LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

PATIENT INFORMATION

Welcome! We would like to thank you for entrusting your care and rehabilitation to the Team at ***LifeCare of Florida.*** Our goal is to provide each and every patient with the highest quality of outpatient rehabilitation service. As you begin your therapy program, this document will explain policies and our Patient Rights & Responsibilities. It is a part of your registration and an important part of your healthcare plan. Please keep this information during the course of your therapy program with ***LifeCare:***

Scheduling Therapy Appointments:

You will have a therapist, or a team of therapists, assigned to your care who will schedule therapy appointments directly with you. If you do need to cancel an appointment, please give as much advanced notice as possible. While we do understand that occasional cancellations are inevitable, frequent cancellations are extremely disruptive not only your therapist, who as set this time aside exclusively for you, but will also ultimately affect your ability to progress toward your therapy goals. We appreciate your consideration in this matter.

Release of Medical Information:

LIfeCare will comply with HIPAA requirements for the release of your protected health information. If this information changes during the course of your care, please notify our office.

Outpatient Therapy Benefits:

LifeCare of Florida is certified by Medicare as an **Outpatient** therapy provider and works under a unique "Mobile Clinic" model of care. This means that if Home Health Services are being provided, our therapy will not be covered. Examples of services that may be provided by a home health agency include nursing services, wound care, lymphedema care and some paid home health aide services. If you begin ANY of these services, please notify our office so we can determine insurance coverage for our care.

Questions ?

We welcome your comments, compliments and concerns and are happy to provide you with additional information. Please contact us at any time.

Admission/Patient Coordinator:	954-773-8314 (Elisha Becker)
E-Mail:	Elisha.Becker@lifecaretherapy.com
Direct/Toll Free:	866-718-5757
Fax:	866-718-5759

Your Therapy Team

Therapist Name	Telephone
Therapist Name	Telephone

LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

PATIENT RIGHTS & RESPONSIBILITIES

LifeCare of Florida is committed to the delivery of the highest quality of rehabilitation service to each and every patient without regard to age, gender, disability, race, color, ancestry, citizenship, religion, pregnancy, sexual orientation, gender identity or expression, national origin, health condition, marital status, veteran status, payment source or ability, or any other basis prohibited by federal, state, or local law.

All Patients Have the Right to:

- Consideration, respect, and recognition of you and your individuality;
- Privacy and confidential treatment of your medical records and health information;
- Understand your treatment plan and recommendations that are that are made
- Know the benefits, expected outcomes and risks (if any) for your therapy program;
- Be told the names, role and qualifications of your therapy team;
- Understand your financial responsibility, if any;
- Request changes to your therapy program or therapy team without discrimination or reprisal.

Patient Responsibilities:

You are an important and active member of your care plan and have certain responsibilities to yourself and to your Team. In the spirit of this shared trust and respect, we ask that you:

- Give accurate and complete information regarding your health, medical history, and other care;
- Let us know if there are any changes to your contact information or health status;
- Ask questions if you do not understand your care plan of recommendations;
- Participate as an active member of your therapy;
- Notify our office of any concerns.

Please:

- Follow your care plan and instructions;
- Let us know if you cannot keep an appointment;
- Be respectful of our staff and other patients.

Thank You,

The ***LifeCare*** Team

LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

Consent for Treatment

Acknowledgment of Financial Responsibility

As a courtesy to you, our Admissions Department verifies your current insurance coverage and deductible before treatment begins. Outpatient therapy services are billed under the Medicare Part B Fee Schedule. If you are covered under Medicare, Medicare will pay for reimbursable charges of our services at 80% of the covered amount. We will bill your co- insurance, or we will bill you, for the remaining allowable 20%. If you are covered under a different insurance policy, a copy of our Insurance Verification will be provided to you so that you are aware of the projected out of pocket expense. However, please know that verification of coverage is not an authorization for payment. We will be happy to bill your insurance company on your behalf, however, if for any reason your insurance company does not pay, the charges are your responsibility.

Insurance Benefits:

- I certify that my primary insurance is_____ and my secondary insurance (if applicable) is: _____.

Financial Acknowledgment:

- I acknowledge that any change to my primary or secondary insurance could affect my financial responsibility and that I will notify ***LifeCare*** if I change my primary or secondary insurance.
- I understand and acknowledge my financial responsibility for any co-payments, deductibles, out of pocket or co-insurance outstanding not covered by my insurance policy.
- I authorize payment directly to ***LifeCare*** due me in my pending claim and/or major medical benefits otherwise payable to me, not to exceed the charges for this period of treatment.
- I understand that if payment is issued directly to me, it is my responsibility to forward this payment to ***LifeCare***.
- Should this account go delinquent, I agree to pay all costs of collection including collection agency fees, court costs and attorney fees.

Patient Confirmation & Consent:

- I certify that I am not currently receiving any services from a home health agency or outpatient rehabilitation facility. If I purposely deceive ***LifeCare*** of this, then I may be held responsible for payment for services. I confirm that prior to starting any home health services, I will notify ***LifeCare of Florida.***
- I confirm that I will notify ***LifeCare*** of any change to my primary or secondary insurance provider.
- I consent to treatment and to participation in this rehabilitation program.
- I understand that ***LifeCare of Florida*** has an outpatient clinic and all services can be provided to me at the clinic.

Please Check if Applicable:

_____ **I have a Power of Attorney (POA) for financial decisions.** (Verbal acknowledgment of financial responsibility is required from the POA prior to evaluation for a patient who is competent, but has deferred financial decisions to a POA.)

_____ **I am the POA for this legally incompetent patient. (**A COPY OF ANY APPLICABLE POA DOCUMENTS MUST BE PROVIDED FOR THE PATIENT'S RECORD PRIOR TO EVALUATION.)

Patient Name (Print Name)	Signature	Date
Responsible Party if Other Than Patient (Print Name)	Signature	Relationship
Therapist Name (Print Name)	Signature	Date

LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

HIPAA Notice of Privacy Practices

Authorization for Release of Information

In compliance with the Health Insurance Portability and Accountability Act (HIPAA) and Health Information Technology for Economic and Clinical Health Act (HITECH), ***LifeCare of Florida*** has a Notice of Privacy Practices which provides detailed information on how we may use and disclose protected health information about you. You have the right to review our Notice **before** signing this consent and prior to any service being provided to you by ***LifeCare of Florida. LifeCare*** reserves the right to change the Notice of Privacy Policies. If we change our notice, you may obtain a revised copy on request. You also have the right to revoke this Consent in writing. However, please note that a revocation shall not affect any disclosures we have already made.

By signing this form, you acknowledge that you have been given the opportunity to read the Notice of Privacy Practices prior to any service being provided and **you consent to the use and disclosure of your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations.** If there are other individuals that you permit and request ***LifeCare*** to release information regarding your condition and/or care, please list these individuals below.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

LifeCare of Florida may contact me in the following manner:

Yes No A Detailed Message CAN be left on my home number

Yes No A Detailed Message CAN be left on my cellular or alternate phone

Yes No A Detailed Message CAN be left with family member/caregivers

Yes No Written communication CAN be sent via fax to: _____

Yes No Written communication CAN be sent via e-mail to: _____

Patient Name *(Print Name)* Signature Date

Responsible Party if Other Than Patient *(Print Name)* Signature Relationship

Therapist Name *(Print Name)* Signature Date

LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

Functional History

For: _____ Date: _____

Interview Completed With: ☐ Patient ☐ Spouse ☐ Caregiver ☐ Other: _____

Please check all areas in which the patient has had difficulty within the past 3 months:

Functional Mobility ☐ No problems reported

- ☐ Mobility inside of home
- ☐ Mobility outside of home
- ☐ Getting in or out of bed
- ☐ Getting on or off of a toilet
- ☐ Bathing or showering
- ☐ Getting in or out of a chair
- ☐ Getting in or out of a car
- ☐ Lifting or carrying objects
- ☐ Reaching below waist or above shoulder level

Activities of Daily Living ☐ No problems reported

- ☐ Feeding self
- ☐ Grooming
- ☐ Oral hygiene
- ☐ Bathing
- ☐ Dressing upper or lower body
- ☐ Opening food packages
- ☐ Opening medications

Oral Motor ☐ No problems reported

- ☐ Swallowing
- ☐ Choking while eating solid foods
- ☐ Choking while drinking

Functional Communication: ☐ No problems reported

- ☐ Difficulties making self understood
- ☐ Difficulties with articulation
- ☐ Shortness of breath while speaking
- ☐ Change in voice volume

Is Patient Interested in Receiving Information On:

- ☐ Transportation
- ☐ Home Aides/Companions
- ☐ Community Support Groups
- ☐ Financial Resources
- ☐ Food Resources
- ☐ Housing Information

Patient Name *(Print Name)* Signature Date

Responsible Party if Other Than Patient *(Print Name)* Signature Relationship

Therapist Name *(Print Name)* Signature Date

Patient has been referred for: ☐ PT ☐ OT ☐ SLP

Patient ☐ Is or ☐ Is Not: Receiving ☐ Nursing Care (verify no b/p checks, catheter care, etc.)

Or ☐ Home Health Therapy ☐ Outpatient Therapy

Based on the above, patient may be a candidate for: ☐ PT ☐ OT ☐ SLP

Action: _____

Reviewed By: _____ Date: _____

LifeCare Therapy Services
Rehabilitation Therapy and Disease Management

Verification of Treatment Signature Log

Patient:_____ Date: _____

In agreement to the Plan of Care and to verify receipt of therapy services on the day rendered, ***LifeCare of Florida*** asks that each patient sign the treatment note at the time that services are provided. In certain situations, a patient may not be able to physically sign a treatment note. In these cases, ***LifeCare of Florida*** asks that a person or persons be identified who can sign the treatment note on the patient's behalf. **This signature is solely for the purpose of acknowledging receipt of therapy and does not authorize the person to act on the patient's behalf in any other manner.**

Person(s) Authorized to Sign Treatment Notes:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

On the day that treatment is rendered, the person(s) identified above shall print the patient's name on the treatment note and then affix his/her signature and date on the note.

Or:

☐(Check the box if appropriate) The patient's signature is the only valid signature for receipt of treatment

Patient Name *(Print Name)*	Signature		Date
Responsible Party if Other Than Patient *(Print Name)*	Signature	Relationship	Date
Therapist Name (*Print Name)*	Signature		Date