medical and health resources, Inc.

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 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. 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 ☐	MALE ☐	PATIENT'S SOCIAL SECURITY NUMBER
PATIENT'S EMPLOYER (If student, give school)				TYPE OF WORK
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.

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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. d/b/a

MEDICAL AND HEALTH RESOURCES

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 us 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: _____

(Ques MHR, Rev. 10/16)