158 State Street, Meriden, CT 06450
Phone: (203) 237-7835 Fax: (203) 237-9187

Welcome to Easterseals Medical Rehabilitation:
On behalf of the staff of Easterseals Rehab Center, I would like to welcome you to our Center. The rehabilitation program that you are starting has been designed specifically for you so that you can achieve your goals. Our mission is to be the rehabilitation organization of choice by combining experience, compassion, high quality care, and to return you to your highest level of function and a fully productive and independent lifestyle.

The rehabilitative program you are about to begin may involve the following services:

- Occupational therapy to address activities of daily living
- Physical therapy to address functional deficits
- Speech therapy to address communication difficulties

Your Participation in Your Treatment Plan
To obtain the maximum benefit from your program it is very important that you attend and fully participate in all sessions and activities scheduled. We will have continuous communication with your physician regarding your progress. In order for the physician to assess your progress, it is imperative that you attend your therapy program to speed up your recovery.

Home Exercise Program (HEP)
Your therapist will provide you with a Home Exercise Program, which is essential to doing well in your rehabilitation. A home exercise program should be performed two to three times per day. We will teach you what the exercises are for and how you can use them to strengthen yourself. Being active in your own rehab will pay off!

Other Treatment Providers
Please know that we recognize that it is your right to choose other types of providers of care. Please inform us if you are receiving treatment/services from other providers as it may impact your care with us as well as your insurance coverage.

Appointment Scheduling & Cancellations
Missing sessions could adversely affect the rehabilitative process, lessening the positive effects of your progress and potentially delaying your rehabilitation as well as slowing your return to activities. Scheduling visits at our center is very important. If you are unable to attend your appointment, please call us as soon as possible. Missing appointments not only delays your personal progress, but it may also be delaying someone else's. If you must cancel, please call us to reschedule at ***203-237-7835 (x110)***

Easterseals Rehab Center operates according to established professional ethical standards. If you are ever unhappy with out services, you have the right to make a complaint at any time. It will be my personal responsibility to investigate and take whatever corrective action is necessary.

Our center has been designed and staffed to make your visit as pleasant as possible. If you would like additional information regarding our services, please feel free to review our website easterseals.com/waterburyct/

We look forward to helping you achieve your personal therapy goals and those of your referring physician. Please let us know if we can assist you in any way possible.

Sincerely,
Christina L. Colon, PTA
Site Manager of Medical Rehabilitation Services

PLEASE READ THE FOLLOWING INFORMATION CAREFULLY ...

PATIENT AGREEMENT AND INSURANCE BENEFITS

PERMISSION FOR GENERAL CARE: I hereby consent to diagnostic and treatment procedures that may be performed on me during my visit at Easterseal Rehab Centers. These procedures are provided under the direction of my referring physician and other physicians involved in my care. I understand that Easterseals Rehab will occasionally accept students of therapy professions and that these students may be involved in observing or rendering services under the direction of a licensed therapist.

AUTHORIZATION TO PAY BENEFITS: I hereby assign benefits to include major medical, private insurance or any other plan to Easterseal Rehab Centers. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges not covered or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of Easterseals Rehab. I HAVE PROVIDED Easterseals Rehab with my insurance information and I understand that the benefits quoted to them may include benefits already used by me. I am responsible for being aware of the benefit limitations of my insurance. PLEASE NOTE: BENEFITS, IF VERBALLY QUOTED BY INSURANCE COMPANIES, ARE NOT CONSIDERED A GUARANTEE OF PAYMENT.

*****Please note: Easterseals will check your benefits as a courtesy to you, the information we are given is not a guarantee of payment and we are not responsible for any misinformation that your carrier has relayed to us. Please call the number for customer service on back of your card to verify your benefits for our services*****

FINANCIAL AGREEMENT: In consideration of the services rendered by Easterseal Rehab Centers at my request and directions, I agree to pay in full, within thirty (30) days of the date of billing, any portion of the bill that is deemed to be my responsibility. If it is necessary for Easterseals Rehab to engage in Attorney or Collection Agency to collect the balance due, I agree to pay lawful and reasonable attorneys collection fees and court costs. In addition, I authorize the release of medical records to the collection agency, collection attorney and/or their agents for collection purposes.

PAYMENT REQUEST FOR MEDICARE/MEDICAID: I certify that the information given by me in applying for payment under TVIIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Medicare/Medicaid Program, its intermediaries, or professional review organization, any information needed for this or a related Medicare/Medicaid claim. I authorize payment of benefits be made on my behalf.

PROTECTED HEALTH INFORMATION: I consent to the user or disclosure of my protected health information by Easterseals Rehab to any person or organization for the purpose of carrying out treatment, obtaining payment or conducting certain healthcare operations. Protected health information used or disclosed by Easterseal Rehab may include HIV/AIDS related information, psychiatric and other behavioral health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which require that I provide specific authorization. I understand that information regarding how Easterseals Rehab will use and disclose my information may be found in Easterseals Rehabs' Notice of Privacy Practices. I understand that consent is effective for as long as Easterseals Rehab maintains my protected health information.

CONSENT FORM FOR USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION
FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

The undersigned patient, consent to have Easterseals Rehab use and disclose my protected health information, including, if applicable, drug/alcohol abuse, HIV and psychiatric information for the purposes of my treatment, healthcare operations and payment by the payer(s) of my health care benefit.

In addition, I consent for Easterseals Rehab to disclose my protected health information to the following for the following:

- Primary Care or referring Physician for follow-up care.
- To other providers for coordination of care.
- To other providers for referral and discharge planning**.**

I have been provided with Easterseals Rehab's Notice of Privacy Practices and understand that I have the right to review this notice before signing this consent. I understand that Easterseals Rehab reserves the right to change its privacy practices, described in its Notice, and that if I wish to receive notification of any changes to the Notice, I may contact Easterseals Rehabs' Patient Service Representative at the clinic where I receive care.

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, Easterseals Rehab may provide me with treatment; however, I will be responsible for charges incurred at the time of service. I understand that treatment required by law, such as emergency care will be provided to me whether or not I sign this consent.

Unless I object, Easterseals Rehab may disclose protected health information of a general nature to my family or other individuals personally involved in my care, including changes in my condition.

I have the right to request that Easterseals Rehab restrict how they use and/or disclose my protected health information for the purpose of providing treatment, obtaining payment and/or conducting health care operations. Easterseals Rehab is not required to agree to any restriction I request. If Easterseals Rehab does decide to agree to my request, Easterseals Rehab must honor the restriction placed on the use and/or disclosure of my health information. I also understand that I have the right to request confidential communications by alternate means or locations. However, Easterseals Rehab may deny the request if it determines that it would be administratively difficult to comply with my request.

I understand that with respect to drug/alcohol abuse, HIV and psychiatric information, this Consent will expire 365 days after the date appearing below or 365 days after my final treatment, whichever is later. I also understand that I have the right to revoke this consent by notifying Easterseals Rehab's Patient Service Representative at the clinic where I receive care in writing. I understand that if I revoke my consent, there will be no effect on uses and disclosures already made in reliance on my prior consent.

HIV RELATED INFORMATION: In the event that information released constitutes confidential HIV related information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

PSYCHIATRIC INFORMATION: In the event that information released constitutes confidential psychiatric information protected under Connecticut Law: This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent by the person to whom it pertains, or as otherwise permitted by said law.

DRUG AND ALCOHOL ABUSE RECORDS: In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records Regulations: This information has been disclosed to you from records protected by Federal confidentiality rules (42CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

easterseals Rehabilitation Center

PATIENT / GUARDIAN AGREEMENT

- ☑ I authorize release of information requested by my insurance plan for payment.
- ☑ I understand that I am financially responsible for any balance due.
- ☑ I have had the opportunity to have my questions answered regarding Easterseals Rehab's privacy practices.
- ☑ I consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.
- ☑ I hereby acknowledge that I have been offered a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date

When completed and signed, please return this paperwork to the receptionist. Thank you.

OUTPATIENT PROGRAMS – DEMOGRAPHIC INFORMATION

Client Name: _____

Date of Birth: _____

ETHNICITY:

- ❑ Caucasian
- ❑ Black
- ❑ Hispanic
- ❑ Non Hispanic White
- ❑ Non Hispanic Black
- ❑ Asian
- ❑ Aboriginal
- ❑ North American Indian/Alaska Native
- ❑ Multiple Ethnicity
- ❑ Native Hawaiian/Other Pacific Islander
- ❑ Declined
- ❑ Other

Patient Attendance Contract

Thank you for choosing Easterseals for your medical rehabilitation needs! We respect your time and request that you value ours as well. The Easterseals staff would like to provide all of our patients with the best possible care. In order to do so we kindly ask:

- If you need to cancel or reschedule, please contact us 24-hours prior to your scheduled appointment.
- If you miss (3) consecutive appointments without notice and we have not been able to contact you, we will remove your appointments from the schedule. You may call the office to schedule one appointment at a time.
- If you are greater than 15 minutes late, we will attempt to see you in the closest time slot available as the schedule permits.
- If you are absent from therapy for more than (4) consecutive weeks, you will need to contact your referring provider for a new referral to receive further treatment.

Attendance to your appointments is critical to achieving your goals in therapy. Missed appointments will affect how well we can provide your treatment. It can also cause other patients to miss out on valuable opportunities for treatment time. The satisfaction and success of all of our patients are important to us at Easterseals!

By signing below, I acknowledge and understand this attendance contract:

_____ Date:

Signature of Patient or Legally Authorized Representative

_____ Date:

Signature of Therapist/Front Desk Representative