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 ____
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: _____

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 and insurance filing policies:

PAYMENT POLICY: Payment is requested at the time of service unless other arrangements are made prior to testing. 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: We are a participating Medicare provider. 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.

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.

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.

Signed _____ Date _____

Relationship to Patient: _____

Witnessed By: _____

(Wel EMG, Rev. 1/18)

Consent for Electrophysiologic Testing

Testing Company: Human Performance and Rehabilitation Centers, Inc. ("HPRC")

Consent to Diagnostic Testing: I authorize HPRC and interpreting physician(s), collectively the "Parties", to provide me with the necessary electrophysiological testing as requested by my physician(s). This consent and authorization includes electrophysiologic tests, including but not limited to the following:

- Nerve conduction studies: A small electrical stimuli will be delivered to specific locations of the body to evaluate the functioning of specific nerves. The stimulations are isolated and controlled to one specific area of the body.
- Electromyography: A small, sterile, single-use needle electrode will be placed in various muscles to evaluate muscle and nerve function. You may develop a small bruise or bump under the skin (hematoma) in some of the areas tested. No other complications are anticipated as a result of this test.

These tests may be mildly to moderately uncomfortable. We request your patience and tolerance for this testing. Any questions you might have as to the testing can be addressed to the technical personnel or the physician(s).

Independent Contractors: HPRC may utilize independent contractors in performing said services as noted above. Independent contractors may include, but are not limited to interpreting physicians and monitoring technicians. I understand that HPRC shall not be liable for the acts or omissions of independent contractors. This Consent to Treatment also applies to any independent contractor utilized by HPRC

Assignment of Benefits: In consideration of medical services provided to me, I hereby promise to pay for those services in accordance with the rates and terms now in effect. I hereby assign to and authorize the Parties to collect any and all benefits and all interest and rights (including causes of action and the right to enforce payment, and appeal insurance denials) for services rendered under any insurance policy. I further authorize my insurance benefits to be paid directly to HPRC and/or interpreting physician(s) when indicated on claim(s). I understand that I am financially responsible for the charges for services rendered.

Assignment of Rights: I hereby assign to the Parties, to the extent allowed by law, the right to collect the unpaid insurance benefits, penalties, attorney's fees, court cost and all other recoverable damages of any nature from medical insurance companies that provided coverage on the date listed herein. This assignment includes the right to sue the undersigned's medical insurance company in the undersigned's/insured's name and assert all claims that the undersigned/insured will have against the insurance company resulting from, or in any way pertaining to, the medical coverage that the undersigned is alleged to have had with his/her insurance company in regard to medical procedures performed on this date signed below. Additionally, the undersigned agrees to cooperate with and authorize the Parties in providing documents and testimony concerning the rights assigned herein.

Authorization of Release of Information and Assignment of Third Party Payments: I understand that the Parties 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 Parties, 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 Parties are permitted to use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- 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 Parties ability to provide me with appropriate care and arrange for payment.

I hereby expressly authorize HPRC and all healthcare professionals providing care to release all necessary information to any insurance company, health plan or other entity (third party payor) which may be responsible for paying for my care. I authorize and direct all payors to pay all benefits due for such care directly to HPRC and all professionals (including independent contractors) providing for such care and I hereby assign such sums to them. I understand this authorization and assignment shall remain valid unless I provide written notice of revocation to HPRC and the third party payor signed and dated by me; however, such revocation shall not be effective as to information released and/or charges incurred prior to such revocation.

No Guarantee of Results: HPRC cannot guarantee any specific result(s) of any examination, treatment, procedure or medical care. I release HPRC, its officers and employees from any liability for any accident or injury that is not directly caused by the negligence of HPRC or its employees.

The undersigned certifies that he/she has read and understands the foregoing, and is either the patient, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

_____
Patient Name (Printed Name)

_____
Patient or Representative's Signature

_____
Description of Representative's Authority

_____
Date

EMG 06/2015

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)