Dora Roberts Rehabilitation Center

Welcome!

We want to thank you for allowing us the opportunity to provide you with the highest level of quality rehabilitation services possible. We are committed to providing you with a comfortable, friendly and patient-oriented environment.

Our Center has a long and proud history in Big Spring and Howard County. Founded in 1961 and named to honor Howard County's Pioneer Mother, Mrs. Dora Ann Roberts, the Dora Roberts Rehabilitation Center was established to improve the quality of life for handicapped and disabled individuals of our community.

In 55 years of continuous services, the Center has grown to include a full range of outpatient rehabilitation services including Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, Audiology, Employment Drug Testing and Wellness Programs.

DRRC is operated as a non-profit organization and is therefore able to provide all rehabilitation services on a Sliding Fee Scale Basis. No one is turned away for an inability to pay. In addition to fees from services, the Center's excellent staff and equipment are made possible due to the ongoing support of the Dora Roberts Foundation, private donors, community donations, memorials and the United Way of Big Spring and Howard County. If you feel pleased with the services you receive here, we would greatly appreciate your support when considering future giving choices.

We look forward to serving YOU. If we can do anything to make your time with us more enjoyable, please let us know.

Sincerely,

Michelle Grove
Executive Director

Authorization for Use or Disclosure of Protected Health Information

I authorize my provider and /or Dora Roberts Rehab Center staff to use the following protected health information, and/or disclose the following protected health information to:

Referring Physician
Health Plan
Other: Please List

This protected health information is being used or disclosed for the following purposes:

Provide treatment to me
Obtaining payment for my health care bill

{Specifically describe the PHI to be used or disclosed such as:
dates of service, type of service, level of detail to be released, origin of information, etc.}

I understand that I have a right to revoke this authorization, in writing, at any time by sending such written notification to:

Dora Roberts Rehab Center
Attention: Privacy Officer
306 West Third Street
Big Spring, TX 79720

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My provider will not condition my treatment, payment, or eligibility for benefits on whether I provide authorization for the requested use or disclosure unless my health care services are provided to me solely for the purpose of creating PHI for disclosure to a third party.

Date

Signature of Patient or Personal Representative

Print Name of Patient or Personal Representative

Description of Personal Representative's Authority

Patient Consent For Treatment

State law requires that you be informed about your condition and the recommended physical, occupational, and/or cardiac rehabilitation therapy procedures to be used so that you may actively participate in the decision whether to undergo the treatments offered as prescribed by your physician. This disclosure is to make you better informed so that you may participate in the decision to give or withhold your consent to the therapies prescribed.

I/We voluntarily request Dora Roberts Rehabilitation Center to treat my condition as described to me by my physician and the therapist involved.

I/We understand that the treatment/procedures to be followed are those prescribed by my physician.

I/We understand that all therapy procedures are planned for me and I/We voluntarily consent and authorize the therapy procedures prescribed. If in the professional opinion of my therapist, additional therapies are needed, I/We understand that additional therapies and/or procedures may be continued by receipt of written or verbal orders from my physician.

I/We understand that no warranty or guarantee has been made to me as to result or cure.

I/We have an opportunity to ask questions about my condition, alternative forms of treatment, risk of non-treatment, the procedures to be used, and/or the risks and hazards involved.

I/We certify that this form has been fully explained to me, that I/We have read it or have had it read to me. I/We understand the above content and believe that I/We have sufficient information to give this consent.

_____ _____

Signature of Patient/Parent/or Legal Guardian Date

_____

Witness

Dora Roberts Rehabilitation Center

Patient Financial Responsibility

We are committed to providing you with the best rehabilitation services possible. If you have special needs, we are here to work with you. The following information is provided to explain our policies concerning payment for services:

1. If you are covered by health insurance, it is your responsibility to know your plan's benefits, limitations and requirements to receive coverage for outpatient rehabilitation services. DRRC billing staff may provide assistance to you; however, we do not guarantee insurance plan reimbursements. Regardless of benefit quotes and preauthorization of services, all balances deemed by the insurance company as "patient responsibility" will be considered due and payable to DRRC. For this reason, we highly recommend each patient to communicate thoroughly with their insurance company to ensure requirements are met for maximum claim reimbursement. Upon completion of your prescribed therapy program, we will collect your portion of balances due on claims that have fully processed through your insurance carrier(s). Remaining patient balances are due as claims finish processing and upon receipt of our statement(s). We cannot stress enough the importance of being an informed and educated patient where your individual insurance is concerned.

2. If you do not have any health insurance coverage, account balances are due weekly with the final balance due on the last day of treatment. Cash discounts are available for those making timely payments.

3. If you are covered under worker's compensation, we will file to your employer's carrier and will schedule your visits according to the worker's compensation benefits.

4. If you are a returning patient with an outstanding patient responsibility balance, payment of this balance is required prior to the initiation of new or continued services.

5. DRRC accepts third party liability claims in some instances. However, we must receive documentation from the attorney or insurance carrier prior to the initiation of services wherein there is an agreement to reimburse the Center directly. If this letter of protection cannot be obtained, then the patient is considered a private payer and will be responsible for services received and payment will be due according to policy.

6. Dora Roberts Rehabilitation Center is a non-profit organization and no person is turned away for an inability to pay. If you believe that you cannot afford services, please inform us immediately because you may be eligible for financial assistance through the Center's forgiven program. Through this program, which is partially funded by the United Way of Howard County and Big Spring, services are provided on a sliding fee scale basis as determined by your personal financial circumstances. We want to help you.

7. If a person does not qualify for financial assistance and refuses to make payment for personal balances due, the Center does make every effort, including the employment of Collection Agencies, to collect appropriate balances due.

8. If the patient is a minor (18 years or younger), the parent or guardian must sign below.

By my signature below, I hereby understand and agree to the terms of Dora Roberts Rehabilitation Center's Financial Policy.

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Patient's Name (if signature above belongs to responsible party)

DORA ROBERTS REHABILITATION CENTER
MEDICAL HISTORY

Patient's Name:_____ Today's Date:_____

Date of **next** Doctor's visit (the doctor that referred you to therapy):_____

Were you injured? ☐Y ☐N If Yes, Date of Injury:_____ Please describe how you were injured:_____

If you were not injured, what date did your symptoms begin?_____

Did you have surgery? ☐Y ☐N If Yes, Date of Surgery:_____

Have you been hospitalized recently: ☐Y ☐N Dates:_____to_____

Are you employed? ☐Y ☐N Occupation:_____

Are you presently working? ☐Y ☐N Restrictions:_____

Please check diagnostic tests performed for your current condition:

☐X-Ray	☐MRI	☐CT Scan	☐Bone Scan
☐Bone Density	☐EMG	☐Ultrasound	☐Other:_____

Have you seen anyone else for your current condition?

☐Physical Therapist (how many visits?__)	☐Pain Management Doctor
☐Chiropractor (how many visits?__)	☐Massage Therapist (how many visits?__)
☐Acupuncturist (how many visits?__)	☐Other:_____

Please list current medications:_____
_____

Please list previous surgeries:_____
_____

Please mark all of your current functional limitations:

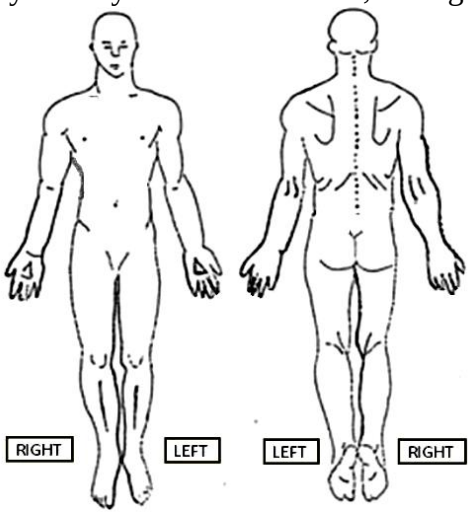
☐Unable to walk community distances due to pain, fatigue, and/or weakness	
☐Unable to climb stairs due to pain, fatigue, and/or weakness	
☐Unable to perform house chores including _____	
☐Unable to perform yard work activities	☐Unable to perform overhead activities
☐Unable to sleep on affected side	☐Unable to dress without assistance
☐Unable to perform personal hygiene	☐Unable to sit for prolonged periods
☐Unable to perform recreational activities such as _____	
☐Other:_____	

Have you ever been diagnosed or treated for any of the following conditions?

☐Diabetes ☐Headaches ☐Dizzy Spells ☐Fainting Spells ☐Epilepsy
☐Stroke ☐Pregnancy ☐Seizures ☐Bleeding Disorder ☐Fracture
☐Osteoporosis ☐Back Injury ☐Arthritis ☐Heart Trouble ☐Pacemaker
☐Tuberculosis ☐Asthma ☐Emphysema ☐Respiratory Problems
☐High Blood Pressure ☐Incontinence (Bowel/Bladder)
☐Cancer:_____ ☐Other:_____

PAIN RATING: On a Scale of 0 to 10 (0 being no pain and 10 being unbearable pain requiring hospitalization), please rate your pain at its best _____ and at its worst _____.

Please put an **X** anywhere you are having pain, and an **O** anywhere you have numbness, or tingling.



Pain is worse:
☐Morning ☐During the day ☐At Night

Pain is worse:
☐Sitting ☐Standing ☐Walking

Pain is worse:
☐With activity ☐At rest ☐When trying to sleep

Pain is:
☐Constant ☐Frequent
☐Occasional ☐Rare

Numbness / Tingling is:
☐Constant ☐Frequent
☐Occasional ☐Rare

What is your main goal for Therapy?_____

Is there anything else your therapist should know before therapy begins?_____
_____

What days are you available for Therapy?
☐Mondays ☐Tuesdays ☐Wednesdays ☐Thursdays ☐Fridays

What time of day is best for Therapy?
☐Anytime ☐Early Mornings ☐Late Mornings ☐Early Afternoons ☐Late Afternoons

It is our policy to provide Cardio-Pulmonary Resuscitation (CPR) when deemed medically necessary. If these are not your wishes, we must have a valid copy of your living will on file.

Please acknowledge:_____
Patient Signature (Parent/Guardian)

DORA ROBERTS REHABILITATION CENTER
306 WEST THIRD STREET
BIG SPRING, TX 79720
PHONE:(432) 267 3806 FAX (432) 267 3809

PATIENT REGISTRATION FORM

Patient Name: _____ Date of Birth: _____ Age: _____

SS#_____

Marital Status (Circle): Single / Married / Widowed Gender (circle): Male / Female

_____
Mailing Address (Street, City, State, ZIP) Physical Address (Street, City, State, ZIP)

Home Phone #:_____Cell Phone #:_____Fax #:_____

Employer: _____Wrk Phone#:_____

Guardian/Spouse's Name:_____

Guardian/Spouse's Employer:_____Wrk Phone#:_____

Emergency Contact: _____ Phone#:_____

Referring Provider:_____ PCP:_____

May we communicate DRRC news or patient billing information to you via e-mail? Y / N
E-Mail Address_____

***Are you currently receiving home health? Y / N If yes, what agency?* _____**

INSURANCE AND BILLING INFORMATION

1)Insurance Company: _____ ID#_____

Name of Policy Holder: _____ PH DOB _____ Grp#_____

2)Insurance Company: _____ ID#_____

Name of Policy Holder: _____ PH DOB _____ Grp#_____

Benefits: Deductible:_____ Met: Y / N Coinsurance:_____% Co-pay:_____

In Network / Out Network Plan Limitation:_____

***Assignment of Insurance Benefits*: I hereby authorize direct payment of benefits to Dora Roberts Rehabilitation Center for services rendered. _____ (initials)**

***Authorization to Release Information*: I hereby authorize Dora Roberts Rehabilitation Center to release any medical information that may be necessary for continued medical care with my physician or to obtain reimbursement from insurance companies and/or third parties. _____(initials)**

***Publications:* I hereby authorize Dora Roberts Rehabilitation Center permission to take photographs & other types of recordings, which may be used for publications and/or presentations. I understand that such information will be completely anonymous. _____**
Initials

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

Dora Roberts Rehabilitation Center

Guidelines For Medicare Patients

Effective January 1, 2017 Medicare has placed a financial limitation of $1980.00 per calendar year for physical therapy services and a separate financial limitation of $1980.00 for occupational therapy services. As a courtesy to our patients we will maintain a treatment and procedure log to monitor the total of Medicare services provided toward the Medicare therapy cap. If you should reach the financial limitation with Medicare and it is deemed necessary by you and your physician to continue with therapy, we will continue with treatment; however, you will be responsible for payment personally or through another insurance that you may have. We will notify you if you are close to reaching your cap so that you understand the cost of further therapy.

By signing below I agree to the aforementioned guidelines and will abide by this agreement.

_____ _____

Signature Date