WELCOME TO THE HUMAN PERFORMANCE AND REHABILITATION CENTERS, INC.

Welcome to Human Performance and Rehabilitation Centers, Inc. The following information will give you a better understanding of our payment, insurance filing and information policies:

PAYMENT POLICY: Payment is requested at the time of service unless other arrangements are made prior to treatment. We accept cash, check, MasterCard, Visa or American Express and most Health savings and Flexible Spending Accounts.

INSURANCE: HPRC will file your primary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance. You are responsible for payment of that balance. If your insurance does not pay, you should contact the insurance company. This office will not negotiate the settlement of a disputed insurance claim.

MANAGED CARE CONTRACTS: HPRC is enrolled in numerous managed care and participating provider insurance programs. Please advise our staff if you are a member of this type program. All co-pays or estimated patient balances are due at time of service. Our participation is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim.

MEDICARE: The therapists at HPRC are participating Medicare providers. We will file your Medicare and one supplement if you provide us with the appropriate insurance information. You will receive a statement each month until your account is paid out. Pay only amounts in patient responsibility on your statement. Medicare will pay 80% of covered services after your deductible is met. You are responsible for your deductible and 20% of covered charges if your supplement does not pay timely. Medicare requires that you see your physician at least every 90 days while you are receiving therapy.

WORKERS' COMPENSATION: Please provide HPRC with the proper information required to verify coverage. Except for acute cases, treatment will not begin until we have authorization from your workers' compensation carrier.

NON-COVERED SERVICES: Some or all of the services provided to you may not be covered by your insurance. You will be responsible for payment of these services.

INFORMATION DISCLOSURE: Federal and state law allows us to use and disclose information about you for purposes of treatment, billing and receiving payment, and routine heal care operations. In order to use or disclose information about you for any other purpose, we need your specific authorization. The "Notice of Privacy Practices" posted in our lobby explains how we use and disclose information. If you request, we will provide you with a copy of the Notice of Privacy Practices.

LEGAL CASES: We cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered.

IF YOU HAVE ANY QUESTIONS, SOMEONE FROM OUR BUSINESS OFFICE WILL BE GLAD TO ASSIST YOU.

CONSENT FOR TREATMENT & AUTHORIZATION: I do hereby consent to treatment by Human Performance and Rehabilitation Centers, Inc. I authorize HPRC to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to Human Performance and Rehabilitation Centers, Inc. when indicated on claim. I understand that I am financially responsible for the charges for services rendered.

Signed _____ Date _____

Relationship to Patient: _____

Witnessed By: _____

PATIENT INFORMATION SHEET

Referring Doctor _____ Primary Care Provider _____
What part of the body are we treating? _____

Personal Information

First Name _____ Middle Initial _____ Last _____ Nickname _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
SSN _____ - _____ - _____ DOB ___ / ___ / ___ Gender M___ F___ Marital Status Married ___ Single ____
Height __ foot, __ inches Weight _____ Are you disabled? Y__ N __ If yes, what is your disability _____

Employer _____ Occupation _____ Phone (____) _____
Emergency Contact _____ Relationship _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____

Can we communicate with you by Email? Yes / No Email address _____ (optional)

Insurance Information

Primary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB __ / __ / _____ Policy Holder's SSN _____ - _____ - _____
Policy Holder's Address (if different): _____

Secondary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB __ / __ / _____ Policy Holder's SSN _____ - _____ - _____
Policy Holder's Address (if different): _____

***If this is an approved claim through Worker's Compensation, please answer the following*:**
Injury Date _____ Employer when injury occurred (if different) _____
Insurance Carrier Name _____ Contact/Adjuster _____
Claim Number _____ Adjuster's Phone (____) _____

***Please complete this section if the patient is a Minor and/or covered under parent's insurance*:**
Mother's Name _____ Phone (____) _____ SSN __ __ __ - __ __ - __ __ __ __
Address (if different) _____Employer _____
Father's Name _____ Phone (____) _____ SSN __ __ __ - __ __ - __ __ __ __
Address (if different) _____ Employer _____

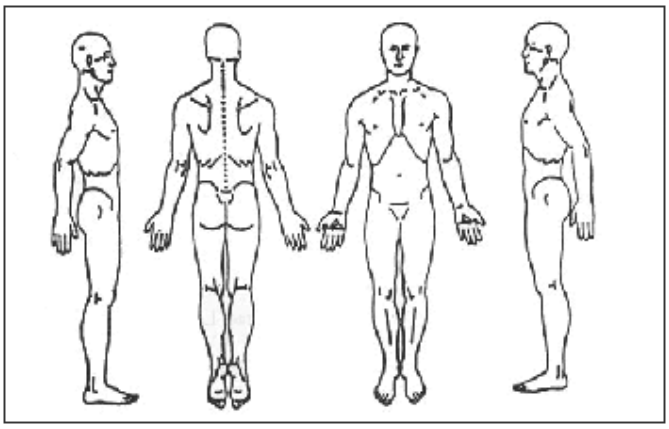
Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.

Signature: _____ Date: _____

Name:	Date:	Gender:	DOB:

CURRENT INJURY: _____

Please mark below where your pain is located



Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

Date started?
Describe the onset and history of current condition _____ _____
Occupation?
□ Full Time □ Retired □ Not employed □ Part Time □ Disabled □ Modified □ Full or Part Time Student

Over the past 6 months, have you been diagnosed with or are you currently experiencing any of the following symptoms?

□ Osteoporosis	□ High cholesterol	□ Difficulty emptying bladder
□ Osteoarthritis	□ High blood pressure	□ Kidney stones
□ Rheumatoid arthritis	□ Asthma	□ Painful intercourse
□ Dizziness	□ COPD/ Emphysema	□ Sexually transmitted disease
□ Clumsiness or staggering	□ Palpitations	□ Numbness
□ Double vision	□ Heart disease	□ Taste or smell change
□ Falls to the ground	□ Heart attack	□ Skin turning yellow color
□ Fatigue	□ Wheezing/ Coughing	□ Rash/Itching or scaly patches
□ Difficulty speaking	□ Difficulty swallowing	□ Hair or nail changes
□ Fever or chills	□ Abdominal pain or fullness	□ Swelling in the arms or legs
□ Night pain or sweats	□ Constipation	□ Liver or gallbladder Issues
□ Muscle cramps	□ Heartburn	□ Thyroid problems
□ Blood clots	□ Vomiting/ Nausea	□ TB □ Current □ Past
□ Diabetes	□ Appetite or weight change	□ Allergies
□ Open sores or wounds	□ Change in bowel habits	**Females:**
□ Dark red/purplish legs	□ Blood in stool or urine	□ Currently Pregnant
□ Fibromyalgia	□ Incontinence	□ Regular Menstrual Cycle
□ Anxiety □ Depression	□ Low urine output	□ Menopausal Symptoms
□ Abuse □ Neglect	□ Urinary infection	□

Have you had any of the following procedures?

□ Bypass Surgery	□ Pacemaker	□ Joint Replacement
□ Cardiac Ablation	□ Stent Placement	□ Metal Implants

Mental Health Background:
*Over the last 2 weeks, have you had thoughts that you would be better off dead? □ Yes □ No

IF NO to the above question, no need to answer 1&2 below. **IF YES** please answer 1&2 below questions:
1. Have you wished you were dead or wished you could go to sleep and not wake up? □Yes □No
2. Have you actually had any thoughts of killing yourself? □Yes □No

Please list your current medications, vitamins or supplements. *(If your medications are written down, please allow us to scan into your chart)* ***Please specify blood thinners and NSAID's***

_____

_____

_____

Please list any major surgeries (past 5 years) ***or pertinent to current condition***

_____

_____

Please list any diagnostic tests you've had performed ***specific to current condition***

□ Biopsy
□ Blood work/Lab Tests
□ Bone Density Scan
□ CT Scan
□ EEG
□ EMG
□ Lower GI Study
□ Motility Study
□ MRI
□ Nerve Conduction Study
□ Swallow Study
□ Upper Endoscopy
□ Ultrasound
□ X-Ray
□ Other

Living Situation

□ Single Story Home
□ 2 Story Home
□ Ground Floor Apartment
□ Upper Level Apartment
□ Assisted Living Facility
□ Skilled Nursing Facility
□ Yes □ No Are there stairs at home?
□ Yes □ No Is there a handrail present?
□ Other situation

Who do you live with?

□ Spouse
□ Spouse + Children
□ Child(ren)
□ Other Family Member
□ Alone
□ Other
□ Yes □ No Are others available to help if needed?

What is your primary role at home?

□ Caregiver for others
□ Financial Provider
□ Housework
□ Home Maintenance
□ Yard Maintenance
□ Other
□ Yes □ No Is the patient currently able to perform these roles?

Social Habits:

Smoker/Tobacco Products?	Current/Past Usage per Day?	Year stopped?
Coffee? Y / N Drinks/week?	Alcohol? Y / N Drinks/week?	Soft Drinks? Y / N Drinks/week?
Current or Prior Exercise Program?		Frequency/Duration?

ACKNOWLEDGEMENT OF NOTICE OF INFORMATION PRACTICES

(To be retained by Medical Provider)

I understand that Human Performance and Rehabilitation Centers, Inc. (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing treatment.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written **Notice of Privacy Practices** that describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will be provided with a copy of the Notice of Privacy Practices upon request.

By:_____ Date:_____

(Patient)

-OR-

By:_____ Date:_____

(Patient's Representative)

Description of Representative's Authority:_____

HUMAN PERFORMANCE AND REHABILITATION CENTERS, INC.

MEDICARE PRIMARY PAYER QUESTIONNAIRE

Medicare requires that we ask the following questions of our patients to determine whether Medicare is the primary or secondary payer under Medicare Regulation 42 CFR 489.20(F).

Part I

Has the Department of Veterans Affairs authorized and agreed to pay for these services? ___ YES ___ NO
Is the patient being treated for a work related injury / illness? ___ YES ___ NO
Is the patient being treated for a non-work related injury / illness? ___ YES ___ NO
If yes: Type of accident: ___ Auto, ___ Residential, _____Other
Date of accident: _____ , Name of insured: _____
Insurance co. name: _____ , Claim #: _____
If the answer to any of the above questions is YES, then an entity other than Medicare will be the primary payer for this visit. If the answer to any of the above questions is NO, continue to Part II below.

Part II

Is the patient currently employed? ___ YES ___ NO
If retired, enter the patient's retirement date: ___ /___ / ___
Is patient covered under any group health insurance plan? ___ YES ___ NO
If yes, under whose plan is the patient covered: ___ Self, ___ Spouse, ___ Other
Name of Insured: _____
Insurance Carrier: _____ , Policy Number: _____

Is the patient undergoing kidney dialysis (ESRD)? ___ YES ___ NO
If yes, have dialysis treatments been for more than 30 months? ___ YES ___ NO

Is the patient covered by any other health insurance that will pay for therapy before Medicare? ___ YES ___ NO

Accurately answering the above questions will assist Human Performance and Rehabilitation Centers, Inc. in determining whether Medicare is the primary or secondary payer for charges you incur.

If Medicare is primary, I understand that I am responsible for my deductable and 20% coinsurance.

If Medicare is secondary, I understand that Human Performance and Rehabilitation Centers, Inc. must bill the primary payment source before they bill Medicare, and that I will be responsible for any remaining balance. .

_____ _____
Patient's Signature OR Patient Representative Date

Description of Representative's Authority: _____ (Que HP rev. 1/18)

HUMAN PERFORMANCE AND REHABILITATION CENTERS, INC.

MEDICARE PART B BENEFICIARY NOTICE OF THERAPY LIMITS

Medicare imposes an annual financial limit of $2,040 per beneficiary for outpatient therapy services. We must certify that therapy exceeding the financial limit is medically necessary. The financial limit affects therapy services provided in all Part B practice settings. The $2,040 limit is based on incurred expenses and includes applicable Part B Deductible ($185) and 20% Coinsurance. There are two separate limits per beneficiary – combined physical therapy and speech therapy limit ($2,040) and occupational therapy limit ($2,040). Patients may not be simultaneously covered by Medicare in an outpatient hospital setting and as a patient in another facility.

The purpose of this notice is to help you make an informed decision about receiving therapy services knowing you may be responsible to pay for these services yourself. To help us better serve you at our facility regarding the cap, please take a moment and answer the following questions:

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1. Have you received physical, speech, or occupational therapy from a home health agency or other outpatient therapy provider during the past year?
   _____No _____Yes
   If yes, please list name, address, and/or telephone number of the facility:
   _____
   Discharge Date: _____

2. Are you currently receiving any type of service from a home health agency?
   _____No _____Yes
   If yes, please list name, address, and/or telephone number of the facility:
   _____

3. Are you currently receiving any therapy services in an outpatient hospital department?
   _____No _____Yes
   If yes, please list name, address, and/or telephone number of the agency:
   _____

4. Have you recently been in a Skilled Nursing Facility (SNF)?
   _____No _____Yes
   If yes, please list name, address, and/or telephone number of the facility:
   _____
   Discharge Date: _____

By answering the above questions, I give the Human Performance and Rehabilitation Centers, Inc. permission to speak with the above service providers regarding my annual financial limitation for billing purposes.

If applicable, I understand that insurance which is secondary to Medicare will generally follow Medicare's determination.

_____ _____
Patient's Signature OR Patient Representative Date

Description of Representative's Authority _____

_____ _____
Witness / HPRC Representative Date (MC Ben rev. 1/19)