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158 State Street, Meriden, CT 06450

PATIENT AGREEMENT AND INSURANCE BENEFITS

PATIENT NAME: _____ Patient Act # _____ DATE: _____

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

AUTHORIZATION TO PAY BENEFITS: I hereby assign benefits to include major medical, private insurance or any other plan to Easter Seal Rehabilitation. A photocop 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 authc said assignee to release all information necessary to secure this payment. I have been informed of the payment policies of Easter Seal Rehabilitation. I HAVE PROVIDED Easter Rehabilitation with the following insurances and I understand that the benefits quoted to them may include benefits already used by me. I am responsible for being aware of benefit limitations of my insurance. **PLEASE NOTE: BENEFITS, IF VERBALLY QUOTED BY INSURANCE COMPANIES, ARE NOT CONSIDERED A GUARANTEE OF PAYMENT.** _____ (initia

Primary Insurance: _____ Deductible: _____

Benefit: _____ Met for Year: _____

Co-Insurance: _____ Co-Pay: _____

Secondary Insurance: _____ Deductible: _____

Benefit: _____ Met for Year: _____

Co-Insurance: _____ Co-Pay: _____

- ☐ I agree to have Easter Seal Rehabilitation bill my insurance and to receive reimbursements/payments.
- ☐ I agree to pay all co-pays on or before the date of service in the amount of $_____.
- ☐ I will pay $_____ per visit. ☐ Payment will be applied **towards my** deductible of $_____.
- ☐ I will pay $10 **toward my** visit if my coinsurance is 10% or $20 **toward my** visit if it is 20%.The balance will either be billed or refunded to me.
- ☐ Any overpayments will be promptly refunded

OR

- ☐ Authorization to use my Debit/Credit Card for above:

Name on Credit Card: _____ OVV Code: _____

M/C or Visa # _____ Exp. Date: _____

I authorize Easter Seal Rehabilitation to use the above credit card to pay for my charges after billed to insurance, as they are dictated by my insura company after applicable insurance adjustments. Easter Seal Rehabilitation will mail me receipts as charges are made.

IS THIS INJURY

1. Related to a Motor Vehicle Accident? ☐ Yes ☐ No
2. Work Related? ☐ Yes ☐ No
3. Related to a Liability or a Fall? ☐ Yes ☐ No

*If you answered "NO" to any of these, please write **How, When and Where the Injury happened** on this line:*

_____

MEDICARE – ARE YOU RECEIVING HOME CARE (VNA)? ☐ Yes ☐ No

If Yes, name of Agency: _____

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

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

BY SIGNING BELOW, I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:

I have read and understand this consent and acknowledgement.
I am authorized to execute this form and I agree to its terms.
I have received a copy of the Easter Seal Rehabilitation Notice of Privacy Practices today or upon an earlier date of service.

X _____ _____

Signature of Patient or Legally Authorized Representative — Today's Date

_____ _____

Representative's Relationship to Patient — Witness (Easter Seal Representative)

FOR EASTER SEAL REHABILITATION USE ONLY: A good faith effort was made to provide the patient with the Easter Seal Rehabilitation Notice of Privacy Practices and the information contained in the Patient Agreement, but the patient did not sign/acknowledge receipt because

_____.

White – Chart Copy Yellow – Patient Copy

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158 State Street, Meriden, CT 06450

TO: Easter Seal Rehabilitation's Patients

REGARDING: Correspondence with Your Insurance Company

Many of our patients are treated for some kind of injury. Sometimes it is work related o related to a motor vehicle accident. In this case, your medical insurance company wants to make sure that your workers compensation or automobile insurance is paying these claims.

Other times, injuries are caused by other things, unrelated to work or auto accidents. In this case, the medical insurance has no problem paying these claims. Oftentimes when insurance company's see a claim for injury, they will send you a letter to verify the injury. They will not pay your claim until it has been verified.

Please be on the lookout for correspondence from your medical insurance company, and promptly complete the form and return it to your insurance company. Otherwise, they will not pay for our services and you will be liable to pay.

Thank you.

Patient's Printed Name _____ Initials _____ Date _____

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CANCELLATION & ATTENDANCE POLICY

Should you need to cancel or re-schedule your appointment, please contact us at least 24-hours prior to your scheduled appointment. Missed appointments or cancellations with less than 24-hour notice will result in a $20.00 charge.

To receive the most benefit from your therapy, good attendance is essential. The staff at Easter Seal Rehabilitation would like to provide you and our other patients with the best possible care.

If you miss two (2) consecutive appointments, or a total of three (3) appointments in total, your name will be taken off the schedule and your physician will be informed. A new referral from your physician will be required for you to continue treatment.

If you are on Worker's Compensation and miss an appointment, your physician and employer will be informed.

If you are late for an appointment, your therapist will see you as the schedule permits.

BY SIGNING BELOW, I UNDERSTAND AND ACKNOWLEDGE THE FOLLOWING:

I have read and understand this consent and acknowledgement.

_____ _____

Signature of Patient or Legally Authorized Representative | Today's Date

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OUTPATIENT PROGRAMS – DEMOGRAPHIC INFORMATION

Name: _____

Gender: ❑ Male ❑ Female DOB: _____ Age: _____

Email: _____

ETHNICITY:

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

INSURANCE:

- ❑ Medicaid
- ❑ Private Pay
- ❑ Medicare
- ❑ Commercial Insurance
- ❑ Medicaid Waiver
- ❑ Veterans Administration
- ❑ Vocational Rehabilitation/ Workman's Compensation

_____ _____

Patient's Signature Date

For Office Use Only

Diagnosis: _____

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

The undersigned patient, give consent to Easter Seal Rehabilitation Center of Greater Waterbury, Inc., Easter Seals of Central CT, to provide evaluation and/or treatment for ___ PT, ___ OT, ___ ST, ___ AU, ___ Social Work, ___ Mobility Evaluation.

The undersigned patient, consent to have Easter Seal Rehabilitation 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 Easter Seal Rehabilitation 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 referral and discharge planning.
- To other providers for coordination of care.

I have been provided with Easter Seal Rehab Center's Notice of Privacy Practices and understand that I have the right to review this notice before signing this consent. I understand that Easter Seal Rehabilitation 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 Easter Seal Rehabilitation' Patient Service Representative at the clinic where I receive care or call Easter Seal Rehab Center at 203-237-7835 ext 10 or 12.

I understand that I have the right to refuse signing this consent. If I refuse to sign this consent, Easter Seal Rehabilitation 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, Easter Seal Rehabilitation 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 Easter Seal Rehabilitation 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. Easter Seal Rehabilitation is not required to agree to any restriction I request. If Easter Seal Rehabilitation does decide to agree to my request, Easter Seal Rehabilitation 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, Easter Seal Rehabilitation 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 Easter Seal Rehab Center'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.

I have had the opportunity to have my questions answered regarding Easter Seal Rehabilitation' privacy practices. I have read a copy of the Notice of Privacy Practice and consent to the use and disclosure of my protected health information for treatment, payment and healthcare operations.

X _____ X _____

Signature of Patient or Legal Representative/Witness — Date

Would you like a copy of this release? ☐ Yes ☐ No

If signed by the Legal Representative, indicate your relationship to the patient below:

☐ Parent ☐ Guardian ☐ Conservator ☐ Executor of Estate ☐ Power of Attorney ☐ Other_____

If unable to obtain patient's consent, indicate the reason below:

- ☐ Emergency treatment situation
- ☐ Required by law to treat the patient and Easter Seal Rehabilitation has attempted but is unable to obtain the patient's consent.
- ☐ Substantial barriers to communicating with the patient (i.e., Foreign language) and Easter Seal Rehabilitation determines that the patient's consent to receive treatment is inferred from the circumstances.
- ☐ Patient refuses to sign the consent.

_____ _____

Signature of Witness (Person documenting reason) — Date

NOTICE

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.