PATIENT INFORMATION FORM

PATIENT LAST NAME: _____ FIRST NAME: _____

MARITAL STATUS: _____ RACE: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

GUARDIAN/POA NAME: _____

GUARDIAN ADDRESS: _____

CITY: _____ STATE: _____ ZIP _____

PHONE NUMBER: _____

EMERGENCY CONTACT: _____ PHONE: _____

PHYSICIAN: _____ PHONE: _____

PHYSICIAN ADDRESS: _____

PHYSICIAN NPI#: _____ DATE OF ONSET/INJURY: _____

DO YOU HAVE/OR HAD ANY OF THE FOLLOWING:

Diabetes	Yes_____	No _____
High Blood Pressure	Yes_____	No_____
Heart Disease	Yes_____	No_____
Pacemaker	Yes_____	No_____
Headaches	Yes_____	No_____
Kidney Problems	Yes_____	No_____
Nervous Disorders	Yes_____	No_____
Circulatory Disorders	Yes_____	No_____
Sensitivity to Heat	Yes_____	No_____
Sensitivity to Ice	Yes_____	No_____

Other Allergies: _____

Previous Surgery: _____

Seizure: _____ Metal Implants: _____

Treatmentl Agreement

HIC Number or SSA#_____

NAME: _____ _____
LAST FIRST MIDDLE DATE OF BIRTH

THIS AGREEMENT is entered into this _____ day of _____, 20 ____ by and between Legacy Rehabilitation, Inc. hereinafter referred in as the "Clinic" and _____ hereinafter referred to as "Patient", and _____ hereinafter referred to as "Patient Guardian/Representative"

THE CLINIC WELCOMES ALL PERSONS WITHOUT REGARD TO RACE, COLOR, NATIONAL ORIGIN, RELIGION, SEX OR QUALIFIED HANDICAPS.

1. PATIENT CARE

1.1 The clinic shall provide services and materials in compliance with the orders of Patient's attending physician.

2. CONSENT TO TREATMENT

2.1 Patient and patient's guardian/representative acknowledge that Patient is under the medical treatment and care of said physician, and that Clinic renders services to Patient under the general and specific instructions of said physician. Patient and Patient Guardian/Representative recognize that said physician furnishing services to Patient is an independent Contractor and is not an employee or agent of the Clinic.

3. RESTRICTIONS AND LIABILITIES

3.1 Patient and Patient Guardian/Representative release the Clinic from any and all harm, injury and loss suffered by Patient while outside the confines of the Clinic or supervision of the Clinic staff.

3.2 The Clinic shall incur no liability for injuries of any kind suffered by Patient while under its care, except where the injury is caused by the negligence of the Clinic or its regular employees thereof.

3.3 Should the Patient discontinue treatment before our therapist and/or the attending physician has so ordered Patient, Patient and Patient's Guardian/Representative agree to assume all responsibility for all results which may follow.

3.4 The Clinic is not liable for injury to Patient caused by visitors, other Patients and/or Patient's guardian attempting to assist or treat Patient in any way. For the safety of Patient and others, the therapist has discretion to designate who may be in the treatment area.

3.5 The Clinic shall not be responsible for personal belongings left in the Clinic.

4. PATIENT'S CERTIFICATION

4.1 Patient certifies and warrants that all information submitted by him/her for purposes of applying for or receiving benefits until the Title XVII of the Social Security Act (Medicare/Medicaid) is true and correct. Patient and Guarantor agree to indemnify and hold harmless the Clinic from and against any and loss, damage, cost, expenses or liability resulting from patient's submission of false or incorrect information to Clinic. The patient authorizes any healthcare facility or doctor to furnish to Clinic and/or disclose all or any part of Patient's medical records or financial records to any person or entity which or may be liable under contract to Clinic, to Patient or to a family member or employer.

Patient to pay all or a portion of the costs of care provided to patient, including but not limited to hospital or medical service companies, insurance companies, worker's compensation carrier, welfare fund or Patient's employer. Patient further authorizes Clinic to disclose all or any part of Patient's medical and or financial records to any independent auditor of Clinic. Patient requests that payment of authorized benefits be made to Clinic on his/her behalf.

4.2 Clinic does not make any assurances of any kind whatsoever that Patient's care will be covered by Medicare/Medicaid, worker's compensation carrier or private insurance companies, and the Patient and Guarantor hereby release the Clinic, its agents, servants, and employees from any liability or responsibility in connection with the Patient's and/or Guarantor's potential claim of coverage under Medicare/Medicaid, worker's compensation carrier or insurance companies.

THE PATIENT AND THE PATIENT REPRESENTATIVE CERTIFY THAT EACH OF THEM HAS READ THIS AGREEMENT AND RECEIVED A COPY THEREOF AND UNDERSTANDS AND AGREES TO ALL THE PROVISIONS IN THIS AGREEMENT.

THE PATIENT REPRESENTATIVE OR OTHER PERSON WHO SIGNS THIS AGREEMENT ON BEHALF OF AND IN THE PLACE OF THE PATIENT REPRESENTATIVE THAT HE/SHE IS AUTHORIZED BY PATIENT TO DO SO, AND THE ABOVE NAMED PATIENT AND EACH PATIENT REPRESENTATIVE SIGNING THIS AGREEMENT AGREES BY SO SIGNING TO ACCEPT ALL OF THE TERMS HEREOF AND TO PERFORM ALL OBLIGATIONS HEREUNDER. THERE ARE NO REPRESENTATIONS MADE BY THIS CLINIC OR ANY OF ITS EMPLOYEES OR AGENTS OTHER THAN IS SET FORTH IN THIS AGREEMENT.

PATIENT: _____ DATE: _____

PATIENT REPRESENTATIVE: _____ DATE: _____

FACILITY REPRESENTATIVE: _____ DATE: _____

OUTPATIENT BILLING INFORMATION

LEGACY REHABILITATION, INC.

Resident Name: _____ Medical Record #: _____

Address: _____

DOB: _____ Sex: (M/F): _____Medicare/Policy # _____

Medicare Part B/Private Insurance Eligibility Verified:

Date: _____ By Whom: _____

Physician (First & Last Name) _____ UPIN # _____

Co-insurance Section

Co-insurance Type (Circle One) Private Medicaid

If Medicaid Medicaid # _____

If Private Is there an insurance policy for Medicare B co-insurance? Y N

No Insurance Responsible Party Name: _____

Billing Address: _____

Contact Phone Number: _____

If Insurance Insurance Company Name: _____

Policy & Group #: _____

Billing Address: _____

Phone Number: _____

Date Coverage Verified: _____

By Whom: _____

Ensure to obtain a copy the following items before therapy is initiated for billing purposes.

1. Copy of Insurance and Co-insurance Cards.
2. Assignments of Benefits Form.
3. Medicare/Insurance Secondary Payer Form
4. Outpatient Treatment/Financial Agreement Form

ASSIGNMENT OF BENEFITS

Provider of Physical Therapy Services

Legacy Rehabilitation, Inc.
1920 Vindicator Drive, Suite 201
Colorado Springs, CO 80919

Patient's Name _____

In consideration of services rendered, or to be rendered to the above named patient, I hereby authorize payment directly to the Clinic of any and all of insurance benefits, as well as extended benefits to such medical coverage to which I, or the above named patient, may otherwise be entitled for services rendered by the Clinic, but not to exceed the Clinic's regular charges for such services.

I hereby authorized the Clinic to file such claims in my behalf so that the clinic may realize payment of its charges. I understand that if the Clinic does not receive payment from the insurer, I am responsible for the timely payment of the Clinic's charges unless application is filed promptly and eligibility is established for Medicaid in the State in which the patient resides and the Clinic has an agreement with.

I authorize the clinic to request from my, or the above named patient's medical insurance payer, either in writing or orally, the remaining benefits that patient is entitled to.

SIGNATURE: _____ PATIENT/GUARDIAN'S NAME: _____

RELATIONSHIP TO PATIENT: _____

DATE SIGNED: _____

WITNESS: _____

DATE: _____

SECONDARY PAYER QUESTIONNARE

PART I

1. Are you receiving Black Lung (BL) Benefits?
_____ Yes. Date benefits began: _____/_____/_____ (MM/DD/YY)
BL IS PRIMARY ONLY FOR CLAIMS RELATED TO **BL**

_____ No.

2. Are the services to be paid by a government program such as a research grant?
_____ Yes. Government will pay primarily benefits for these services.
_____ No.

3. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for therapy services at this Clinic?
_____ Yes. DVA IS PRIMARY FOR THESE SERVICES.
_____ No.

4. Was the illness/injury due to a work related accident/condition?
_____ Yes. Date illness/injury began: _____/_____/_____ (MM/DD/YY)
Name and address for worker's Compensation (WC) plan:

_____
_____
_____
_____

Patient's policy or identification number: _____
Name and address of your employer:
_____
_____
_____
_____

WC IS PRIMARY PAYER ONLY FOR CLAIMS RELATED TO WORK RELATED INJURIES OR ILLNESS. GO TO PART III.

_____ No. GO TO PART II.

PART II

1. Was illness/injury due to a non-work related accident?
_____ Yes. Date of accident. _____/_____/____ (MM/DD/YY)
_____ No. GO TO PART III

2. What type of accident caused the illness/injury?
_____ Automobile
_____ Non-automobile

Name and address of no-fault or liability insurer.

_____
_____
_____
_____

Insurance claim number: _____

NO-FAULT INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ Other

3. Was another party responsible for this accident?

_____ Yes

Name and address of any liability insurer.

_____
_____
_____
_____

Insurance claim number _____

LIABILITY INSURER IS PRIMARY PAYER ONLY FOR THOSE CLAIMS RELATED TO THE ACCIDENT. GO TO PART III.

_____ No. GO TO PART III

PART III

1. Are you entitled to Medicare based on:

_____ Age. GO TO PART IV
_____ Disability. GO TO PART V
_____ ESRD. GO TO PART VI

PART IV - Age

1. Are you currently employed?

_____ Yes

Name and address of your employer

_____
_____
_____
_____

_____ No. Date of retirement: _____/_____/_____ (MM/DD/YY)

2. Is your spouse currently employed?

_____ Yes

Name and address of spouse's employer?

_____

_____
_____
_____

_____ No. Date of retirement: _____/_____/_____ (MM/DD/YY)

IF THE PATIENT ANSWERED NO TO BOTH QUESTIONS 1 AND 2. MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED **YES** TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on your own, or a spouse's, current employment?

_____ Yes

_____ No STOP: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR PART II.

4. Does the employer that sponsors your GHP employ 20 or more employees?

_____ Yes STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

_____
_____
_____
_____

Policy Identification Number _____

Group Identification Number _____

Name of Policy Holder _____

Relationship to patient _____

_____ No STOP: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR PART II.

PART V – Disability

1. Are you currently employed?

_____ Yes

Name and address of your employer:

_____
_____
_____
_____

_____ No Date of retirement: ___/___/___ (MM/DD/YY)

2. Is a family member currently employed?

_____ Yes

Name and address of their employer:

_____
_____
_____
_____

_____ No

IF THE ANSWER TO QUESTIONS 1 AND 2 IS NO.MEDICARE IS PRIMARY UNLESS THE PATIENT ANSWERED **YES** TO QUESTIONS IN PART I OR PART II. DO NOT PROCEED ANY FURTHER.

3. Do you have Group Health Plan (GHP) coverage based on your own, or a spouse's, current employment?

_____ Yes

_____ No STOP: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR PART II.

4. Does the employer that sponsors your GHP employ 100 or more employees?

_____ Yes STOP. GROUP HEALTH PLAN IS PRIMARY. OBTAIN THE FOLLOWING INFORMATION:

Name and address of GHP:

_____

_____

_____

_____

Policy Identification Number _____

Group Identification Number _____

Name of Policy Holder _____

Relationship to patient _____

_____ No STOP: MEDICARE IS PRIMARY PAYER UNLESS THE PATIENT ANSWERED YES TO THE QUESTIONS IN PART I OR PART II.

PART VI – ESRD

1. Do you have group health plan (GHP) coverage

_____ Yes

Name and address of GHP:

_____

_____

_____

_____

Policy Identification Number _____

Group Identification Number _____

Name of Policy Holder _____

Relationship to patient _____

Name and address of employer, if any, from which you receive GHP coverage:

_____

_____

_____

_____

_____ No STOP: MEDICARE IS PRIMARY

2. Have you received a kidney transplant?

_____ Yes Date of transplant: _____/_____/_____ (MM/DD/YY)

_____ No

3. Have you received maintenance dialysis treatment?

_____ Yes Date dialysis began: _____/_____/_____ (MM/DD/YY)

If you participated in a self dialysis training program, provide date training started: _____/_____/_____ (MM/DD/YY)

_____ No

4. Are you within the 30 month coordination period?
_____ Yes
_____ No STOP. MEDICARE IS PRIMARY

5. Are you entitled to Medicare on the basis of either ESRD or age of ESRD and disability?
_____ Yes
_____ No STOP. GHP IS PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?
_____ Yes STOP. GHP CONTINUE S 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 (i.e. is the GHP primary based on age or disability entitlement)?
_____ Yes STOP. GHP CONTINUE S TO PAY PRIMARY DURING THE 30 MONTH COORDINATION PERIOD.
_____ No MEDICARE CONTINOUS TO PAY PRIMARY.

FAILURE TO OBTAIN THE INFORMATION LISTED IN THESE SECTIONS IS A VIOLATION OF YOUR PROVIDER AGREEMENT WITH MEDICARE. (SEE SECTION 142.3F). THE INFORMATION YOU MUST OBTAIN IS ESSENTIAL TO FILING A PROPER CLAIM WITH MEDICARE OR A PRIMARY PAYER. FAILURE TO FILE A PROPER CLAIM CAN RESULT IN THE UNNECESSARY DENIAL OR DEVELOPMENT OF CLAIMS.

_____ _____
Signature of Patient/Responsible Party Date

HIC #/Policy/Group # _____

Acknowledgement of Receipt of Notice

I have been given a copy of the Notice of Privacy Practices that describes how my health information may be used and disclosed and how I can get access to my health information. I understand the Notice may be changed at any time as permitted by applicable law. I may obtain a current copy of the Notice by contacting the Clinic or by visiting its website at www.legacyrehabilitation.com

_____ _____

Signature of Patient or Legal Representative Date

If signed by legal representative, relationship to patient: _____