TEXAS
REHABILITATION &
HABILITATION
SPECIALISTS, LLC.

Dear Patient,

Thank you for your interest in our therapy services. Please return the attached patient intake documents upon completion. Please be advised that a physician referral or prescription is required for the *initial evaluation*. After the evaluation is completed, we shall forward the results to the physician for concurrence of findings and the proposed duration and frequency of any therapy sessions.

As a courtesy to you and with your authorization, we will coordinate all information needed to verify therapy benefits under your insurance plan that would reimburse services provided by our center. However, this is not a guarantee of benefits and processing/payment of services may not be determined until after receipt of claim and/or supporting medical information.

After approval from your insurance company and verification of benefits, we will try our best to accommodate an appointment time for ST, OT or PT.

If you have not visited our website, we invite you to do so at www.txrehabspecialists.com. We look forward to meeting you. If you have any questions regarding the intake packet, please contact us at 830-214-7640.

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

NEW PATIENT INFORMATION
(All sections must be filled out)

Date: _____/_____/_____ **Referring Physician: _____**

Patient Name (First, Middle Initial, Last): _____

Home Address (If Apt., include Apt. #): _____

City: _____ **ZIP: _____** **Home Phone: _____**

Cell: _____ **Email: _____** **Other: _____**

Date of Birth _____/_____/_____ **Age: _____Sex: _____ Social Security #: _____**

Other Person's Living In Household: _____

Home Address (If Apt., include Apt. #): _____

City: _____ **ZIP: _____** **Driver's License #: _____**

Social Security #: _____ **Date of Birth _____/_____/_____**

Email: _____ **Home Phone: (____)_____** **Cell: (_____)_____**

Emergency Contact (Not living at same address): _____

Home Phone: _____ **Cell: (_____)_____** **Email: _____**

INSURANCE INFORMATION

Plan Name: _____

Policy Number: _____Group Number: _____

Policy Holder Name: _____ **Name of Employer: _____**

Date of Birth: _____/_____/_____

Relationship to Patient: _____

Have you received therapy in the past? If yes, please list: Facility name:_____

Date of last visit:_____ **Reason for leaving: _____**

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

PATIENT MEDICAL HISTORY

MEDICAL HISTORY: Check any that apply

☐ Heart disease ☐ Heart attack, heart defects ☐ Asthma, TB, emphysema, other lung diseases ☐ Heart murmurs
☐ Rheumatic fever ☐ Stroke, hardening of arteries ☐ High blood pressure ☐ Hepatitis, other liver diseases
☐ Stomach problems, ulcers ☐ Family history of diabetes, heart problems, tumors ☐ AIDS ☐ Tumors, cancer ☐ Arthritis, rheumatism ☐ Eye diseases ☐ Skin diseases ☐ Anemia ☐ VD (syphilis or gonorrhea) ☐ Herpes ☐ Kidney, bladder disease
☐ Thyroid, adrenal disease ☐ Diabetes ☐ Chest pain (angina) ☐ Swollen ankles ☐ Shortness of breath
☐ Recent weight loss, fever, night sweats ☐ Persistent cough, coughing up blood ☐ Bleeding problems, bruising easily
☐ Sinus problems ☐ Difficulty swallowing ☐ Diarrhea, constipation, blood in stools ☐ Frequent vomiting nausea
☐ Difficulty urinating, blood in urine ☐ Dizziness ☐ Ringing in ears ☐ Headaches ☐ Fainting spells ☐ Blurred vision ☐ Seizures
☐ Excessive thirst ☐ Frequent urination ☐ Dry mouth ☐ Jaundice ☐ Joint pain, stiffness

ALLERGIES: Are you allergic to any medications, foods, or latex? (If none write NONE)

Allergies to: _____

_____

SURGICAL HISTORY: Please list any operations you've had including tonsillectomy, appendectomy, or hernias, with the year of the surgical procedure. (If none write NONE)

Operation	**Date**
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

HOSPITALIZATIONS: Please tell us of any non-surgical hospitalizations you've had, including heart, lung, kidney, or other serious medical problems. (If none write NONE)

Problem requiring hospitalization	**Date**
_____	_____/_____/_____
_____	_____/_____/_____
_____	_____/_____/_____

MEDICATIONS: Please tell us of **all medications** you are regularly taking. (If none write NONE)

Medication

_____

_____

ASSIGNMENT OF BENEFITS: I authorize payment of medical benefits to Texas Rehabilitation & Habilitation Specialists, LLC for services rendered. I recognize my financial obligation for any co-insurance or deductible and non-covered services that may be required. RELEASE OF INFORMATION: I authorize the release of any medical information necessary to process this claim or to assist another health professional with my care. This is a lifetime authorization.

Signature of Patient (or responsible party) _____ **Date** ____/____/_____

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

CONFIDENTIAL RELEASE OF INFORMATION

PATIENT: _____ **DOB:** _____/_____/_____

I hereby grant permission for confidential medical/ school records concerning the above named person to be released to Texas Rehabilitation & Habilitation Specialists, LLC. (TRHS)

_____ _____/_____/_____
Signature of Patient **Date**

****

I hereby grant permission for confidential medical records concerning the above named person to be released from the Texas Rehabilitation & Habilitation Specialists, LLC. (TRHS) to Team Members and concerned parties for medical and/or developmental follow-up, and also to the following:

1._____

Address: _____

2._____

Address: _____

3._____

Address: _____

4._____

Address: _____

_____ _____/_____/_____
Signature of Patient **Date**

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

Consent to Treatment and Release of Information

I authorize the staff of Texas Rehabilitation & Habilitation Specialists, LLC. to:

1. Administer and perform those treatments that have been prescribed by my physician.

2. Release pertinent medical information to my physician, referring agency, or insurer and others as may be required.

3. Request and obtain medical information from my physician and other health care professionals as necessary to provide quality therapy services.

Signature: _____ Patient Name:_____ Date: _____

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

FINANCIAL AGREEMENT

- Texas Rehabilitation & Habilitation Specialists, LLC will be responsible for verification of benefits prior to initial evaluation.

- Texas Rehabilitation & Habilitation Specialists, LLC will be responsible for billing primary insurances for payment.

- Payment, co-payment, deductibles, and co-insurance for services are due each visit for charges incurred up through your last visit. We accept cash, checks, VISA, and Master Card. **Please understand that you are financially responsible for all charges whether or not they are paid by insurance.**

- Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. **Please note insurance companies may indicate the services were not medically necessary and claims that because Texas Rehabilitation & Habilitation Specialists, LLC is a preferred provider you do not have to pay the balance, this is NOT the case and you will be billed for the services.** This office can not accept responsibility for negotiating settlements on disputed claims.

- Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. As a courtesy to our patients we will bill your insurance carrier; however, we cannot guarantee payment in a timely manner. If for any reason any portion of a bill is not paid by your insurance within 60 days from the date of service, you agree to make arrangements for prompt payment.

Again, our relationship is with you, not your insurance company. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you!

I hereby understand the above financial policy and agree to abide by it.

_____ _____

Signature Date

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation:

Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices.

Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number. Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Your signature below indicates you have received a copy of Texas Rehabilitation & Habilitation Specialists, LLC. Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in Texas Rehabilitation & Habilitation Specialists, LLC. Notice of Privacy Practices, please do not hesitate to contact Texas Rehabilitation & Habilitation Specialists, LLC. Patient Privacy Officer as indicated on your Notice.

Patient Name: _____

Patient Representative: _____

Relationship: _____

Signature: _____

Date: _____

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

Policy Acknowledgment Form

1. Evaluation

-Your initial visit will involve a comprehensive evaluation in order for us to develop an individualized treatment plan.
Patients play an active role on the therapeutic team.
-Patient goals and expectations are incorporated into the plan of treatment developed by the therapy team and communicated to the referring physician.
-The staff will demonstrate and recommend techniques and strategies to use at home and school to solidify skills learned during treatment.

2. Appointments

-Appointment times are based on therapist availability and may be subject to change. We will make every effort to accommodate your schedule to the best of our ability.
-Your therapist has determined the optimal amount of time for each visit.
-Clinical therapy services may be provided by a licensed therapy assistant under the direct and close supervision of a licensed and/or certified therapist.
-The assistant will follow the treatment plan designed by the supervising therapist. Any necessary changes and updates will be performed by the supervising therapist.

3. Attendance/Timeliness

-Regular attendance is important to obtain maximum benefits from your therapy. Following **three consecutive absences** or a **pattern of absenteeism**, the therapist will recommend discharge from the program.
-Please notify the clinic 24 hours in advance of an appointment cancellation.
-Patients with **two consecutive No Show** appointments are subject to discharge from therapy.
-Promptness is appreciated. Patients arriving 15 minutes or more past their therapy time may not be seen, as this interferes with our ability to address goals.
-If tardy to a session, no extension may be given and the session will end at the regularly scheduled time.
-We strive to provide a healthy environment for our other patients and our staff. If your child has a contagious illness, we ask that you please cancel accordingly.

4. Communication

-Patients are encouraged to participate in therapy and communicate concerns to therapists. If a concern cannot be resolved with the therapist, patients can request to speak with the Supervisor of Therapy.
-A discharge summary will be sent to your physician upon completion of the course of therapy.

I have read the above Policy Acknowledgment Form, and fully understand and agree with the statements therein.

Signature of Parent or Guardian _____ Date _____/_____/_____

TEXAS REHABILITATION & HABILITATION SPECIALISTS, LLC.

RELEASE OF LIABILITY

I, _____ hereby release "Texas Rehabilitation & Habilitation Specialists, LLC." from any and all liability resulting in any possible injury.

_____ _____

Patient signature Date

I, _____, understand that there are inherent risks involved with a patient's participation in therapeutic activities at Texas Rehabilitation & Habilitation Specialists, LLC.. The use of equipment such as trampolines, treadmills, utensils, balls, and unstable surfaces among many other unlisted equipment & therapeutic objects may be used during therapeutic sessions. Although the staff at Texas Rehabilitation & Habilitation Specialists, LLC prioritizes safety with all treatment sessions, I understand that there is potential for injury while participating in activities at Texas Rehabilitation & Habilitation Specialists, LLC.

I, _____ for myself, and on behalf of my heirs, assigns, personal representatives, & next of kin, hereby release and hold harmless Texas Rehabilitation & Habilitation Specialists, LLC., it's directors, officers, agents, contract workers, volunteers, employees, and other participants of, and from any and all claims, demands, lawsuits, expenses, damages, and liabilities of every kind and nature whether known or unknown with respect to any injury, disability, death, or loss or damage to person or property in connection to participation in activities affiliated with Texas Rehabilitation & Habilitation Specialists, LLC. to the fullest extent of the law.

_____ _____

Parent/Caregiver signature Date