)?	❑ Age	❑ ESRD
	❑ Disability	
9. Are you **currently** employed?	❑ Yes	❑ No
10. Do you have a spouse who is **currently** employed?	❑ Yes	❑ No
11. Do you have Group Health Plan (GHP) based on your own or your spouse's **current** employment?	❑ Yes	❑ No
12. Do you have GHP through your **current** employer and are there more than 20 employees?	❑ Yes	❑ No
13. Is your spouse **currently** working and are there more than 20 employees in that company?	❑ Yes	❑ No
14. Were you employed prior to your disability or before becoming Medicare eligible?	❑ Yes	❑ No
15. Do you have Group Health Plan coverage based on your own or a spouse's **current** employment?	❑ Yes	❑ No
16. Do you have Group Health Insurance through another family member who is working?	❑ Yes	❑ No
17. If you have Group Health Plan (GHP) coverage based on your **current** employment, does your employer employ 100 or more employees?	❑ Yes	❑ No
18. If you have Group Health Plan (GHP) coverage based on your spouse's **current** employment, does the employer employ 100 or more employees?	❑ Yes	❑ No
19. If you have Group Health Plan (GHP) coverage based on a family member's employment, does the employer employ 100 or more employees?	❑ Yes	❑ No
20. Do you have a Group Health Plan (GHP)?	❑ Yes	❑ No
21. Have you had a kidney transplant?	❑ Yes	❑ No
22. Have you received maintenance dialysis and/or self-dialysis training?	❑ Yes	❑ No
23. Has it been more than 30 months since dialysis began and/or since a kidney transplant?	❑ Yes	❑ No
24. Are you entitled to Medicare on the basis of either Early Stage Renal Disease (ESRD) and age or ESRD and disability?	❑ Yes	❑ No
25. Was your initial entitlement to Medicare (including simultaneous or dual entitlement) based on Early Stage Renal Disease (ESRD)?	❑ Yes	❑ No
26. Is the Group Health Plan (GHP) primary based on age or disability entitlement?	❑ Age	❑ Disable

***** Patient signature or designee : _____ Date: _____

Not part of the Medical Record

Henry Ford Health System

HENRY FORD MACOMB HOSPITALS

Patient Label

GENERAL CONDITIONS OF TREATMENT

1. Consent to treatment: I freely consent to such hospitalization and/or care any of my physicians consider necessary. This may include treatments, tests, nursing care, x-rays, blood transfusions and other procedures performed by the physicians, their designees and other persons who work at the hospital. I understand that most physicians who practice at the hospital are not hospital employees, but independently provide services. I will be billed separately for these services. No one has given me a promise or guarantee of what the results of my medical care will be. I understand that my care may be terminated upon reasonable notice or immediately if I violate hospital policies. I understand that Henry Ford Macomb Hospital is a teaching institution and consent to various procedures and tests being performed by students, residents, or medical staff and support staff who are supervised by experienced doctors and nurses.

2. Payment of charges: I authorize payment of my insurance benefits (including Medicare/Medicaid) to be made directly to Henry Ford Macomb Hospital and my physicians. I agree to pay for all charges promptly after I am billed and will not refuse to pay bills if the hospital gives me extra time to pay. If I do not pay on time, I will pay the hospital's collection expenses. If I have a right to receive money due to a claim related to this hospital visit, I assign to the hospital my rights to that money up to the amount I owe the Hospital in payment of my bill. I understand that the hospital is not obligated to seek payment from my insurer before billing me.

3. Payment for services rendered: I understand that according to the terms of coverage through any provider/payer agreement, that I am responsible for obtaining authorization(s) from my designated provider. I acknowledge that without authorization from my designated primary provider, I am responsible for the payment for services rendered.

4. Release of information: I agree that designated individuals who work at the hospital are authorized to release any information from my financial or medical records, to any person or organization which they reasonably think may be responsible for authorizing payment or processing bills related to medical care and other services provided during my hospital stay. This information includes, but is not limited to, information about history, testing or treatment of serious communicable diseases and infections, as defined by statute and the Michigan Department of Public Health Rules (for example, venereal disease "VD", tuberculosis "TB", hepatitis, human immunodeficiency virus "HIV", acquired immunodeficiency disease syndrome "AIDS" and AIDS related complex "ARC"). This release also includes information regarding substance abuse treatment protected by 42 C.F.R. Part II and any mental health information. I also release such information to my primary care/referring physician and others who are responsible for my ongoing nursing/medical care. I consent to the release of identifying information, including my social security number, to manufacturers of any medical device that I may receive, in order to help them if they need to locate me regarding the device. My permission for release of information for payment purposes will end when the insurance company or its agent no longer needs the information. If I revoke permission, the hospital will stop releasing information to the individuals mentioned above. Transmission of information may be verbal, electronic (e.g. computer or facsimile) or by mail.

5. Personal belongings: I have been advised to leave my valuables at home. This hospital is not responsible for my belongings, including clothing, eyeglasses, dentures and or other personal items. If necessary, valuables may be temporarily placed in the hospital safe. I recognize the hospital has a right to search my personal belongings at any time during my stay for the protection of everyone at the hospital.

6. Consent to HIV testing: I understand that if a person working at the hospital is exposed to blood or body fluids while providing me care, the hospital may test my HIV status in accordance with the Michigan Public Health Code 1988, Public Act 488.

I understand this form and agree that by signing it I am bound by what it says, whether I am the patient or someone acting on the patient's behalf.
THIS FORM APPLIES TO MY UPCOMING OUTPATIENT PROCEDURE AND/OR ADMISSION, AND ANY PRELIMINARY TESTING.

(Witness to signature)	(Signature of patient or person acting on patient's behalf)

(Date)	(Time)	(Relationship to patient)

HENRY FORD
MACOMB HOSPITALS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT WITH OPPORTUNITY TO AGREE OR OBJECT

I ACKNOWLEDGE:
A copy of the Henry Ford Macomb Hospital Notice of Privacy Practices was made available to me at the place where I went for health care services.

The Notice of Privacy Practices was posted in a clear and prominent location where I was able to read the Notice of Privacy Practices. A copy of the Notice of Privacy Practices was made available for me to keep.

If I came in for health care services in an emergency treatment situation, I was able to view the Notice as soon as reasonable after the emergency treatment situation.

I received the Notice of Privacy Practices before April 14, 2003, or no later than the first day I received health care services on or after April 14, 2003.

_____
(**Print** Name of Patient)

_____ _____
(**Signature** of Patient or Representative) (Date)

****

OPTIONAL: OPPORTUNITY TO AGREE OR OBJECT
It is our practice to leave messages at your home regarding appointment reminders, prescription refills, or referral/testing arrangements. (Note: Actual test results are not left as messages)

- ❑ Yes, leave messages on my answering machine or with a person who answers the phone.
- ❑ No, do not leave messages at my home. I prefer to be called at: _____
  or contacted by mail at this address: _____

I understand that my test results are private and will not be released to anyone other than myself unless I authorize it. I request that:

_____ _____
(Name) (Relationship)

be given my test results. I understand that the above instructions will be in force until I notify the organization of any changes.

_____
(Initials)

****

If an acknowledgement is not obtained, document below the good faith efforts to obtain the acknowledgement and the reason why the acknowledgement was not obtained:

Patient's name: _____

Date of attempt to obtain Acknowledgement: _____

Reason Acknowledgement was not obtained [describe reason, such as an emergency treatment situation or substantial barrier to communication]:

_____

****

_____ _____ _____
(Signature of Associate) (Date) (Time)

_____ _____
(Print Name) (Department)