343 E Okmulgee Street
Muskogee, OK 74403

Phone: (918) 310-2212
Fax: (918) 513-5808
E-mail: www.okrehabandwellness.com

Patient Information

Client Name: _____ Age: _____ DOB: _____
First Middle Last mm/dd/yy

Street Address:
_____

City:_____ State:_____ Zip Code:_____ Phone: (___)_____
☐ Cell ☐ Work ☐Home
E-mail: _____ Social Security #: _____

Spouse's Name: _____ Phone: (___)_____
First Last ☐ Cell ☐ Work ☐Home

Age: _____ Date of Birth: _____ Occupation: _____

Emergency Contact: _____ Phone: (___)_____
First Last ☐ Cell ☐ Work ☐ Home

Referral Source: _____ Phone: (___)_____

Main Concerns:

_____

_____

Medical History	
Check if yourself or family history is present for the following:	Member(s) with diagnosis
☐ Heart Defects/Disease	
☐ Autoimmune Disorders	
☐ Diabetes	
☐ Sensory Processing Disorder	
☐ Anxiety or Compulsive Disorders	
☐ Mood disorders (Bipolar, depression, etc.)	
☐ Learning disability or developmental delay	
☐ Traumatic Brain Injury	
☐ Cardiopulmonary Disease (COPD, Emphysema, etc.)	
☐ Drug/Alcohol Dependency	

List any formal diagnoses, person(s) who provided diagnoses, and date received: _____

_____

List all surgeries or medical procedures and dates performed: _____

_____

List all current medications (or attach): _____

_____

List all known allergies (medicinal, food, and otherwise) and reaction: _____

Service History		
Client has received the following:	Where/Whom	When
☐ Psychological testing		
☐ Occupational Therapy		
☐ Physical Therapy		
☐ Behavioral Health or Counseling		
Audiological (Hearing) Testing ☐Normal ☐Other: _____		
Vision Testing ☐Normal ☐Needs Correction		
☐Allergen Testing		

Person filling out form: _____ **Relation to Patient:** _____
First Last

Signature: _____ **Date:** _____

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Authorization and Consent for Treatment, Payment, and Operations

Please initial the following true statements:

_____ I have a prescription from my physician to authorize an initial evaluation.

_____ I have checked with my insurance company prior to this therapy visit and assert that I have obtained the necessary information regarding limits of coverage, co-pays, and co-insurance.

_____I hereby give 40:31 Rehab & Wellness permission to evaluate and provide treatments to me, and I understand there will be written, oral, and electronic communication between care providers/physicians, insurance companies, and 40:31 Rehab & Wellness staff. I understand that state representatives for the purpose of insurance certification or licensing and quality assurance may review my records. I understand that all practices of confidentiality will be followed in use of the information gathered.

_____ I give 40:31 Rehab & Wellness, PLLC permission to submit bills directly to the insurance carrier.

_____ I have read and agree to follow 40:31 Rehab & Wellness office and financial policies.

_____
Printed Name of Client or Guardian

_____ _____
Signature of Client or Guardian Date

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Consent for Release of Information

Client Name:_____ Date of Birth: _____

I hereby give authorization to 40:31 Rehab & Wellness, PLLC to release or receive information regarding occupational therapy needs and services for me from the following:

Physician: _____

Hospital: _____

Therapist: _____

Specialist_____

Other: _____

_____

Printed Name of Client or Guardian

_____ _____

Signature of Client or Guardian Date

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PATIENT AGREEMENT

40:31 Rehab & Wellness, PLLC offers Occupational Therapy services for patients referred to our practice. We are a licensed provider who develops individualized treatment plans to identify the services that will best suit your therapy needs. We will also work with your primary care practitioner to coordinate your care. Following the initial assessment visit(s), we develop a specific plan of care (POC) for review and approval by your child's referring provider. Once your referring provider signs the POC, we can begin working with you or your family to improve your condition. We are pleased to serve your Occupational Therapy needs and encourage your feedback to alert us to anything we can do to provide you the highest quality of care. We require certain information from each patient in order to begin providing this care. The attached forms need to be completed in order for us to begin serving you as our patient. Please do your best to complete all the information. If certain information does not apply to you, please indicate that by noting "N/A" ("Not Applicable") so that we know that you did not overlook anything. Each healthcare insurance payor has different guidelines for allowing coverage of Occupational and Physical Therapy services. Therefore, it is helpful if you let us know your healthcare payor when starting service so that we may find out if prior authorizations are necessary.

OKLAHOMA MEDICAID RECIPIENTS: Oklahoma Medicaid requires that a physician, physician assistant, or advanced nurse practitioner refer you to our practice before we can perform an initial assessment of you. After we have completed your initial assessment, we develop an individualized POC to meet your specific therapy goals. Your primary care practitioner will need to review and approve your POC, and then return it to our practice before we can begin treatment.

MEDICAID & PRIVATE INSURANCE CO-PAYMENTS, DEDUCTIBLES, AND NON-COVERED SERVICE

Private insurance companies may have limits on the amount of Occupational and Physical Therapy services covered. Once you have exceeded the financial limit of your benefits and you do not have additional healthcare coverage, you are responsible for the payment of your services. Additionally, private healthcare insurance payors have deductibles and co-payments for occupational therapy services that are the responsibility of the patient (or caregiver). While this

practice will not discontinue your services for financial hardships, it is expected that patients pay at the time of service and/or set up payment arrangements. All payment arrangements are made at the discrepancy of an authorized representative of 40:31 Rehab & Wellness, PLLC. and must be signed by both parties to be considered a valid payment arrangement.

COLLECTION OF PAST DUE ACCOUNTS

We communicate with our patients and/or guardians to resolve past due accounts in all cases. If we cannot reach a patient's or their guardian by phone following the return of undeliverable mail, or if a patient payment agreement cannot be made or paid as agreed, we are forced to use the services of a professional collection agency. Once an account is placed with a collection agency, we cannot take the account back. Please let us know when or if your patient contact information changes so that we can always reach you, if needed, to discuss past due accounts.

FINANCIAL AGREEMENT

New patients approved for Occupational and/or Physical Therapy services are responsible for any and all charges not paid for by healthcare insurance payors (Medicaid, private health insurance carriers, etc.). By signing this patient agreement, you are acknowledging that you understand this condition of service and commit to promptly paying 40:31 Rehab and Wellness, PLLC. for the services we provide to you, our valued customer. Following the receipt of your monthly patient statement, please contact our practice to make payment arrangements. We accept cash, personal checks, money orders, and credit cards (VISA, MasterCard, and Discover Card). We also are willing to make reasonable payment arrangements to keep your account current.

QUALITY ASSURANCE & COMPLAINT RESOLUTION

Should you or your caregiver experience a situation that requires the attention and resolution of a Supervisor and/or Manager, please contact our practice either in writing or by phone at (918) 310-2212. A member of our management team will collaborate with you to reach a resolution of any identified situation where our quality of service has been compromised. We use such situations to alert us to improvements we can make to better serve all our patients.

PATIENT STATEMENT OF AGREEMENT

My signature below signifies that I have read and understand this patient agreement for 40:31 Rehab & Wellness, PLLC to provide me Occupational Therapy services. I agree to the terms in this patient agreement and intend to comply with them to the best of my ability. I understand that if I fail to follow the terms of this agreement, I could be discharged from service.

_____ _____

Signature of Patient or Guardian **Date**

FINANCIAL POLICY

Welcome to our office! We are committed to providing you with the best possible care. If you have medical insurance, we are willing to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy. Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, MasterCard, and Discover Card. Please understand that you are financially responsible for all charges, whether or not they are paid by insurance. Please read carefully:

1. Your insurance is a contract between you, your employer, and/or your insurance company. We are not a party to that contract. As a courtesy to our patients, we will bill insurance carriers; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

2. Should your insurance coverage change, our office should be notified in writing within 30 days of the effective date and the card or stickers should be available for copying. If you fail to provide us this information, your account and all future balances will be your responsibility. We will no longer bill insurance and you will be responsible for submitting claims to your insurance. Payment will also be due at the time of service in full.

3. Our fees are generally considered to fall within the acceptable range by most insurance carriers and therefore are covered up to the maximum allowance determined by each carrier. This applies to the companies who pay a percentage (such as 50% or 80%) of the usual, customary, and reasonable rate (UCR). This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.

4. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. Please note insurance companies may indicate the services were not medically necessary and claim that, because 40:31 Rehab & Wellness, PLLC is not a preferred provider, you do not have to pay the balance. This is NOT the case and you will be billed for the services. This office cannot accept responsibility for negotiating settlements on disputed claims.

5. Any returned checks will be subject to a NSF fee of $25.00 which will be due at the next visit.

6. Accounts that are past due will incur a finance charge at the rate of 10.5% annually. Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact our billing department promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

By signing below you are stating that you hereby understand the above financial policy and agree to abide by it.

_____ _____

Signature of Patient or Guardian **Date**

CANCELLATION POLICY

Our clinic strives to provide the best therapy services possible. In order to ensure optimal use of valuable therapy time, please discuss schedule changes at the end of your appointment with your therapist and the front desk administrator. We understand occasional changes are necessary due to illness, vacations, etc. Please call our office within 24 hours of a scheduled appointment if you need to cancel or reschedule that appointment. This allows for clients to reschedule into additional openings therapists may have. For Monday morning appointments, our office appreciates being notified no later than Friday noontime. This will allow other patients in need of care to be accommodated, as we have many patients. It is both unfair to the other patients and your child's therapist to not allow for others to schedule in the open time slots.

Please initial the following true statements:
_____ I understand it is my responsibility to communicate to the front desk. Any schedule changes or appointment cancellations.

_____ I understand that if a session is delayed for more than 15 minutes due to late arrival of the client, the caregiver/guardian will be charged a $10.00 late fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the patient/guardian.

_____ If a therapy session is not cancelled prior to an appointment time or is missed without any notice, this missed appointment is counted as a no-show which will result in a charge of a $50.00 no-show fee. **Note: Insurance companies DO NOT reimburse for late fees; this is the responsibility of the patient/guardian.

_____ Two consecutive no-shows may require your child to be placed on a hold status until the issue of missed appointments is resolved. If a resolution is not made within 5 business days, your child will lose his/her therapy time and be placed on our information list.

____ We require an 80% attendance rate and may need to remove the patient from the therapist's schedule if efforts are not made to maintain this rate. Note: We track visit frequently and, as a courtesy, will notify you if your percentage drops below the required 80%.

_____ We are happy to work out scheduling problems with you. Please let us know if you are experiencing a problem with your current schedule. If therapy needs to be canceled for a couple of weeks, (such as for an extended trip), we will hold your therapy spot for up to three weeks. We will then place you on the information list and will fit you back in the schedule as soon as we can.

I hereby understand the above cancellation policy and agree to abide by it.

_____ _____

Signature of Patient and/or Guardian **Date**

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Release of Photographs and/or Videos

I, _____ give 40:31 Rehab & Wellness, PLLC permission to photograph and/or record me, _____ to release for use in research, to show progression of his/her skills, or for educational purposes. Additional confirmation/permission will be attained if photographs are to be used for promotional purposes.

_____ _____

Signature of Parent/Guardian Date

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Privacy Notice

As required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION. PLEASE REVIEW THIS DOCUMENT CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

40:31 Rehab & Wellness, PLLC is dedicated to maintaining the privacy of individually identifiable health information as protected by law, including the Health Insurance Portability and Accountability Act (HIPAA). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. This information is referred to as 'protected health information' or PHI. We are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our organization concerning your PHI. By federal and state law, we must follow the terms of the Notice of Privacy Practices that we have in effect at the time.

This notice contains the following required information:

- How we may use and disclose your PHI
- Your Privacy Rights within your PHI
- Our obligations concerning the use and disclosure of your PHI

The terms of this notice apply to all records containing your PHI that are created or retained by our organization. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our organization has created or maintained in the past, and for any records that we may create or maintain in the future. Our organization will have a copy of our current Privacy Notice posted in our office(s) in a visible location at all times. You may request a copy of our most current Notice at any time.

B. WE MAY USE AND DISCOLSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

The following categories describe the various ways in which we may use and disclose your PHI:

1. **Treatment**. Our organization may use your PHI to provide you with medical treatment. For example, we may ask you to have evaluations and we may use the results to assist in development of an individualized Plan of Care. Many of the employees within our organization, including, but not limited to, therapists, therapy assistants, case managers, educators, consultants, and administrative staff may use or disclose your PHI in order to provide competent medical treatment or to assist others in providing you with medical treatment. Additionally, we may also disclose your PHI to your primary care physician or other outside healthcare providers for purposes related to your treatment. Finally, we may disclose your PHI to family members or other who may assist in your care.

2. **Payment**. Our organization may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from our organization. We may contact your health insurer, including, but not limited to private, state, and/or federal organizations and providers, to certify your eligibility for benefits and to provide you with a detailed explanation of your benefits. We may also provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. You PHI may also be disclosed in order to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your PHI to bill you directly for your services and/or items received from our organization. Lastly, your PHI may be disclosed to Medicaid and other payers or providers to coordinate and assist their billing efforts.

3. **Health Care Operations**. Our organization may use and disclose your PHI to operate our business more efficiently. Your PHI may be used and disclosed in order to evaluate the quality of care provided to you, to conduct cost-management and business planning activities within our organization, and to assist other health providers and entities in their healthcare operations.

4. **Appointment Reminders**. Our organization may use and disclose your PHI to contact you and remind you of an appointment. This correspondence may occur via telephone, email, or text message, but will remain in accordance to your requested mode of communication, as indicated in your initial intake form.

5. **Treatment Options**. Our organization may use and disclose your PHI to inform you of potential treatment options or alternatives.

6. **Health-Related Benefits and Services**. Our organization may use and disclose your PHI to inform you or health-related benefits or services that may be of interest to you.

7. **Release of Information to Family/Friends**. Our organization may release your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. This may include, but is not limited to, parents, guardians, or caregivers responsible for your care or payments of services provided by our organization.

8. **Disclosures Required by Law**. Our organization will use and disclose your PHI if and/or when we are required to do so by federal, state, and/or local law.

C. USE AND DISCLOSURE OF YOUR PERSONAL HEALTH INFORMATION (PHI) IN CERTAIN SPECIAL CIRCUMSTANCES.

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks**. Our organization may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of:
    1. Maintaining vital records, such as births and deaths
    2. Reporting child abuse or neglect
    3. Preventing or controlling disease, injury, or disability
    4. Notifying a person regarding potential exposure to a communicable disease
    5. Reporting reactions to drugs or problems with products or devices
    6. Notifying individuals if a product or device they may be using has been recalled
    7. Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult persona served. *We will only disclose this information if the person served agrees or we are required or authorized by law to disclose this information.*
2. **Health Oversight Activities.** Our organization may disclose your PHI to a health oversight agency for activities authorized by law. Oversight activities can include, but are not limited to, investigations, inspections, audits, surveys, licensure and disciplinary actions, civil, administrative, and criminal procedures or actions, or other activities necessary for the government to monitor government programs, compliance with civil rights and laws, and the health care system.

3. **Lawsuits and Similar Proceedings**. Our organization may use and disclose your PHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your PHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. **Law Enforcement**. We may release your PHI, if asked to do so by a law enforcement official:
    1. Regarding a crime victim in certain situations, *if we are unable to obtain the person's agreement.*
    2. Concerning a death we believe has resulted from criminal conduct
    3. Regarding criminal conduct at our offices
    4. In response to a warrant, summons, court order, subpoena, or similar legal process
    5. To identify or locate a suspect, material witness, fugitive, or missing person
    6. In an emergency, to report a crime (including the location or victim[s] of the crime, or the description, identify, or location of the perpetrator)

5. **Deceased Persons**. Our organization may release PHI to a medical examiner or coroner to identify cause of death. If necessary, we may also release information to allow funeral directors to perform their job duties.

6. **Research**. Our organization may use and disclose your PHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your PHI for research purposes, except when Internal or Review Board or Privacy Board has determined that the waiver of your authorization satisfies the following:

    1. The use or disclosure involves no more than a minimal risk to your privacy based on the following:
        - An adequate plan to protect the identifiers from improper use and disclosure
        - An adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law)
        - Adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study or for other research for which the use or disclosure would otherwise be permitted.
    2. The research could not practicably be conducted without the waiver
    3. The research could not practicably be conducted without access to and use of the PHI

7. **Serious Threats to Health and Safety**. Our organization may use and disclose your PHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of anther individual or the public. Under these circumstances, we may only make disclosures to a person or organization able to help prevent the threat.

8. **National Security**. Our organization may disclose your PHI to federal officials for intelligence and national security activities authorized by law.

9. **Worker's Compensation**. Our organization may release your PHI for worker's compensation and other similar programs.

D. YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION (PHI)

You have the following rights regarding your PHI that we maintain about you:

1. **Confidential Communications**. You have the right to request that our organization communicate with you about your health and related issues in a particular manner or at a certain location. To request a type of confidential communication, you must make a written request to the Program Director or Privacy Officer specifying the requested method of contact, or the locations where you wish to be contacted. Our organization will accommodate *reasonable* requests. You do not need to give a reason for your request.

2. **Requesting Restrictions**. You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your PHI to only certain individuals involved in your care of the payment for your care. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to provide you with medical treatment. To request a restriction in our use or disclosure of your PHI, you must make your request in writing to the Program Director or Privacy Officer. Your request must describe in a clear and concise fashion:
    - The information you wish restricted
    - Whether you are requesting to limit our organization's internal use, outside disclosure, or both
    - To who you want the limits to apply

3. **Inspection and Copies**. You have the right to inspect and obtain a copy of the PHI that may be used to make decisions about you, including medical and/or billing records, but not including psychotherapy notes. You must submit your request in writing to the Program Director or Privacy Officer for inspection and/or to obtain a copy of your PHI. Our organization may charge a fee for the costs of copying, mailing, labor, and supplies associated with your request. Our organizations may deny your request to inspect and/or copy in certain limited circumstances, however, you may request a review of our denial. Another licensed health care professional chosen by use will conduct reviews.

4. **Amendment**. You may ask us to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our organization. To request an amendment, your request must be made in writing and submitted to the Program Director or Privacy Officer. You must provide us with a reason that supports your request for amendment. Our organization will deny your request if you fail to submit your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion:
    - Accurate and complete
    - Not part of the PHI kept by or for the organization
    - Not part of the PHI which you would be permitted to inspect and copy
    - Not created by our organization, unless the individual or entity that created the information is not available to amend.

5. **Accounting and Disclosures**. All persons served by our organization have the right to request an "accounting of disclosures". An "accounting of disclosures" is a list of certain non-routine disclosures our organization has made of your PHI (e.g. for non-treatment, non-payment, or non-operative purposes). Use of your PHI as part of the routine care in our organization is not required to be documented. We are also not required to document disclosures pursuant to an authorization signed by you. To obtain an "accounting of disclosures", you must submit your request in writing to the Privacy Officer. All requests for an "accounting of disclosures" must state a time period, which may not be longer than six years from the date of disclosure and may not include dates before April 20, 2017. The first list you request within a twelve-month period is free of charge, but our organization may charge you for additional lists within the same twelve-month period. Our organization will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. **Right to a Paper Copy of This Notice**. You are entitled to receive a paper copy of our Notice of Privacy Practices. You may ask us to give you a copy of this notice at any time. To obtain a paper copy of this notice, contact any Program Director or the Privacy Officer.

7. **Right to File a Complaint**. If you believe your privacy rights have been violated, you may file a formal complaint with our organization or with the Secretary of the Department of Health and Human Services. To file a complaint within our organization, contact the Program Director or Privacy Officer. We urge you to file your complaint with us first and give us the opportunity to address your concerns. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

8. **Right to Provide an Authorization for Other Uses and Disclosures.** Our organization will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorizations you provide to us regarding the use and disclosure of your PHI may be revoked at any time *in writing*. After you revoke your authorization, we will no longer use or disclose your PHI for the reasons described in the authorization. Please note, however, that we are required to retain records of your healthcare.

I have reviewed and received a copy of the above Privacy Notice from 40:31 Rehab & Wellness, PLLC and understand the contents within.

_____	_____
Printed Name	**Relationship to Patient**
_____	_____
Signature	**Date**