**Classic Rehabilitation, Inc.**
504 N Carrier Pkwy, Grand Prairie, TX 75050 Office (972)263-7042 Fax (972)263-7046
2911 Medlin Dr., Arlington, TX 76015 Office (817)226-2622 Fax (817)226-

## Consent to Treatment

I, _____ hereby authorize the Classic Rehabilitation Inc. staff to administer and carry out all procedures as ordered or prescribed by my physician modalities, and exercise prescriptions. Review of my medical records by Specialist for appropriate service.

I have received and understand the patient bill of rights, including rights of the elderly.

## Release of Health Information

Classic Rehabilitation may release my health information to other doctors and staff who treat me. This could include health care providers who treat me who are not part of Classic Rehabilitation.

Classic Rehabilitation may release my health information to insurance companies or other companies that Classic Rehabilitation uses to bill for services.

Classic Rehabilitation may release my health information to companies that help Classic Rehabilitation improve the quality and cost of care provided to patients by reviewing the health care provided by the practice.

If I cannot be reached, a representative of Classic Rehabilitation can give information about my therapy, my care or my bills to:

Name: _____ Phone Number: _____

Relationship: _____

Name: _____ Phone Number: _____

Relationship: _____

_____ I do NOT want my information given to my family, friends or others.

## Social Security Number

Classic Rehabilitation will follow any federal and state laws about the use and protection of my social security number.

## Personal Items

Classic Rehabilitation is not responsible for taking care of my personal items. This includes items such as jewelry, eyeglasses, hearing aids, dentures, clothing, and cell phones. I know that I must take care of my personal items.

Print Name: _____

Signature: _____

Date: _____

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## Financial Policies

The doctors and other healthcare providers of Classic Rehabilitation charge fees for the care provided to me.

I know that my health insurance company may not pay the full amount of the fees charged by Classic Rehabilitation. This means I may have to pay Classic Rehabilitation for the cost of care that is not paid by my health insurance company.

If I have not given Classic Rehabilitation the right health insurance information, then I may have to pay the

fees for my care. If I do not have health insurance, then I will have to pay the fees for my care.

If I have paid Classic Rehabilitation too much money for my care, then the dollar amount can be used to pay the balance of some other account that I have with Classic Rehabilitation.

Medicare will only pay for the care that is acceptable and needed under section 1862(a)(1) of the Medicare Law. The facts I have given to Classic Rehabilitation for payment under Titles XVIII and XIX of the Social Security Act are correct.

Classic Rehabilitation can bill my health and liability insurance companies for my care. Payments will be made to Classic Rehabilitation on my behalf.

## Notice of Privacy Practices

The Notice of Privacy Practices tells me my rights as a patient of Classic Rehabilitation. This includes how my medical records are protected at all doctors' offices.

## Patient Acknowledgement

I prove with my signature below that:

- The above facts that I have given to Classic Rehabilitation are correct.
- I have read and understand all the above facts.
- I have had the chance to ask questions about the facts in this form, and all of my questions have been answered.

I consent to treatment as a patient of Classic Rehabilitation.

| | |
|---|---|
| Signature of Patient or Responsible Party | Date |
| Print Name | Relationship (if not Patient |
| Witness | Date |

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# NOTICE OF PRIVACY PRACTICES FOR WORKER'S COMPENSATION CLAIMS

"This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review carefully."

1. I understand and agree that Classic Rehabilitation, Inc. (the "Company") is required by Texas law and TWCC to release any and all related documentation to my Referring Physician, Worker's Compensation Insurance Carrier, and/or Case Manager or other interested party.
2. I understand and agree that any and all information provided by me to the Company relating to my injury or treatment thereof must be documented and released as above and that any confidential information not related to my injury will remain privileged.
3. I understand that all applicable privacy laws are honored by the Company including Federal Confidentiality Rules 42 C.F.R. Part III, however, that my records may be reviewed by any licensing or accrediting agency.
4. I understand that the Company reserves the right to transfer documents related 1o health care operations electronically July in compliance with "the Health Insurance Portability and Accountability Act of 1996" (HIPAA), but that the stipulations regarding the protection of protected health care information contain in HIPAA do not apply to Worker's Compensation Claims.
5. I understand that I, or my representative, may request copies of my records relating to my care and that such a request must be made in writing and that copy fees will apply at the rate of $0.25 per page in compliance with the Physician's Fee Schedule for the State of Texas.
6. I understand and agree that I have read and understand the Company's privacy policies pertaining to a worker's compensation claims and that Ihave chosen to proceed with care as an informed consumer as evidenced by my signature below.

Print Name: _____

Signature: _____

Date: _____

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# ASSIGNMENT OF BENEFITS

# And

# CONSENT TO PAYMENT FOR WORKER'S COMPENSATION CLAIMS

ASSIGNMENT OF BENEFITS/CONSENT TO PAYMENT FOR WORKER'S COMPENSATION CLAIMS

1) I assign to Classic Rehabilitation, Inc., (the "Company") the right to receive payment for all health care services rendered to me under my worker's compensation coverage.
2) I understand and agree that l will abide, and assist the Company in procuring payment for all health care services rendered to me by my worker's compensation coverage including providing any and all information or documentation required by the Company, my employer, or my employer's worker's compensation insurance coverage and I further understand that failure to do so may result in my worker's compensation claim being denied.
3) I understand and agree that it is solely my responsibility to obtain a current physician's prescription for health care services rendered to me by the Company and that such a prescription will expire 30 days from the date written.
4) I understand that the Company will bill my employer's worker's compensation coverage directly under provisions and stipulations of the current TWCC or Federal Worker's Compensation Fee Schedules.
5) I understand and agree that the Company will make every REASONABLE EFFORT to acquire appropriate authorization for health care service rendered by the Company to me required by my employer worker's compensation insurance coverage.
6) I understand and agree that I will not be billed directly for health care services rendered unless my Worker's Compensation claim or authorization of health care services rendered is denied.
7) I understand and agree that I am responsible for providing the Company with a current mailing address where I will receive U.S. Mail.
8) I understand and agree that in the event that my Worker's Compensation Claim and/or authorization for health care services rendered to me by the Company and that I will pay for any health care services rendered in full when billed.
9) I understand and agree that in the event that the Company is required to enter into collections proceedings against me personally for payment of health care services rendered that a 40% collections fee will be charged as this is the fee charged to the Company in collections proceedings.
10) I state by my signature below that I have read, understand, and agree to the stipulation set forth in this agreement and agree to proceed with care as an informed consumer.

Print Name: _____

Signature: _____

Date: _____

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## Classic Rehabilitation Pool Rules

To better assist you the Classic Rehabilitation staff would like for you to adhere to the following pool rules.

1) DO NOT enter the pool without a Classic Rehabilitation staff member present.
2) It is recommended that you use the restroom just prior to entering pool.
3) If you need assistance dressing please bring an attendant along to assist you.
4) Only swimwear will be allowed in the pool. (Bathing Suit or swimming trunks). If needed a White T-Shirt may be worn over your swimming attire.
5) Water shoes must be worn at all times during your work out. (Please do not wear these shoes outdoors, only put them on when you enter the pool area).
6) A shower must be taken before and after entering the pool by all patients. This must be done due to the chemicals in the pool.
7) For safety reasons please do not wear wet swimsuits for long periods of time following you aquatic session.
8) Please empty all contents in pockets before entering the pool.
9) Please remove all jewelry.
10) If you have any ear, eye, or throat infections please do not enter the pool until they are no longer contagious, and have been cleared by their physician or therapist.
11) If you have any open wounds, sore, or rashes please do not enter the pool. Clearance must be given by treating therapist.
12) Anyone who has had diarrhea within the last 48 hours may not be allowed to enter the pool.
13) Patients on their menstrual cycle will not enter the pool (NO EXCEPTIONS).
14) Children are not allowed in the pool area unless they are being treated, or required for interpretation.
15) Cell phones and electronic devices in the pool area. (I.e. headphones, mp3 players)
16) Classic Rehabilitation, Inc. is not responsible for lost or stolen items.

These rules are in effect to make sure each patient has a pleasant experience while attending aquatic therapy. If you have any questions please see any Classic Rehabilitation staff member.

I have read and agreed with the above terms and conditions concerned with the Aquatic Therapy Program.

Print Name: _____

Signature: _____

Date: _____