



WELCOME TO THE HUMAN PERFORMANCE AND REHABILITATION CENTERS, INC. d/b/a

MEDICAL AND HEALTH RESOURCES

Welcome to Human Performance and Rehabilitation Centers, Inc. d/b/a Medical and Health Resources (MHR). 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 treatment. We accept cash, check, MasterCard, Visa or American Express and most Health savings and Flexible Spending Accounts.

INSURANCE: MHR 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: MHR 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 MHR 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 the amount 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 MHR 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 health 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. This Notice is also posted on our web site at www.hprc.net. 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 for treatment at The Human Performance and Rehabilitation Centers, Inc. d/b/a Medical and Health Resources. I authorize MHR 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 Medical and Health Resources when indicated on the claim. I understand that I am financially responsible for the charges for services rendered.

Signed _____ Date _____

Relationship to Patient: _____

Witnessed By: _____



medical and health resources

PATIENT INFORMATION

DATE: _____

REFERRING PHYSICIAN: _____

Email: _____

PATIENT'S FULL NAME		HOME TELEPHONE (if none, give neighbor) () -	
PATIENT'S HOME ADDRESS (Street/Apt. No.)		City	State Zip
DATE OF BIRTH	AGE	FEMALE <input type="checkbox"/>	MALE <input type="checkbox"/>
PATIENT'S EMPLOYER (If student, give school)		PATIENT'S SOCIAL SECURITY NUMBER	
EMPLOYER'S ADDRESS		City	State Zip TELEPHONE NUMBER
SPOUSE'S NAME		SPOUSE'S EMPLOYER	
CONTACT IN EMERGENCY (not living with you)			
NAME		RELATIONSHIP	TELEPHONE NUMBER
ADDRESS		City	State Zip
COMPLETE THIS PORTION IF PATIENT IS MINOR AND/OR STUDENT			
FATHER'S NAME (or Guardian)		MOTHER'S NAME	
EMPLOYER	PHONE	EMPLOYER	PHONE
WORKER'S COMPENSATION INFORMATION			
Were you hurt on the job? ___ Yes ___ No Date of injury: _____ (If yes, complete the following information)			
CONTACT PERSON TO VERIFY COVERAGE		TELEPHONE NUMBER	
EMPLOYER AT TIME OF INJURY		TELEPHONE NUMBER	
ADDRESS			
PRIMARY INSURANCE INFORMATION: (List only one)			
MEDICARE: Do you have Medicare? ___ Yes ___ No MEDICARE # _____			
INSURANCE: Group or Individual Insurance Information			
Insurance Company: _____		ID# _____	
Mail Claim to: _____			
Insured: _____ Self, if other, insured's name: _____		DOB _____	
Please review our payment policy. Our staff will be happy to answer any question you may have concerning payment for services received.			



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: _____
(Patient)

Date: _____

-OR-

By: _____
(Patient’s Representative)

Date: _____

Description of Representative’s Authority: _____