MARSH BROOK
REHAB
Patient-focused. Results-driven.

PATIENT INFORMATION SHEET

Last Name:		First Name:	M.I.:
Street Address:			P.O. Box (if applicable)
City:	State:		Zip:
Home Phone:	Email:		
Cell Phone:			
Date of Birth: (mm/dd/yyyy):	Marital Status: † Single † Married † Other † Student		Sex: M_____ F______
If minor, parent/guardian:			
Employer	Work Telephone:		
Referring Physician	Telephone:		
Primary Care Physician:	Telephone:		
Date of Injury or Onset of current episode/illness:			

PRIMARY MEDICAL INSURANCE INFORMATION

Please circle one below:

† Workers' Compensation † Motor Vehicle Accident † Health Insurance † Self Pay

(For workers' compensation and motor vehicle claims, please complete the appropriate information on next page. We also need your health insurance information as many insurance companies require authorizations to be obtained even though we are not billing them.)

Health Insurance Company (***Please bring insurance card***):	Telephone:
Insurance ID Number:	Insurance Group Number:
** Subscriber's Name:	Date of Birth:
Relationship to Patient:	
Subscriber's Employer:	

** If you have this policy through your spouse, parents or other sources, he or she will be the subscriber of your insurance policy.

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Workers' Compensation Information

If this is a work-related injury, please complete the information below.

- Date of Injury: ________________
- State where injury occurred: ______________________
- Employer Workers' Compensation Carrier information:

Insurance Name: ____________________

Address: ____________________ P.O Box: ____________

City: ____________ State: ____________ Zip Code: ____________

Telephone Number: ____________________

Adjustor: ____________________

File Claim Number: ____________________

Motor Vehicle Information

If this is a motor vehicle related injury, please complete the information below.

- Date of Injury: ________________
- State where injury occurred: ______________________
- Auto Insurance information:

Your Auto Insurance Name: ____________________

Address: ____________________ P.O Box: ____________

City: ____________ State: ____________ Zip Code: ____________

Telephone Number: ____________________

Medical Payments Representative: ____________________

File Claim Number: ____________________

** **If someone else was responsible for the motor vehicle accident, please complete below.**

Responsible Party's Auto Insurance Name:: ____________________

Address: ____________________ P.O Box: ____________

City: ____________ State: ____________ Zip Code: ____________

Telephone Number: ____________________

Claim Representative: ____________________

File Claim Number: ____________________

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Acct #:_____________ Date:__________ Reviewed with Pt

Patient Name (Please Print):____Date of Birth:__________________

Emergency Contact Person: ________________________ **Tel #:**_______________________**Relationship:**_________________

Diagnosis:____ Primary Care MD & Tel #:_________________________________

Health History	Yes	No	If Yes, Treatment/Condition/Date
Lung Disease			
Liver Disease (Ex. Hepatitis)			
Kidney Disease			
Heart Disease			
Diabetes (Type)			
High or Low Blood Pressure			
Arthritis			
Blood Clots/Circulation Problems			
Mental Health (Ex. Anxiety, Depression)			
Seizures/Epilepsy/Fainting (syncope)			
Recent Weight Loss or Gain			
Cancer: Location__________			
Tuberculosis			
Bruise Easily (Ex. Anemia, From Medications)			
Multiple Sclerosis			
Thyroid Disease			
Stroke			
Osteoporosis/Osteopenia			
Recent Falls			
Contagious Disease (Ex MRSA, C-Diff, HIV)			
Neurological/Cognitive Impairments			
Hearing/Vision Impairments			

Other Medical Conditions:____
Precautions (i.e. Pacemaker, Hip Replacement):____
Current Medications (Include Herbs and Vitamins):____
____
Past Surgeries and Date (Orthopedic, Cardiac, etc): ____
____
Recent Hospitalization (Reason and Date):____
Allergies:____
Height:______________ Weight:______________ Age:_____________
Do you smoke: No Yes: How many packs per week: _________________
Do you drink: No Yes: How many drinks per week: ________________
Women: Are you Currently Pregnant? Yes___ No___
Marital Status: Single____ Married___ Widowed___ Divorced___
If employed, occupation: ____

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AOB, Revised 9/14/09

ASSIGNMENT OF INSURANCE BENEFIT

I hereby agree to be evaluated by Marsh Brook Rehab and agree to such treatment that in the opinion of the physician(s) and therapist(s) is necessary.

I understand that it is my responsibility to obtain any insurance referrals prior to my first Occupational or Physical Therapy appointment. If I schedule and attend my appointments without the proper insurance referrals, I understand that I will be asked to sign a waiver form for all visits, accepting financial responsibility for each visit without a referral.

I understand that it is my responsibility to verify Occupational and Physical Therapy coverage with my insurance carrier(s) and that I am financially responsible for charges not covered by my insurance carrier.

I understand that as a courtesy Marsh Brook Rehab will do their best to obtain accurate therapy benefit information from my insurance company. Insurance companies are not always able to tell the details of a health plan, nor can they guarantee coverage in advance. Insurance payment for treatment is always subject to health plan limitations, restrictions, and coverage criteria often outside of our control or knowledge. For these reasons Rehab 3 at Marsh Brook cannot be 100% certain of my therapy coverage either and cannot be held liable for inaccurate or incomplete information given to them by my insurance company.

I understand that it is the policy of Marsh Brook Rehab to ask for back-up health insurance for all Worker's Compensation patients in the event the W/Comp claim is denied. I also understand that it is my responsibility to obtain any health insurance referrals for this back-up insurance prior to my first appointment. If no referral available, and my W/Comp claim is denied, I will be held liable for all charges.

I acknowledge that I have received a copy of the Consumer Bill of Rights and Responsibilities and the Marsh Brook Rehab billing, payment, and cancellation policy.

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Assignment of Insurance Benefit (Medicare Included), Release of Information And Financial Responsibility

- I authorize and request payment of medical benefits directly to Marsh Brook Rehab.
- I authorize the release of any medical information necessary to process my insurance claim(s).
- I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.
- I agree that a photocopy of this form may be used in lieu of the original.
- **I accept financial responsibility for any and all charges incurred at Marsh Brook Rehab**, including (but not limited to) any balances which may not be covered by my insurance, such as my deductible, co-insurance, co-payments, and the balance of the usual and customary fee. This balance is payable at the time of service or upon receipt of statement.

Signature: ____ Date: ________________

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Dear Patient:

Welcome to Marsh Brook Rehab. We are a division of Strafford Health Alliance, which is a joint venture of both Frisbie Memorial Hospital in Rochester and Wentworth-Douglass Hospital in Dover. Although we work closely with Seacoast Orthopedics and Sports Medicine (SOSM), we are two completely separate companies without financial or ownership relationship. We handle all billing, documentation, and any other patient information independent of SOSM. As part of our registration procedure, we would like to inform you of our current billing policies. If you would like a list of our current therapy charges, please request one at registration.

INSURANCE INFORMATION AND BILLING POLICY:

In order to properly and efficiently process your therapy claim(s), accurate insurance information is needed at your initial visit. While most insurance companies cover physical and occupational therapy charges, IT IS YOUR RESPONSIBILITY TO VERIFY COVERAGE FOR PHYSICAL AND/OR OCCUPATIONAL THERAPY OUTPATIENT SERVICES in a freestanding clinic. While we are a participating provider with many insurance companies, please ask our front office staff if we are in your network.

PAYMENT POLICY:

- Patients with health insurance coverage (other than NH Medicaid or Worker's Compensation) will be expected to make a co-payment or percentage co-insurance payment consistent with their policy at each visit. If deductibles have not been met, patients are responsible for payments as claims are processed by your insurance, unless other arrangements are made. After final payment has been received from the insurance company, the patient will be billed for any remaining balance. **Please note that Financial Assistance is available if applicant meets income guidelines. Please ask our receptionist for more information.**
- Parents of MINORS and/or COLLEGE STUDENTS who are able to drive themselves to appointments are expected to send in payment with their child at each visit.
- All SELF-PAY patients are expected to pay weekly balance in FULL, unless other arrangements are made with us prior to treatment.

CANCELLATION POLICY:

Please be sure to notify us 24 hours in advance at (603) 749-6686 if you cannot make your scheduled appointment. Failure to do so may generate a charge to your account. This will be your responsibility, because it is not covered by any type of insurance coverage. **TWO CANCELLATIONS OR NO-SHOWS WITHIN A 30-DAY PERIOD WILL TERMINATE ALL FUTURE THERAPY SESSIONS,** unless otherwise approved by the treating clinician.

- Any billing questions should be directed to the Patient Accounts Coordinator.
- Any returned checks will result in a $15.00 charge to your account.

Thank you for choosing us to help meet your rehabilitation needs. We are pleased to serve you and welcome your feedback at all times.

7 Marsh Brook Drive • Suite 101 • Somersworth, NH 03878 • Ph: 603-749-6686 • Fax: 603-749-9270

CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES AT MARSH BROOK REHAB (MBR)

As a person who makes use of the services available at our clinic, you have the RIGHT:

- To receive considerate and respectful care at MBR without discrimination based on your race, creed, color, national origin, religion, sex, sexual preference, handicap, or age;
- To be given the information you need to give informed consent for treatment prior to your treatment being started and to consider use of alternative services which may be available to you;
- To receive complete information about and/or participate in the development of your plan of care and the updating or reassessment of that plan;
- To refuse medical treatment or other services provided and to be informed of the possible results or consequences of your refusal;
- To know that information about your health, social and financial circumstances and about what takes place during your care is considered private and confidential;
- To know that all verbal communications and written records pertaining to the services you receive will be handled confidentially;
- To expect that all clinic staff employed by MBR will, within the limits of your plan of care, respond in good faith to your requests for assistance in any way;
- To receive information about the clinic's operations, policies and procedures, such as information on service costs, qualifications of staff, supervision of staff, and your eligibility for third-party payment(s);
- To receive services as is needed and available to meet your health care needs;
- To examine all bills for services regardless of whether they are paid for by you or by other sources;
- To be given information about any anticipated transfer of your health care to another facility and/or ending of the care provided to you;
- To voice a grievance and/or suggest a change in what service is provided and/or the staff that provides it without fear or being threatened, discriminated, or otherwise retaliated against.

As a MBRS consumer you have the RESPONSIBILITY:

- To give accurate and complete health care information concerning past illnesses, prior hospitalizations, medications used, allergies, and other subjects related to your health care;
- To inform the clinic when you will not be able to keep an appointment for a scheduled visit;
- To follow your current plan of treatment;
- To request further information concerning anything which you do not understand;
- To sign a Fee Agreement informing you of your financial responsibility for payment of services not covered by your insurance company; and
- To give honest feedback, preferably to someone who has a supervisory role at the clinic, regarding concerns or problems you have about clinic services or staff.

Marsh Brook Rehab: For more information go to www.marshbrookrehab.com

Attachment D

Strafford Health Alliance
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

I acknowledge receipt of the Notice of Privacy Practices from Strafford Health Alliance ("SHA").

I understand this Notice contains important information about how my protected health information may be used and disclosed and how I can get access to this information. I understand that SHA has the right to change this Notice at any time and I may obtain a current copy upon request.

Signature of Patient or Representative: ____

Physical and Occupational Therapy Student Consent Form

As a Physical Therapy/Occupational Therapy teaching facility, Marsh Brook Rehab is a clinical training center for several colleges and universities. *To ensure that all patients receive the high quality care that we demand, student interns work only under the direct supervision of our experienced physical and occupational therapist Clinical Instructors.* Please understand, however, that we encourage you to speak with our Practice Manager or Clinical Director to request a change in your caregiver at any time if you are dissatisfied with the services you receive.

By signing below, you are confirming that you have read and understand the above information, and that you consent to allow student physical or occupational therapy interns to participate in your treatment. This consent will remain in effect until we are otherwise notified.

Patient/Responsible Party Signature: ___________________________________ Date:____________