Revive Rehab Inc.

4745 Sutton Park Ct.
Suite # 403
Jacksonville FL, 32224
Ph (904) 371-4649
Fax (888)393-1099
Info@ReviveRehab.com

Patient Information

Today's Date: _____

To be completed by patient, responsible party/legal guardian or nearest relative prior to treatment.

1. Patient Name:_____
2. Date of Birth:_____
3. Social Security Number: _____ (For record keeping purposes only)
4. Name of Parent/Guardian/Tricare sponsor:_____

   -Relationship to the Patient:_____

   -Date of Birth: _____SSN#_____
5. Patient mobile phone: _____ Home phone:_____
6. Employer Name:_____
7. Home Mailing Address: (no P.O. Box please)

   _____

   _____

   _____

   _____
8. Please provide name and phone # in case of emergencies: _____
9. Patient E-Mail Address: _____
10. Insurance Coverage (if applicable): Primary:_____

    Secondary: _____

    Tertiary: _____

    (If any insurance is Tricare please add Sponsor's Name as on the card)
11. Referring Doctor: _____

    Medical Diagnosis:_____

    _____

    _____

"LIVE BETTER"

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Patient History

1. What is your current occupation? What was your previous occupation?

2 Briefly describe the reason or problem for which you are seeking rehabilitation services (ex: unable to walk, perform activities of daily living, self care, etc)

3. Were you referred by a Medical Doctor (M.D.)? If not, how did you find out about our services?

4. If referred by an M.D., do you have a written order for services from the M.D.?

5. Are you currently receiving any rehabilitation services elsewhere or have you received any rehabilitation services in the past 30 days ?

6. Please describe any and all medical condition or symptoms that you are aware of that are directly or indirectly related to your health.

7. Have you been advised by a physician or any other healthcare professional to take any precautions during physical and/or mental activities?

8. Have you been diagnosed with any heart conditions?

9. Are you waiting for the results of any medical procedure or test?

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10. Do you have any breathing problems or respiratory conditions that you are aware of?

11. Are you currently a hospice patient or receiving home health services?

12. Are you currently experiencing any pain? If so please describe on a scale from 1-10
    (1) means – can easily tolerate, or minor discomfort and (10) means- very painful, will take you to emergency room)

13. Do you currently smoke or have you smoked within the last year?

14. Do you drink alcohol other than social drinking?

15. Are you under any medication that affects your heart rate, blood pressure, or breathing?

16. Do you have any family/living problems, or transportation issues, which you think might affect your therapy?

17. Do you have any social or vocational issues or are you in need of any service that could benefit with your current problem(s) of impairment, pain, or disability?

18. Have you had any falls or accidents in your lifetime? Please provide injuries sustained and when they occurred :

19. Are you pregnant? or is there a possibility that you may be pregnant ?

20. Do you have any scars from previous surgeries/procedures/injuries ?

21. Have you ever broken or fractured any bones in your body?

22. Are there any findings from previous MRI, CT, or X-ray that we should know about ? If so, please include below:

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23. Do you have abdominal surgeries or conditions such as: mesh implantation, IBS, Diverticulitis, or Celiac Disease?

24. Do you have any chronic conditions such as: Fibromyalgia, EDS, Diabetes, OA, Osteoporosis, POTS, Hoshimotos?

25.Do you have a pacemaker or any other implants ?

26. Do you have any incontinence issues?

27. Do you suffer from migraines or headaches ?

28. Do you have any conditions with your blood pressure?

29. Have you had any long term stays at a hospital in the past ? If so, how long were you admitted?

30. Are you currently taking any medications? If so, please list them:

Agreement: The above questions have been answered to the best of my knowledge and are believed to be true. I have not withheld or concealed any information.

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Treatment Consent

By signing this agreement I am consenting to the rehab procedures, exercises, and/or activities, which may be performed during the course of treatment.

I _____, hereby release Revive Rehab, Inc. from any liability that may arise during and after my course of treatment. Each person signing below, whether as a patient, guardian, or any other legal capacity agrees to the terms and conditions in its entirety. Each person also agrees, either individually or jointly, that they are obligated to pay all charges arising out of this course of treatment, which includes co- pay, deductible and non-covered charges, regardless of insurance type, which includes Medicaid, Medicare, Tricare and/or other private insurance. I also verify that I have been given the opportunity to ask questions and express concerns. I have received a copy of privacy rights, commitment to quality assurance, cancellation policy, waiting room policy, authorization to release records, and patient's rights and responsibilities.
This office may disclose any portion of the patient's records to insurance companies and carriers to obtain reimbursement for services rendered.
I have received a copy of medical record policy and a copy of patient's rights and responsibilities. I also understand and agree that in the absence of the therapist assigned to me, another therapist on staff will see me.

Signature of Patient or Guardian: _____
Date: _____

Name of the Patient or Guardian (please print):
_____

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Authorization to release information:

I _____ (print name), hereby authorize Revive Rehab, Inc. to release my medical information, insurance information, and any other information concerning my rehabilitation process. I also authorize Revive Rehab, Inc. to receive any information about how my rehabilitation treatment will be paid by insurance.

The release in any manner of all information by you is hereby authorized whether such information is of record or not and I do hereby release all persons, agencies, or firms from any liabilities resulting from providing such information.

This authorization is valid from the date of my signature below for 90 days. Please keep this copy of my release request for your files. Thank you for your cooperation.

Signature: _____
Date: _____

Witness: _____Date: _____

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HIPAA Privacy Act:

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Please review this information carefully.
The Health Insurance Portability and Accountability Act of 1997 (HIPAA) is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This act requires us to notify you of information and gives you, the patient, significant new rights to understand and control how your health information is used.

According to HIPAA, we may use and disclose your protected health information without your written authorization for the following reasons:

1. Treatment including the provision, coordination or management of health care and related services by one or more health care providers such as in the case of a referral of a specialist.

2. Payment including activities such as filing an insurance claim in order to obtain reimbursement for services by one or more health care providers such as in the case of a referral of a specialist

3. Payment including activities such as filing an insurance claim in order to obtain reimbursement for services, confirming insurance coverage, obtaining a pre-authorization, billing and collections procedures.

4. Health care operations including administrative, financial, legal, and quality improvement activities, such a compliance audit, necessary to support and properly conduct treatment and payment activities.

5. We may contact you by telephone or mail to provide appointment reminders, test results, and or treatment alternatives. You may notify us in advance if you do not wish for us to contact you for any reason.
Any other uses and disclosures, except as allowed or required by law, which does not require a written authorization.

Examples of other uses and disclosures allowed or required by law, which does not require a written authorization include:

1. To notify family or other individuals involved in your care of emergency or critical care situation.

2. For public health and safety purposes or control disease, injury, or disability threats.

3. To report suspected victims of abuse, neglect or domestic violence.

4. For judicial and administrative proceedings pursuant to a court order or subpoena.

5. For law enforcement purposes pursuant to due process.

6. To assist coroners, medical examiners, and funeral directors in the performance of their duties.

7. For organ donation purposes.

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8. For research purposes pursuant to a board approval waiver of authorizations and research protection policies.

9. For specialized governmental functions such as national security and intelligence activities.

10. To comply with workers compensation requirements pursuant to a signed release.

You have the following rights with respect to protected health information:

1. The right to request restrictions on certain uses and disclosures. However, we are not required to agree to such a request.

2. The right or reasonable request to receive confidential communications of health information from us by alternative means or at alternative locations.

3. The right to inspect and/or receive a copy of your records for a reasonable fee.

4. The right to request a correction or amendment to your records.
5. The right to receive accounting disclosures of your health information.
6. The right to obtain a paper copy of this notice from us upon request.

For assistance with exercising any of these rights, you may contact the Privacy Officer/Compliance Officer at the address listed below. The notice is effective as of April 14, 2003, but we reserve the right to change the terms of this notice in accordance with new/revised laws or office procedures and make the new notice effective for all protected health information that we maintain. We will abide by the terms of the notice currently in effect, and you may receive a copy of the current notice at any time upon request.

If you feel that your privacy rights have been violated, you may file a formal, written complaint with our Privacy Officer/Compliance Officer and/or with the Department of Health and Human Services Office of Civil Rights at the addresses listed below. We respect your right to file such a complaint we will not retaliate against you for doing so.

Compliance Officer
4745 Sutton Park Ct.
Suite #403
Jacksonville, FL 32224

US Department of Health and Human
Office of Civil Rights
200 Independence Avenue
Washington D.C. 20201

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Patients Rights and Responsibilities

1. You have the right to be treated with dignity and respect, as an individual who has personal needs, feelings, preferences and requirements.

2. You have the right to privacy in your treatment, in your care, and in the fulfillment of your personal needs.

3. You have the right to be fully informed of all services available to you at Revive Rehab, Inc. and explanation of any charges for those services.

4. You have the right to be fully informed of your rights as a patient and of all the regulations observing your conduct as a patient in this facility.

5. You have the right to know about your physical condition.

6. You have the right to receive information necessary to give informed consent prior to the start of therapy.

7. You have the right to refuse treatment to the extent permitted by law and to be informed of these rights.

8. You have the right to access and/or referral to guardians, conservator; self help groups and/or advocacy services.

9. You have the right to develop advance directives, if you have not already.

10. You have the right to voice opinion, recommendations and grievances in relation to policies and services offered by the facility, without fear of restraint, interference, coercion, discrimination, or reprisal.

11. You have the right to be free from physical, chemical and mental abuse. Physical and chemical restraints may only be applied when ordered by your physician, in writing, and for a specific limited period of time, except when necessary to protect you from injury to yourself or others.

12. You have the right to confidential treatment of your personal and medical records. Information from these sources will not be released without your prior consent, except in your transfer to another health care facility, or as required by law, or under third party payment contracts.

13. You have the right to refuse to perform any service for the facility, or for other patients. Unless they are a part of your therapeutic plan of treatment, which you have approved.

14. You have the right to retain and use your personal clothing and belongings, as space permits, unless to do so would infringe upon the rights and safety of others, or are contrary to your written plan of treatment.

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15. You have the right to reasonable access to a telephone in case of an emergency to conduct probate telephone communications. You have the right to both make and receive phone calls.

16. You have the right to refuse participation in research activity at Revive Rehab, Inc.

17. You have the right to refuse photographs and videotaping taken during your rehabilitation program.

18. You have the right to be informed in advance of any visitors to Revive Rehab, Inc. and the right to privacy if you do not wish to see visitors, or participate in activities while visitors are present at Revive Rehab, Inc.

19. You have the responsibility for participation in the development of your treatment plan.

20. You have the responsibility for attending therapy sessions and participation in activities prescribed by the treatment plan you approved.

21. You have the responsibility for consideration of the rights of other patients while at Revive

22. Rehab, Inc. You have the responsibility of providing us change or addition of insurance information.

I have received, read and understand the patient's rights and responsibilities information sheet. I have been given opportunities to ask questions and express concerns.

Patient/Legal Guardian Signature: _____
Date: _____

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Revive Rehab, Inc. Commitment to Quality Assurance

If you have questions, concerns, or are dissatisfied with our services here at Revive Rehab, Inc. and wish to file a complaint, you may email our Compliance Officer at info@ReviveRehab.com or send a letter to the following address:

Revive Rehab, Inc.
4745 Sutton Park Ct.
Suite #403
Jacksonville, FL 32224

Should you have any questions about this notice, please feel free to let us know.

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Patient Waiting-Room Policy

To ensure Patient Safety:
All patients who are driven and/or accompanied to this facility must have their guardian/responsible party wait in the lobby during their treatment session and must be accompanied by their guardian/party upon departure. No drop-offs will be permitted at any time.

_____
Legal Guardian/Responsible Party Signature

_____
Witness Signature

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Revive Rehab, Inc. Cancellation Policy

To: All Established and New Patients
Ref: Cancellation Policy

Thank you for choosing Revive Rehab, Inc. for your therapy. We continuously strive to make your goal functional, timely and cost effective. **Due to the increase in missed appointments and cancellations, Revive Rehab, Inc. will be implementing the following new policy**. If you are receiving rehab services from our facility, this policy applies towards canceling and rescheduling of services. **We request if you are unable to keep your appointment that you notify us 24 hours prior to your scheduled appointment.**

You will be charged $50.00 for any therapy session missed. If you miss more than 2 appointments in a 4 week period, each 3rd appointment will be charged for the whole session. This cancellation fee must be paid before services are reinstated.
You are subject to be discharged from our services after 3 missed appointments within a 4 week period.
No call/no show will be charged for the whole session.
If you have any questions, please feel free to speak with our Office Manager.
Respectfully, Revive Rehab, Inc.

_____
Patient Signature

_____
Date