



**SERVICE AGREEMENT, CONSENT, AUTHORIZATION & ASSIGNMENT OF BENEFITS**

**PATIENT'S NAME:** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_ **DATE:** \_\_\_\_\_

I hereby authorize Integrity Rehab to provide therapy services to me, the above named, which have been ordered by my physician and are under the direct supervision of a licensed health care professional. I also understand that it is my right to accept or refuse medical treatments. **Patient's Initials:** \_\_\_\_\_

Are you pregnant? Y \_\_\_\_\_ N \_\_\_\_\_ Are you receiving home health? Y \_\_\_\_\_ N \_\_\_\_\_

**AUTHORIZATION OF RELEASE OF INFORMATION AND PAYMENT**

In applying for payment under Title XVIII or Title XIX of the Social Security Act, or other third party payor sources, I certify that the information given by me or persons authorized by me are correct. This authorization and request shall begin on \_\_\_\_\_ (TODAY'S DATE), and continue until such time that it is revoked by me, my legal representative, physician or this clinic. I also agree if there are any changes to the billing information (i.e., change in insurance company or policy, becoming ineligible or eligible for Medicare and/or Medicaid, etc.) that I will notify the clinic immediately. I understand that should I become liable for any charges after said changes, I will, after receiving a list of charges, be responsible for payment. I authorize the release of any information necessary in order to process any billing. **Patient's Initials:** \_\_\_\_\_

**RELEASE OF INFORMATION/CONFIDENTIALITY**

I hereby authorize any physician, hospital/medical facility, laboratory, or other health care provider to release to Integrity Rehab any information requested by them for the purpose of continuity of care. I also authorize Integrity Rehab to release any of my health care information from them to other health care providers involved in my care, or any facility where I may be admitted for the purpose of continuity of care. I understand and agree that the information requested may be disclosed by facsimile, mail or other reasonable means and also agree that Integrity Rehab cannot assure that the information will be maintained as confidential by any recipient. I also understand and agree to authorize release of information for purposes of State Survey and agency auditing personnel. It is Integrity Rehab's policy to keep all of patient information confidential and to protect clinical records against loss, theft, tampering, and damage or from use by unauthorized persons. A written consent from patient or legal representative is required to release medical information to persons not otherwise authorized by law (federal and state). **Patient's Initials:** \_\_\_\_\_

**ADVANCE DIRECTIVE**

I have been given written materials regarding Advance Directives. I have been informed of my right to formulate an Advance Directive and that I am not required to have one in order to receive medical attention/treatment from this clinic. I understand that should I have an Advance Directive or choose to obtain one in the future clinic personnel will honor the terms.

- I **have not** executed an Advance Directive       I **have** executed Advance Directives as follows:
- Living Will       Out-of-Hospital Do Not Resuscitate       Mental Health Declaration
- Durable Power of Attorney for Health Care    Agent: \_\_\_\_\_

**(NOTE: I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PROVIDE THE CLINIC WITH A COPY OF MY ADVANCED DIRECTIVE. IF I DO NOT PROVIDE THE CLINIC WITH A COPY OF MY ADVANCE DIRECTIVE, THEY HAVE NO RESPONSIBILITY TO HONOR THE TERMS OF THE DIRECTIVE.)** **Patient's Initials:** \_\_\_\_\_

**NOTICE OF NON-DISCRIMINATION**

As a recipient of Federal healthcare reimbursement funds, Integrity Rehab does not exclude, deny benefits to, or otherwise discriminate against any person on the basis of race, color, or national origin, or on the basis of disability or age in admission to, participation in or receipt of services and benefits under any of its programs or activities, whether carried out by Integrity Rehab directly or through a contractor or any other entity with which Integrity Rehab arranges to carry out its programs and activities.

**Patient's Initials:** \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**SERVICES TO BE PROVIDED:** You have the right to be advised, informed of, and participate in the planning of care and/or treatment prior to the start of care. You also have the right to be a part of any future changes/additions to your plan of care. Services to be provided: Physical Therapy Occupational Therapy Speech Therapy **Patient's Initials:** \_\_\_\_\_

**SUPERVISION OF SERVICES AND FREQUENCY:** **Patient's Initials:** \_\_\_\_\_  
PT: Re-evaluation occurs at least every 30 days you are receiving treatment.  
OT: Re-evaluation occurs every 6 months or earlier for re-assessment of goals.  
SP: Re-evaluation occurs every 6 months or earlier for re-assessment of goals.

**HOLIDAYS:** The clinic will be closed on the following holidays: Thanksgiving Day, Christmas Day and New Year's Day. **Patient's Initials:** \_\_\_\_\_

**PATIENT LIABILITY FOR PAYMENT:** You have the right to be informed prior to the start of care what amount you are responsible for.

TriCare Medicare Medicaid Scott & White BCBS Other: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_

Insured's name: \_\_\_\_\_ Relationship to insured: Spouse Child Other

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ Policy/Group #: \_\_\_\_\_

YTD Deductible \$: \_\_\_\_\_ YTD Deductible Met \$: \_\_\_\_\_ Co-Pay \$: \_\_\_\_\_

Insurance Coverage %: \_\_\_\_\_ Patient's %: \_\_\_\_\_ Visits Authorized: \_\_\_\_\_ Pre-Auth Needed? \_\_\_\_\_

**The above named insurance company is authorized and directed to pay any and all benefits due for services rendered to Integrity Rehab, P. O. Box 10340, Killeen, Texas 76547.**

Other payment source: Payment is per the payment source agreement.

Source: \_\_\_\_\_ Billing information: \_\_\_\_\_

Payment source liability \$: \_\_\_\_\_ Patient Liability \$: \_\_\_\_\_

**I agree that I am financially responsible for any deductible and/or co-payment on any of the above.**

**Patient's Initials:** \_\_\_\_\_

**PAYMENT:** In the event it becomes necessary to collect this account, I agree to pay all costs incident thereto, including reasonable attorney fees. I also understand that in the event the insurance company pays me directly, I agree to forward all monies to Integrity Rehab. In the event an outstanding account balance accrues, I will be responsible for interest and/or late fees associated with debt.

**Patient's Initials:** \_\_\_\_\_

**PATIENTS RIGHTS AND RESPONSIBILITIES:** I have been informed of both my rights and responsibilities verbally and in writing at time of admission. **Patient's Initials:** \_\_\_\_\_

**RIGHTS OF THE ELDERLY (over 60):** I have received a copy of the Human Resources Code, Chapter 102-Rights of the Elderly. I have also been informed of my rights verbally and in writing prior to the start of care.  N/A  (given to patient by) \_\_\_\_\_

**Patient's Initials:** \_\_\_\_\_

**ABUSE/NEGLECT/EXPLOITATION:** I have been advised of, and received a copy of the policy relating to the reporting of abuse, neglect, and exploitation of a client. **Patient's Initials:** \_\_\_\_\_

**CELLULAR TELEPHONE USAGE:** Integrity Rehab highly encourages that cellular telephones not be used in the clinic. Cellular telephones can create interference with therapy equipment and also create a disturbing environment for other patients.

**Patient's Initials:** \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

**CHILD POLICY:** I have received a copy of Integrity Rehab's Child Policy.

**Patient's Initials:** \_\_\_\_\_

**MISSED APPOINTMENT/CANCELLATION POLICY:** I have received a copy of Integrity Rehab's Missed Appointment/Cancellation Policy.

**Patient's Initials:** \_\_\_\_\_

**DRUG TESTING POLICY:** I have been informed that I have the right to receive a copy of Integrity Rehab's policy on drug testing their employees.

**Patient's Initials:** \_\_\_\_\_

**EMERGENCY PLAN:** Integrity Rehab's operating hours are from 7:00 a.m. -7:00 p.m. M-TH and 8:00 a.m. – 5:00 p.m. F. After hours calls will be forwarded to an answering machine. For medical emergencies, you are to call **EMS/911**. I have received a copy of the emergency plan.

**Patient's Initials:** \_\_\_\_\_

**PRIVACY PRACTICES:** I have been informed of Integrity Rehab's policy regarding privacy practices and received a copy of the Privacy Act Statement.

**Patient's Initials:** \_\_\_\_\_

**CONSENT TO RELEASE INFORMATION:** I authorize Integrity Rehab to obtain all confidential pertinent medical information necessary for evaluation and a comprehensive plan of care. I have signed a release of information consent and understand that I may revoke this at any time.

**Patient's Initials:** \_\_\_\_\_

**CONSENT FOR TREATMENT:** I authorize Integrity Rehab to provide me with any and all therapy services as ordered by my physician.

**Patient's Initials:** \_\_\_\_\_

**EMPLOYEE RESPONSIBILITY:** I understand that employees are only responsible for the patients they are assigned to. They are not responsible for the care/safety of others while providing services.

**Patient's Initials:** \_\_\_\_\_

**GRIEVANCE/COMPLAINT PROCEDURE:** Should you have a complaint or grievance, we will do everything in our power to rectify the situation without fear of reprisal. Please call the Administrator or Director of Physical Therapy at **(254) 699-3933**. If the complaint is not resolved within 30 days and to your satisfaction, it is your right to call the State Hotline at **1-800-821-3205** or send your written complaints via email to [info@ecptote.state.tx.us](mailto:info@ecptote.state.tx.us).

**Patient's Initials:** \_\_\_\_\_

**I acknowledge that the information above has been provided to me in my primary language, or via an interpreter.**

\_\_\_\_\_  
**Patient signature and date**

\_\_\_\_\_  
**Authorized agent signature and date**

\_\_\_\_\_  
**Relationship to patient**

\_\_\_\_\_  
**Integrity Rehab Representative**