

## FOR OUR PATIENTS

### Conditions for Admission:

Patients must be referred by a physician to our services. For those patients that are not under the care of a physician, we have a physician on staff who is board certified in Physical Medicine and Rehabilitation. A referral from your insurance may also be necessary prior to Evaluation, (you may contact us to verify if a referral is needed at any time).

### Business Hours:

**Monday to Friday: 8 AM to 5PM**

**After hours and Saturdays by Previous Appointment:**

### Appointments:

Appointments can be made during our business hours. You will need an appointment for an initial evaluation. All other appointments will be set on the initial evaluation date.

The primary reason for appointments is to make efficient use of everyone's time. If you arrive early for an appointment, we will try to see you early. If you arrive late for an appointment, your treatment may be shortened. We sincerely appreciate your cooperation in saving valuable time.

If you need to cancel an appointment, as a courtesy to other patients and the therapists, please call by 9:15AM of the appointment day. Appointments that are not cancelled by 9:15AM will result in a charge to you of \$25.00

### Payment Policy:

We accept most health insurances, private pay, automobile insurances and workers compensation claims.

The following is a list of the insurances we accept. If you do not see your insurance carrier in the list, please contact us at 305-552-9505 just in case the information has not been updated.

MEDICARE	LEON MEDICAL	WELLCARE	WORKERS COMPENSATION
HUMANA	NHP	MEDICA	AUTOMOBILE ACCIDENTS
AVMED	PREFERRED	HEALTHSUN	PERSONAL INJURIES
AETNA	VISTA	DOCTORS CARE	PRIVATE PAY FINANCING AVAILABLE

It is our policy to bill your insurance company and collect your co-pay or co-insurance at each treatment. Upon your first appointment, billing policy and payment plan will be discussed and formalized. We accept cash, check, money orders for your convenience.

### Patient Forms:

These are the forms you will be completing on your initial evaluation day. Please download and print to bring to your first appointment

[Patient Registration Form](#)

[Medical History Form](#)

[Pain Assessment Form](#)

The following are documents you will be reviewing and signing. Please review them and you may ask any questions you may have to the receptionist or therapist on the day of your evaluation.

[Patient Information](#)

[Notice of Health Information Practice \(HIPAA\)](#)

[Information on Advance Directives](#)

[Patient Bill of Rights](#)

# CONFIDENTIAL PATIENT INFORMATION/REGISTRATION FORM

FIRST, MIDDLE AND LAST NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY \_\_\_\_\_ FL 33 \_\_\_\_\_

HOME TEL: (\_\_\_\_) \_\_\_\_\_ WORK TEL: (\_\_\_\_) \_\_\_\_\_ CELL TEL: (\_\_\_\_) \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_ SEX: F M MS: MARRIED SINGLE WIDOW

REFERRED BY: ( )SELF ( )MD ( )INSURANCE COMPANY ( )OTHER: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ TEL: \_\_\_\_\_ REL: \_\_\_\_\_

EMPLOYMENT INFORMATION: N/A *Must be filled out by all WC patients.*

EMPLOYER NAME: \_\_\_\_\_ Tel: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_ WORK STATUS: \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION:

INSURED: ( )SELF INSURANCE PLAN: \_\_\_\_\_ ID: \_\_\_\_\_

GROUP NO: \_\_\_\_\_ CLAIM NO: \_\_\_\_\_ EFFECT DATE: \_\_\_\_\_

ADJUSTER'S NAME: \_\_\_\_\_ TEL/EXT: \_\_\_\_\_

IF PATIENT IS NOT THE INSURED, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT PRIMARY INSURED:

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TEL: \_\_\_\_\_

## SECONDARY INSURANCE INFORMATION:

INSURED: ( )SELF INSURANCE PLAN: \_\_\_\_\_ ID: \_\_\_\_\_

GROUP NO: \_\_\_\_\_ CLAIM NO: \_\_\_\_\_ EFFECT DATE: \_\_\_\_\_

ADJUSTER'S NAME: \_\_\_\_\_ TEL/EXT: \_\_\_\_\_

IF PATIENT IS NOT THE INSURED, PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT PRIMARY INSURED:

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ TEL: \_\_\_\_\_

ATTORNEY'S NAME: \_\_\_\_\_ TEL: \_\_\_\_\_

## OFFICE USE ONLY

INSURANCE VERIFICATION:

Primary: DEDUCTIBLE :\$ \_\_\_\_\_ COPAY: \_\_\_\_\_ VERIFIED ON: \_\_\_\_\_ BY: \_\_\_\_\_

Secondary: DEDUCTIBLE :\$ \_\_\_\_\_ COPAY: \_\_\_\_\_ VERIFIED ON: \_\_\_\_\_ BY: \_\_\_\_\_

Transportation Needed: ( )Regular ( )Wheelchair ( )Transportation provided by us

# MEDICAL HISTORY AND PHYSICAL CONDITION INFORMATION

Answers to the following questions will assist the therapist in providing a safe and effective treatment program.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Age: \_\_\_\_\_ Sex: \_\_\_\_\_ HGT: \_\_\_\_\_ WGT: \_\_\_\_\_ R L Dominance

Reason for your visit today? (If personal injury of worker's comp case) Date of Injury: \_\_\_\_\_

---

---

---

Have you had treatment for this problem before? YES NO

If YES state where: \_\_\_\_\_ When \_\_\_\_\_

What has been the medical management for this problem up to now?

Rest Specialist: \_\_\_\_\_ Blockages Medications: \_\_\_\_\_

Any diagnostic test ordered? YES NO If YES which: MRI XRAYS CT SCAN BONE DENSITY EMG NCV ENG Other: \_\_\_\_\_

Results: \_\_\_\_\_

Have you had surgery associated with this problem? YES NO When \_\_\_\_\_

Have you ever had physical therapy before? YES NO When: \_\_\_\_\_ Where: \_\_\_\_\_

Are you currently taking any medications? YES NO

If YES, please list all medications?

---

---

---

Do you now have/or have you ever had any of the following:

High Blood Pressure

Heart Disease

Heart Attack

Hernia

Diabetes

Headaches

Kidney Problems

Nervous Disorders

Hearing Problems

Pregnant

Sensitivity to Heat/Ice

Allergies: \_\_\_\_\_

Pacemaker

Metal Implants

Seizures

Dizzy Spells

Balance Problems

Vision Problems

Cancer

HIV +

List any other major illness, or surgery that has occurred in the past one year:

---

---

---

IS YOUR NEXT MD APPOINTMENT: \_\_\_\_\_ WHICH MD: \_\_\_\_\_

---

---

# Initial Pain Assessment Tool

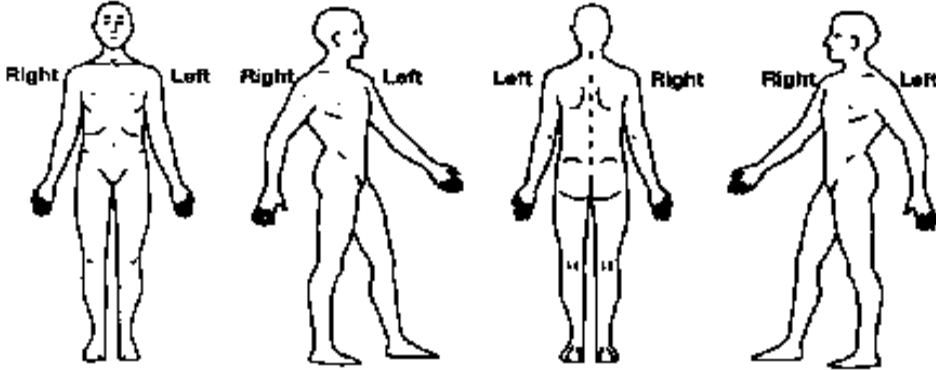
Date: \_\_\_\_\_

Patient's name: \_\_\_\_\_ Age: \_\_\_\_\_ Room: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Physician: \_\_\_\_\_

Nurse: \_\_\_\_\_

## I. Location: Patient or nurse marks drawing



## II. Intensity: Patient rates the pain. Scale used 0-10: \_\_\_\_\_

Present: \_\_\_\_\_

Worst pain gets: \_\_\_\_\_

Best pain gets: \_\_\_\_\_

## III. Quality:

Knife like      Burning      Electric Shock      Throbbing      Dull      Ache

## IV. Duration, variations, rhythms:

Constant      Comes & Goes      Always present, worse at times

## VI. What relieves the pain?

Rest      Hot Shower      Heating Pad      Cold      Exercise      TENS

## VII. What causes or increases the pain?

Sitting      Walking      Damp Weather      Cold      Stress

## VIII. Effects of pain:

Decreased function      Decreased quality

## IX: Medications for pain:

---

---

---

## PATIENT INFORMATION

Thank you for choosing our facility for your rehabilitation needs.

You will be evaluated today and treated (if approved by your insurance). If only the evaluation was approved for today, our staff will submit all necessary information to your insurance for further authorization and we will contact you to arrange follow up appointments as soon as we receive such authorization from your insurance.

The attached documents are information about our Privacy Health Notice (HIPAA), Patient Bill of Rights and Information on Advance Directive. Please read then carefully and contact our receptionist for any information you do not understand and for any questions you may have about this form.

The success of your rehabilitation depends also on your compromise to comply with the frequency established by your therapist and/or physician. It is very important for you to complete the assigned treatment and attend all of your scheduled sessions. If for any reason, you are unable to attend to any of your sessions, you must contact our receptionist to re-schedule with 24 hours in advance. Please be aware that there is a **\$25.00** charge for sessions that are not cancelled within 24 hours in advance.

Also please be aware that for most insurances, physician's certifications are only good for 30 days, if you do not complete the assigned sessions within 30 days, you must go back to your physician for a new referral. Furthermore, be aware that if you miss three consecutive visits without contacting us to reschedule you will be automatically discharge from our services due to non compliance.

Your co-payment or co-insurance is due at the time of your visit when you sign in with the receptionist.

We would like to encourage you to provide us with any suggestions or concerns that you may have. If at any time you feel dissatisfied with our services, facility or staff please let us know immediately so we can correct it. You may contact our customer service representative Sonia Rivero or our office manager Franceline Pena at 305-552-9505 for your complaints, concerns or suggestions.

Your rehabilitation is our number one priority. We hope that you become our client for life, and that you are experience with us is a satisfying one.

Sincerely,

Juan Aleman  
President

## Notice of Health Information Practices

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

### *Introduction:*

At Associates Rehabilitation we are committed to treating and using protected health information about your responsibility. This notice of health information practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective 01/01/2003 and applies to all protected health information as defined by federal regulations.

### **Understanding your health record /information:**

Each time you visit Associates Rehabilitation a record of your visit is made. Typically this record contains your symptoms, examination and test results, diagnosis, treatment and a plan for future care or treatment. This information often referred as your health or medical record serves as a:

- ❖ Basis for your care and treatment
- ❖ Means of communication among the many health professional who contribute to your care.
- ❖ Legal document describing the care you received
- ❖ Means by which you or third –party payer can verify that services billed were actually provided
- ❖ A tool in educating health professionals
- ❖ A source of data for medical research
- ❖ A source of information for public health officials charged with improving the health of this state and the nation
- ❖ A source of data for our planning and marketing
- ❖ A tool with which we can asses and continually work to improve the care we render and the outcomes we achieve

Understanding with is in your record and how your health information is used helps you to: ensure its accuracy. Better understand who, what, when, where and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

### **Your Health Information Rights**

Although your health record is the physical property, Inc., the information belongs to you. You right to:

- ❖ Obtain a paper copy of this notice of information practices upon request.
- ❖ Inspect and copy your health records as provided for in 45 CFR 164.524.
- ❖ Amend your health record as provided in 45 CFR 164.528.
- ❖ Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528.
- ❖ Request communications of your health information by alternative means of alternative locations.
- ❖ Request a restriction on certain uses and disclosures of your information as provided by 45 CFR164.522 and revoke your authorization to use o disclose health information except to the extent that action has already been taken.

### **Our responsibilities:**

Associates rehabilitation is required to:

- ❖ Maintain the privacy of your health information
- ❖ Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- ❖ Abide the terms of this notice
- ❖ Notify you if we are unable to agree to a requested restriction and
- ❖ Accommodate reasonable request you may have to communicate health information by alternative means or at alternative location

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change? We will mail a revised notice to the address you've supplied us or if you agree. We will email the revised notice to you.

We will not use or disclose information without your authorization except as describe in this notice. We will also discontinue to use or disclosed your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

### **For more information or to report a problem:**

If have question and would like additional information you may contact the practice's privacy officer franceline peña 305-552-9505

If you believe your privacy rights have been violated, you can you can file a complaint with the practice's privacy officer or with the office for civil rights US Department of health and human services. There will be no relation for filling a complaint with either the privacy officer of the office for civil rights. The address for the OCR is listed below:

*Office for civil rights*  
US DEPARTMENT OF HEALTH AND HUMAN SERVICES  
200 INDEPENDENCE AVE SW  
ROOM 509 F HHH BUILDING  
WASHINGTON DC 20201

## **EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH OPERATIONS**

### *We will use your health information for treatment*

FOR EXAMPLE: information obtained by a nurse, physician or other member of your health care team will be recorded and your record and used to determine the course of treatment that should work best for you. Your physician will document in your records his or her expectations of the member of your health care team. Member of your health care team will then record the actions they look and their observation. In that way the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider of copies of various reports that should assist him or her in treating you once you are discharged from this hospital.

### *We will use your health information for payment*

FOR EXAMPLE: a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you as well as your diagnosis, procedures, and supplies used.

### *We will use your health information for regular health operations.*

FOR EXAMPLE: members of the medical staff the risk or quality improvement manager of members of the quality improvement team may use information in your health record to assess the care or outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

*Business associates:* there are some services provided in our organization through contacts with business associates.

Examples: include the physician services in the emergency department and radiology certain laboratory test and a copy service we use when making copies of your health record. When these services are contracted we may disclose your health information to our business associates so they can perform the job we have ask them to do and bill you or your third-party payer for services rendered, to protect your health information however we require the business associates to appropriately safeguard your information.

*Directory :* unless you notify us that your object we will use your name location in the facility general condition and religious affiliation for directory purposes. These information may be provided to members of the clergy and expect for religious affiliation to other people who ask for you by name.

*Notification:* we may use or disclose information to notify or assist in notifying a family member, personal representative or another person responsible for your care, your location and general condition.

*Communication with the family:* health professional using their best judgment may disclose to a family member other relative close person, friend or any other person you identify health information relevant to that person's involvement in your care or payment related to your care.

*Research:* we may disclose information to researchers when an institutional review board that has review the research proposal and established protocols to ensure the privacy of your health information.

*Funeral directors:* we may disclose health information to funeral directors consist with applicable law to carry out their duties.

*Organ procurement organizations:* consistent with applicable law we may disclose health information to organ procurement organizations or other entities engaged in the procurement banking or transportation of organ for the purpose of tissue donation and transplant.

*Marketing:* we may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

*Fund raising:* we may contact you as part of a fun-raising effort.

Food and drug administration (FDA): we may disclose to the FDA health information relative to adverse events with respect to food. Supplements product and product's defects or post marketing surveillance information to enable products recalls, repairs or replacement.

*Workers compensation:* we may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

*Public health:* as required by law we may disclose your health information to public health or legal authorities charged with preventing or controlling disease injury or disability.

*Correctional institution:* should you be an inmate of a correctional institution, we may disclose to the institution or agents there of health information necessary for your health and the health and safety of other individuals.

*Law enforcement:* we may disclose health information for law enforcement purposes required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency public health authority attorney provided that a work force member or business associates believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients workers or the public.

## **INFORMATION ON HEALTH CARE ADVANCE DIRECTIVES PATIENTS RIGHTS TO DECIDE**

All adult individuals in health care facilities such as hospitals, nursing homes, rehabilitation facilities, home health agencies and health maintenance organization have certain right under Florida law.

You have the right to fill out a paper known as “advance directive” the papers say in advance what kind of treatment you want or do not want under special serious medical conditions. That would stop you from telling your doctor how you want to be treated. For example: if you were taken to a health care facility in a coma would you want the facility’s staff to know your specific wishes about decisions affecting your treatment?

### **WHAT IS AN ADVANCE DIRECTIVE?**

An advance directive is a written or oral statement wishes is made and witnessed in advance of a serious illness or injury about how you want medical decisions made. Two forms of advance directives are:

- ❖ A “living will” and
- ❖ Health care surrogate designation

An advance directive allows you to state your choices about health care or to name someone to make those choices for you if you become unable to make decisions about your medical treatment.

### **WHAT IS A LIVING WILL?**

A living will generally states the kind of medical care you want or do not want if you become unable to make your own decisions. It is called “living will” because it takes effect while you are still living Florida law provides a suggested form for a living will. You may use it or some other form. You may wish to speak to an attorney or physician to be certain you have completed the living will in a way so that your wishes will be understood.

### **WHAT IS A HEALTH CARE SURROGATE DESIGNATION?**

A “health care surrogate designation” is a signed dated and witnessed paper naming another person such as a husband, Wife, Daughter, Son, or close friend as your agent to make medical decisions for you if you should become unable to make them for yourself. You can include instructions about any treatment you want or wish to avoid. Florida laws provide a suggested form. You may use it or some other form. You may wish to name a second person to stand in for you. If your first choice is not available. You may wish to speak to an attorney or physician to be certain you have completed the health care surrogate form so that your wishes will be understood.

### **WHICH IS BETTER?**

You may wish to have both or combine them into a single document that describes treatment choices in a variety of situations and name someone to make decisions for you, should you be unable to make decisions by yourself.

### **DO YOU HAVE TO WRITE ADVANCE DIRECTIVE UNDER FLORIDA LAW?**

No. There is no legal requirement to complete an advance directive. However if you have not make an advance directive or designated a health care surrogate, health care decisions may be made for you by a court appointed guardian, your spouse, your adult child, your parent, your adult sibling and adult relative or a close friend in that order. This person would be called a proxy.

### **CAN I CHANGE MY MIND AFTER I WRITE A LIVING WILL OR DESIGNATE A HEALTH CARE SURROGATE?**

Yes. You may change or cancel these documents at any time. Any change should be written signed and dated. You can also change and advance directive by oral statement.

WHAT

### **IF I HAVE FILLED OUT AN ADVANCE DIRECTIVE IN ANOTHER STATE AND NEED TREATMENT IN A HEALTH CARE FACILITY IN FLORIDA?**

An advance directive completed in another state in compliance with others state’s law can be honored in Florida.

### **WHAT SHOULD I DO WITH MY ADVANCE DIRECTIVE IF I CHOOSE TO HAVE ONE?**

Make sure that someone such as your doctor, lawyer or family member knows that you have an advance directive and where it is located. Consider the following:

- ❖ If you have designated a health care surrogate, give a copy of the written designation form or the original to the person.
- ❖ Give a copy of your advance directive to your doctor for your medical file.
- ❖ Keep a copy of your advance directive in a place where it can be found easily.
- ❖ Keep card or note in your purse or wallet, which states that you have an advance directive and where it is located.
- ❖ If you change your advance directive make sure your doctor, lawyer and or family member has a latest copy.

## **PATIENT RIGHTS AND RESPONSABILITIES**

### **STATEMENT OF PURPOSE:**

It is anticipated that observance of these rights and responsibilities will contribute to more effective care and greater satisfactions for the patients as well as the staff. The rights will be respected by all personal and integrated into all facility programs. A copy of these rights will be prominently displayed within the facility and made available to patients and their family.

### **PATIENT HAS THE RIGHT:**

1. To be fully informed of all rights and responsibilities.
2. To appropriate and professional care relating to physician orders.
3. To request services from the facility of their choice and to request full information from the provider concerning services provided alternatives available licensure and accreditation requirements organization ownership and control.
4. To receive the information necessary to give informed consent prior to the start of any procedure or treatment.
5. To participate in the planning of care based on his unique health care needs and in planning changes in the care and selection of options for alternative levels of care and referral to the organization.
6. To refuse treatment within the confines of the law and to be informed of the consequences.
7. To treatment with utmost dignity and respect by all facility representatives regardless of the patient's chosen lifestyle culture mores, political, religious, ethical beliefs, having or not having an executed advance directive and source of payment without regard to race, creed, color, sex, age, or handicap.
8. To receive and access services consistently and in a timely manner from the agency to his/her request for service.
9. To be admitted for service only if the agency has the ability to provide safe professional care at the level of intensity needed.
10. To reasonable continuity of care.
11. To an individualized plan of care and teaching plan developed by the entire health team including the patient the patient and or family when possible.
12. To expect confidentiality of the access to medical records according to the state of Florida statutes.
13. To be informed within reasonable time of anticipated termination of services or plans for transfer to another health care facility/provider.
14. To be informed of agency policies and charges for services including eligibility for third party reimbursements. To be informed of any changes in these procedures within 15 days from the date the organization is made aware of change.
15. To honest, accurate, forthright information regarding the rehabilitation industry in general and his her chosen facility in particular including cost per visit employee qualification names and little of personal etc
16. To access necessary professional services 24 hours a day, 7 days per week.
17. To be referred to another facility if he she is dissatisfied with the facility or if the facility cannot meet the patient's needs.
18. To receive disclosure information regarding any beneficial relationships the organizations has that may result in profit for the referring organization.
19. To education, instruction and a list of requirements for continuity of care when the services of the facility are terminated.
20. To be free from abuse of any kind.
21. To privacy to maintain his or her personal dignity and respect.
22. To know that the facility has liability insurance sufficient for the needs of the facility.
23. To voice grievances and suggest changes in services of staff without fear or restrain or discrimination and receive documented response it requested.  
A: a fair hearing will be available to any individual aggrieved by the provider.  
B: the fair hearing procedure will be set forth by each affiliate as appropriate to the unique patient client situation.  
C: call 305-552-9505 x12 from 8 am to 5 pm for any grievances.
24. To be advised of the toll free abuse hotline 1800-96-abuse (1800-9622873) used to report abuse, neglect or exploitation.

### **THE PATIENT HAS THE RESPONSIBILITY**

1. To provide to the best of his/her knowledge accurate and complete information about:  
A: past present medical histories  
B: unexpected changes in his her condition  
C: whether he/she understands a course of action selected.
2. To follow the treatment recommended by the therapist handling the case.
3. For his her actions of he she refuses treatment or does not follow physician's orders.
4. For assuring that the financial obligations of his her health care are fulfilled as promptly as possible.
5. To respect the right to all staff providing service.
6. To notify the agency promptly in advance of an appointment or visit you must cancel.
7. To respect the right of all staff providing service.
8. To become independent in care to the extent possible utilizing self-family and other sources.
9. To pay for care or services not covered by third party payer.
10. For complying with the rules and regulations established by the facility and any subsequent rules.