WHITTIER
Rehabilitation Hospital

Primary Emergency Contact:

Name: _____ Phone Number _____

Relationship: _____

Secondary Emergency Contact:

Name: _____ Phone Number _____

Relationship: _____

Primary Care Physician:

Name: _____ Phone Number _____

Relationship: _____

Whittier Rehabilitation Hospital
Conditions of Admission / Treatment

1. CONSENT TO CARE: I am presenting myself for admission to Whittier Rehabilitation Hospital ("Whittier"), or I am the designated patient representative, and I voluntarily consent to the rendering of such care including diagnostic procedures, hospital care, and medical treatment that may be deemed necessary or beneficial while I am a patient at Whittier or receiving outpatient services. I acknowledge that no guarantees have been made to me as to the effect of such examination or treatment on my condition and that the practice of medicine and rehabilitation is not an exact science. I realize that during the course of my care at Whittier, or for follow-up care, it may be necessary for Whittier or my attending physicians to make available to other health care providers, copies of my medical records for information relating to my care, and I consent to such releases. I also authorize Whittier to request copies of my medical record from other health care facilities or physicians for the purpose of continuity of care. I further understand that this authorization is valid for the length of this treatment period and I do hereby indemnify and hold harmless the physician, Whittier, and other persons who act in reliance upon this authorization.

2. ASSIGNMENT OF INSURANCE BENEFITS AND CONSENT TO RELEASE MEDICAL INFORMATION: I hereby assign the benefits of my insurance contract to Whittier Rehabilitation Hospital and authorize payment directly to Whittier Rehabilitation Hospital of the hospital insurance benefits otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of treatment. I assign payment for the unpaid charges for certain hospital physicians' services furnished by specialists, physicians or therapists for whom the hospital is authorized to bill. I understand I am financially responsible to Whittier for charges not paid by insurance unless determined otherwise by the regulations or statutory law. I also authorize Whittier to release or obtain such information as is necessary for the completion of any claims for hospitalization insurance or workmen's compensation. I understand there may by psychiatric information included on these records.

3. RESPONSIBILITY FOR PAYMENT: In consideration for services and treatment rendered by Whittier to the above, I hereby assume full responsibility for and agree to pay all charges of the hospital of every kind for described services, equipment, facilities, medication, etc., supplied or furnished to the patient. Whittier and its subsidiaries reserves the right to terminate any delinquent account for non-payment after thirty days written notice and said account will thereafter be placed into collections. I further agree that if I am more than thirty (30) days overdue in the payment of any bill connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission, a finance charge of 1.5% per month will accrue on the unpaid balance; and if the overdue account is referred by collection, I agree to pay the attorney's fees, court costs and/or collection agency fees associated with the collection process. I specifically waive any exemption of wages from garnishment which might be available by law, and agree that my wages can be garnished in the event a Judgment is entered against me for collection of the hospital charges I have agreed to pay.

4. PERSONAL VALUABLES / BELONGINGS: I understand that the Whittier cannot and will not accept responsibility for the safekeeping of any of my valuables/belongings and is not responsible if they are lost, misplaced or damaged. I understand that I am, at all times, responsible for the safekeeping of my personal belongings. Dentures, glasses, hearing aids, medications, my garments and essential daily necessities are considered personal belongings.

5. PHOTOGRAPHY AND OTHER IMAGING: I understand that photographs, videotapes, digital, or other images may be recorded by Whittier, and I consent to this. I understand that Whittier will retain ownership rights to these photographs, videotapes, digital, or other images. Images that identify me will be released and/or used outside Whittier only upon written authorization from me or my legal representative.

6. GUARANTOR AGREEMENT: By signing in the space below as Patient/Guardian or Guarantor, or as Patient's/Guardian's Spouse or Guarantor's Spouse, I hereby agree that all charges connected with this treatment, and past and future treatment if related to the incident or condition giving rise to this admission, not covered by any insurance, program, sponsorship or other third party coverage are due and payable by me at the time of discharge or discontinuation of treatment.

7. UTLIZATION OF HEALTHCARE INFORMATION: I acknowledge that Whittier may utilize my medical information for data collection purposes within its health care operations, including but not limited to performance improvement and quality assurance initiatives.

8. I acknowledge receipt of a copy of *Whittier Rehabilitation Hospital's Rights and Responsibilities of Patients.*

9. This form has been fully explained to me and I certify that I understand its contents.

_____ _____

Witness Date Signature of Patient Date

_____ _____

Responsible Party Date Relationship to Patient

WHITTIER
Rehabilitation Hospital

THE OUTPATIENT CENTER
ATTENDANCE AND INSURANCE STATEMENT

Thank you for choosing Whittier Rehabilitation Hospital for your outpatient rehabilitation needs. To ensure that you receive the optimum results from the treatment you receive, we ask that you follow these guidelines:

1. If patient needs to cancel an appointment, please call the office as soon as you know you will not be able to make the appointment. We will make every effort to reschedule the patient's appointment to a time convenient for you.

2. If patient dos not show up for a scheduled appointment and does not call the office, this will be considered a "no-show". **A "no-show" appointment will result in a $50.00 fee.**

3. **If a patient has 2 "no-shows" on record the patient will be discharged from services** and his/her referring physician will be notified in writing of his/her termination of treatment.

4. **If a patient cancels 50% of his/her scheduled appointments the patient will be discharged from services** and his referring physician will be notified in writing of his/her termination of treatment.

5. It is the patient's responsibility to notify the office if there is a change of the patient's primary care physician, insurance company, or relocation of outpatient services to another facility. **If failure to notify the front office of a change in primary care physician, insurance company, relocation of outpatient services to another facility result in insurance reimbursements being denied it is the patient's responsibility to pay all denied claims and other cost associated with patient's account.**

6. **ALERT**: Home health care services and outpatient rehabilitation services are not covered simultaneously by insurance provides. If the patient is currently receiving home health care services covered by their insurance, they are unable to receive covered outpatient therapy services. In this situation, outpatient services will not be billed to the insurance provider and will be the responsibility of the patient.

- I have read and understand the above guidelines.

_____ _____
Patient's Signature Date

_____ _____
Responsible Party's Signature Date

Whittier Rehabilitation Hospital

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, , have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

1. Individual Refused to Sign
2. Communications barriers prohibited obtaining the acknowledgement
3. An emergency situation prevented us from obtaining acknowledgement
4. Other (Please Specify)

_____

_____

_____

THE OUTPATIENT CENTER
WHITTIER REHABILITATION HOSPITAL
145 Ward Hill Avenue Bradford, MA 01843
Phone 978-469-1425 / Fax 978-372-0404

Patient Identification

Outpatient Therapy Clinical Summary Form

Please take a moment to fill out this entire form. There are three pages. It will help us better direct your care. * * *This information is confidential and remains part of your chart.*

Name_____

Home/Cell Phone_____

Occupation_____

Work Status: ☐ Full Time ☐ Part Time ☐ Medical Restrictions ☐ Medical Leave

☐ Retired ☐ Disabled ☐ Other_____ Date last worked_____

Rehab Information

What is your chief complaint/ailment/injury? _____

The date it started_____ The date of surgery_____

Briefly describe how you were injured_____

_____

_____

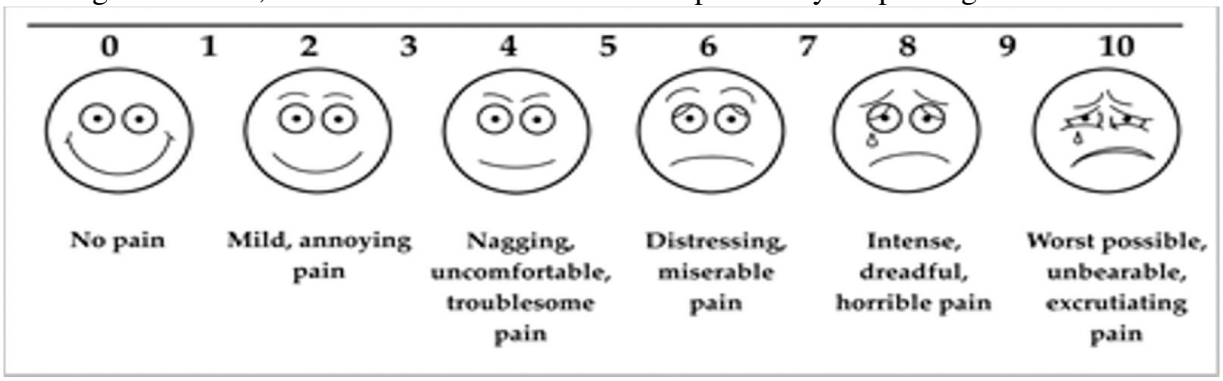
Has your condition been getting: ☐ Worse ☐ Same ☐ Better

Are your symptoms: ☐ Constant ☐ Intermittent

What eases your symptoms? _____

What aggravates your symptoms? _____

Looking at the chart, mark the number that best corresponds to your pain right now.



What is the number when your pain is the best? _____

What is the number when your pain is the worst? _____

Does this complaint affect your daily activities? (i.e. washing, dressing, or chores) ☐ Yes ☐ No

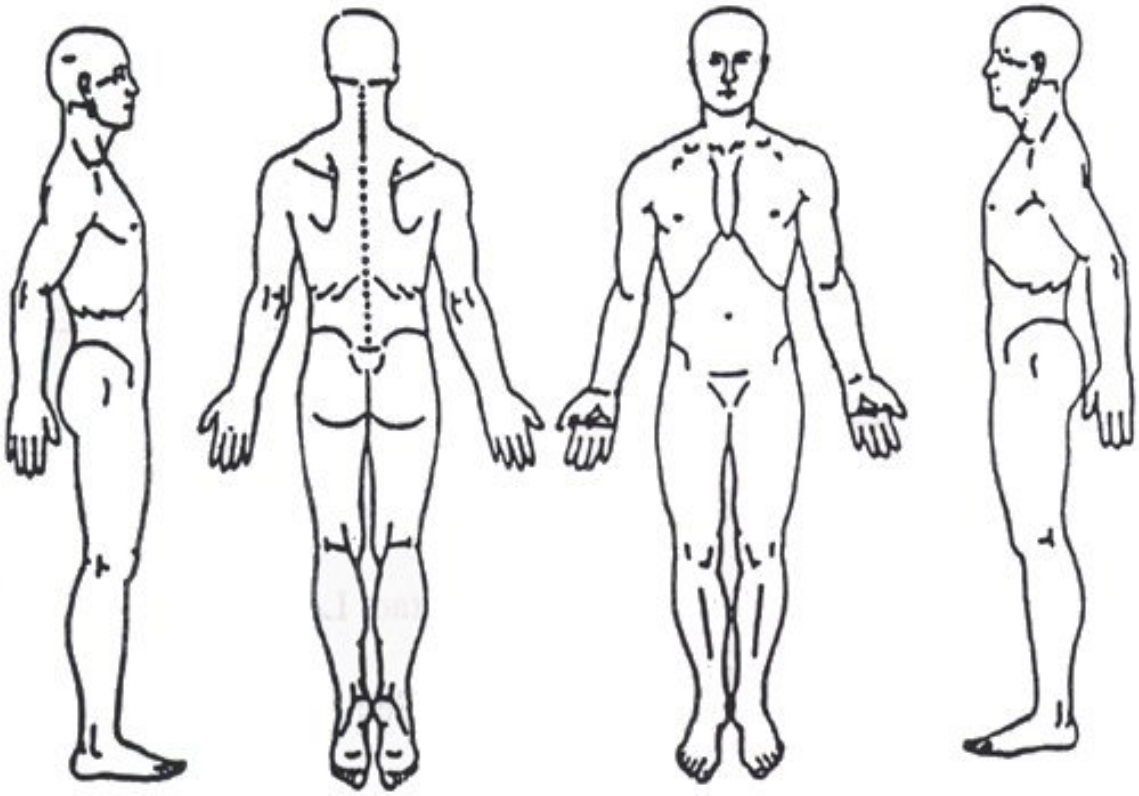
If "Yes", what activites_____

Have you received previous interventions for this complaint? ☐ Physical Therapy

☐ Occupational Therapy ☐ Chiropractic ☐ X-Ray ☐ MRI ☐ Cat Scan ☐ none

☐ Bone Scan ☐ Nerve Test ☐ Blood Test ☐ Other_____

Please shade in the areas of pain on the body diagrams.



Other significant past medical history (i.e. hospitalizations, falls, or infections)(include dates)

_____

_____

Previous Surgeries (include dates)_____

Falls in the past 6 months ☐Yes ☐No

If yes explain _____

Medications (If you have a copy of your medication list, please give it to the receptionist.)

_____

_____

Allergies_____

What are your goals to be achieved by the end of therapy?_____

_____

_____

Medical Information

Please check all that apply to your medical history.

☐ Angina/Chest Pain	☐ High/Low Blood Pressure	☐ Pacemaker
☐ Irregular Heartbeat	☐ Shortness of Breath	☐ Asthma
☐ Arthritis	☐ Unexplained Weight Loss	☐ Cancer
☐ Epilepsy/Seizures	☐ Fever/Chills/Sweats	☐ Diabetes
☐ Osteoporosis	☐ History of Smoking	☐ Anemia
☐ HIV/Hepatitis	☐ History of Drug/Alcohol Abuse	☐ Blood Clots
☐ Depression/Anxiety	☐ Open Sores/Wounds	☐ Dizziness/Faint
☐ Nausea/Vomiting	☐ Loss of Appetite	☐ Diarrhea
☐ Bloody Sputum	☐ Cough > than 3 weeks	☐ Bone Fractures
☐ Difficultly controlling your bowels or bladder		☐ Other_____

Have you had the Flu/H1N1 shot? ☐ Yes ☐ No Date_____

Have you had a Pneumovax shot? ☐ Yes ☐ No Date_____

Do you have a Heath Care Proxy? ☐ Yes ☐ No Name_____

I certify that the statements I have made and furnished in the above form are true.

Signature/Guardian Signature_____ Date_____

Staff Reviewer_____ Date/Time_____

Thank you for taking the time to complete this form. Your therapist will be with you shortly after reviewing your chart.

WHITTIER Health Network

Questions to Ask Medicare Beneficiaries

Bradford

Date: _____ Marital Status: ___ Patient Identification

Part I	**Part II**
1. Are you receiving Black Lung (BL) benefits? _____No _____Yes: dates benefits began:_____ month/day/year 2. Are the services to be paid by a government program such as a research grant? ____No ____Yes 3. Has the Dept. Of Veteran affairs (DVA) authorized and agreed to pay for care at this facility?____No ____Yes 4. Was the illness/injury due to a work-related accident/condition? ___No (**go to part II**) ___Yes: date of injury/illness _____ month/day/year Name & address of W/C Plan: _____ _____ Policy or ID Number: _____ Name & Address of Employer: _____ _____ _____	1. Was this illness/injury due to a non-work related accident? ____No (**go to Part III**) ____Yes: date of accident _____ month/day/year 2. What type of accident caused the illness/injury? ____automobile ____non-automobile Name and Address of no-fault or Liability Insurance Co. _____ _____ Insurance Claim #: _____ 3. Was another party responsible for this accident? ____ No (**go to Part III**) ____ Yes: name and address of any liability insurer: _____ _____ Insurance Claim #: _____
Part III	**Part IV - Age**
Are you entitled to Medicare Based On: ____Age (**go to Part IV**) ____Disability (**go to Part V**) ____ESRD (End Stage Renal Disease) (**go to Part VI**) Note that both "**Age**" and "**ESRD**" or "**Disability**" and "**ESRD**" may be selected simultaneously. An individual cannot be entitled to Medicare based on "**Age**" and "**Disability**" simultaneously. Please complete **ALL PARTS** associated with the patient's selections.	1. Are you currently employed? ___No: date of retirement _____ month/day/year ___ Never Been Employed ___Yes: Name & Address of Employer _____ _____ 2. Is your spouse currently employed? ___No: date of retirement _____ month/day/year ___ Never Been Employed ___Yes: Name & Address of Employer _____ _____ ***If you answered no to both question 1 & 2 STOP HERE.** If you answered yes, continue: 3. Do you have group health plan (GHP) coverage based on your own or spouses' current employment? ___No: **STOP HERE** ___Yes: Name & Address of GHP _____ _____ 4. Does the employer that sponsors your GHP employ 20 or more employees? ___No: **STOP HERE** ___Yes: Name & Address of GHP _____ _____ Policy ID Number: _____ Group ID Number: _____ Name of policy holder: _____ Relationship to Patient: _____ **STOP HERE**

Date: _____ Patient Identification

Part V – Disability

1. Are you currently employed?
   ___No: date of retirement _____
   month/day/year
   ____ Never Been Employed

   ___Yes: Name & Address of Employer
   _____
   _____

2. Do you a spouse who is currently employed?
   ___No: date of retirement _____
   month/day/year
   ____ Never Been Employed

   ___Yes: Name & Address of Employer
   _____
   _____

* If you answered no to both questions 1 & 2
STOP HERE

If you answered yes, continue:

3. Do you have group health plan (GHP) coverage based on your own or a family member's current employment?
   ___No: **STOP HERE**
   ___Yes: Name & Address of GHP
   _____
   _____

Policy ID Number: _____
Group ID Number: _____
Name of policy holder: _____
Relationship to Patient: _____
STOP HERE

Part VI – End Stage Renal Disease

1. Do you have group health plan (GHP) coverage?
   ___No: **STOP HERE**

   ___Yes: Name & Address of GHP
   _____
   _____

Policy ID Number: _____
Group ID Number: _____
Name of policy holder: _____
Relationship to Patient: _____
Name & Address of employer, if any, from which you receive GHP coverage: _____
_____

2. Have you ever received a kidney transplant?
   ____No
   ____Yes: date of transplant _____
   month/day/year
3. Have you ever received maintenance dialysis treatments?
   ____No
   ____Yes: date dialysis began _____
   month/day/year
   Have you participated in a self-dialysis program,
   Please provide date training began _____
   month/day/year
4. Are you within the 30 month coordination period?
   ___No**: STOP HERE**
   ___Yes 30-month period start _____
   month/day/year
5. Are you entitled to Medicare on the basis of either ESRD and age, or ESRD and disability?
   ____No ___Yes
6. Was your entitlement to Medicare (including simultaneous entitlement) based on ESRD?
   ___No
   ___Yes **STOP HERE**
7. Does the working aged or disability MSP (Medicare as secondary payor provision apply, i.e. is the GHP primary based on age or disability entitlement?
   ___No ____Yes

Comment