

OUTPATIENT THERAPY SERVICES

Letter of Agreement

Client Name: _____

Patient's Rights

I have read, or have had read to me, and received a copy of the Patient's Rights and Responsibilities and Grievance Procedure Statement. I understand my rights and responsibilities and grievance procedure as stated.

Consent for Treatment

I hereby authorize the Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics and its agents to provide the above named patient with the care, treatments, and procedures ordered by his/her physician and as requested by this patient or his/her guardian. The risks and possible adverse consequences of treatment will be explained prior to initiation of treatment and I have the right to refuse said treatment.

Authorization for Release of Information

I hereby authorize the Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics to release such information as may be necessary for the coordination or continuation of my care to other service providers and to the third party payor (including the Fiscal Intermediary) as required to receive payment. I also consent to the release of information from prior health records to the Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics as needed by its agents.

This medical information may include the medical record as well as information concerning treatment of drug or alcohol abuse, drug-related conditions, alcoholism, psychiatric/psychological conditions and AIDS or AIDS related conditions. The review of the records is also authorized.

Emergency

I understand that it is the policy of Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics that in case of an emergency, 911 will be notified immediately and CPR will be initiated by staff trained in these basic techniques.

Attendance: Client Initials: _____

_____ *In order to show progress toward therapy goals, a client MUST attend scheduled sessions. A client who misses three (3) consecutive or more than four (4) visits will be discharged from skilled therapy.*
_____ *CO-PAY MUST be paid at time therapy is rendered.*

Privacy

I acknowledge that I have received the “Summary of Privacy Practices” enclosed in the Outpatient Rehabilitation Welcome Packet. For this course of treatment, I authorize release of medical information to the following: *(excluding direct care medical personnel)*

- Family members (*List specific individuals*)**

- Other personal representatives (*List specific individuals*)**

- No one**

Payment for Services

I understand therapy and/or nutritional counseling must be ordered by a private physician. Complete medical information, forms and physician referral must be received from the private physician BEFORE the evaluation can begin. Third party payers, such as Medicare, workers compensation, auto insurance, or any other insurance provided will be billed for therapy evaluations and treatment for services rendered. The participant/family will be responsible for fees not covered or paid for by these third party payers.

CO-PAY must be paid at time service is rendered.

Responsibility of Payment

- Are you here as a result of a car accident? YES NO
- Are you here as the result of a work related accident? YES NO
- Are you here as a result of an accident that another party is responsible? YES NO

If any of the above answers yes, please provide:

Name and address of insurer: _____

Insurance Claim Number: _____

I have reviewed and understand the Letter of Agreement as described above and my Bill of Rights/Responsibilities.

| | | |
|--------------|-------------------|------|
| Client Name | Client Signature | Date |
| Witness Name | Witness Signature | Date |

Note: If client is under 18 years of age or is unable to understand these rights, a guardian or client representatives’ signature is required.

CREDIT CARD GUARANTEE POLICY

All clients are being requested to provide credit card information as a guarantee for payment for all services rendered by Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics.

Credit card information is not entered into the data base of any computer. A copy of your authorization is stored in a secure location with access limited to the office manager and select employees in the billing department.

Medicare and/or your insurance (if applicable) will be billed for covered services. Once we have received a response you will be sent one statement for any balance your insurance company has determined to be your responsibility. You will have an opportunity to call the billing department to question your balance and/or make payment arrangements. If we do not receive a phone call or payment by the due date printed on your statement, your credit card will be charged for the balance due. A copy of the credit card receipt will be mailed to you the following day.

I _____, address _____, as the identified card holder of this *(please circle)*:

American Express Discover Master Card Visa

Credit card number _____ date of expiration _____

CID number (3 digits on the back of card) _____ Billing Zip Code _____

Authorize Peter B. Lewis Aquatic & Therapy Center and/or Menorah Park Outpatient Therapy Clinics the use of this card for the identified reason stated above as of today's date of _____.

****Is this a debit card? **YES** **NO**

Signature of Cardholder _____

COMMENTS _____
