PATIENT FINANCIAL RESPONSIBILITY FOR OUTPATIENT THERAPY

Patient Name: _____ Date: _____

I have requested medical services from Shawnee PARC on behalf of myself and understand that by making this request, I become financially responsible for any and all charges incurred during the course of my treatment.

I understand, as a courtesy to me, Shawnee PARC will submit all of my medical claims to my insurance carrie (s). In addition, I recognize that billing my insurance carrier(s) is a timely process. Shawnee PARC is allowed a timely filing limit of 18 months from the date of service with Medicare and most major insurance carriers, therefore, it would be unreasonable for me to expect anything less than a 120 turn around for final processing of my claims with all of my carriers, barring any complications.

I further understand that fees are due and payable for services that are rendered to me and agree to pay such charges incurred in full immediately upon presentation of the appropriate statement unless other arrangements are made with the Administration Department.

Please initial each section:

_____*Financial Responsibility*: I acknowledge that my statement is due, in full, including room and board and ancillaries by the fifth day of each month. An interest of 1.5% (18% per annum) will be added to all accounts 30 days past due. In the event my account is placed with an attorney or collection agency for collection, the undersigned agrees to pay reasonable attorney fees, legal expense and lawful collection costs in addition to all other sums due hereunder.

_____ *Treatment Consent*: I hereby consent to the examinations, treatments and medications ordered or recommended by my physician or designated alternate.

_____ *Authorization for Release of Information*: I hereby authorize Shawnee PARC to:

Release any information necessary for processing of my claim to my insurance carrier(s) regarding my illness and treatment.
Process insurance claims generated during the course of my treatment.

_____ *I hereby authorize my insurance carrier(s) to*:

1. Release any information regarding eligibility, benefits, claim status and payment information to Shawnee PARC on my behalf.

_____ *Assignment of Benefits*: I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/life/medical plan to issue payments directly to Shawnee PARC for medical services rendered to me.

_____ *Home Health*: I acknowledge that I cannot receive Outpatient Therapy while I am receiving Home Health services, I understand that I will be financially responsible for ALL medical services rendered to me by Shawnee PARC as I cannot receive dual therapy services as stipulated by Medicare.

I acknowledge the financial information that has been provided to me. I understand that I am ultimately financially responsible for all services rendered at Shawnee PARC. Furthermore, I understand that my statement balance is due on the fifth day of each month, paid in full once all insurance parties have processed my claim(s).

Signature of Guarantor or Representative: Date:

_____ _____

PLEASE READ EACH SECTION, ANSWER YES/NO THEN SIGN AND DATE

Shawnee PARC
Post Acute & Rehabilitation Center

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Name of Beneficiary: _____ HIC #::_____

Date(s) of Service: _____ Provider #:_____

SECTION I (Employment)

A. Are you currently working? ☐ Yes ☐ No ☐ No, Never Employed
Date of Retirement, if applicable:_____
Employer:_____ Insurance Co:_____ Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

B. Are you covered by an Employer Group Health Plan? ☐ Yes ☐ No
Employer:_____ Insurance Co:_____ Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

C. Is your spouse currently working? ☐ Yes ☐ No ☐ No, Never Employed
Date of Retirement, if applicable:_____
Employer:_____ Insurance Co:_____ Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

D. Are you covered under an employed spouse or family member: ☐ Yes ☐ No
Employer:_____ Insurance Co:_____ Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

SECTION II (Disability)

A. Are you entitled to Medicare Benefits SOLELY because of a disability? ☐ Yes ☐ No
If yes, date of disability:_____ Describe Disability:_____

SECTION III (Accident/Injury)

A. Was your illness/accident related to a WORK injury, past or present? ☐ Yes ☐ No
Employer:_____ Insurance Co:_____ Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____
Name of Workers Compensation Carrier:_____ Attorney:_____

B. Was your illness/injury related to an AUTOMOBILE accident? ☐ Yes ☐ No
Date of accident:_____ Location:_____
How did accident occur:_____
Automobile medical or no-fault insurance:_____ Claim/Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

C. Was your illness/injury related to an accident, OTHER than an automobile accident? ☐ Yes ☐ No
Date of accident:_____ Location:_____
How did accident occur:_____
Automobile medical or no-fault insurance:_____ Claim/Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____
Can payment be made by third party liability insurance: ☐ Yes ☐ No
Third party liability or attorney:_____
Address:_____ City:_____ State:_____ Zip: _____

SECTION IV (VA/Black Lung)

A. Are you entitled to any Veteran's Administration Benefits for a service related illness or injury? ☐ Yes ☐ No
VA Plan Name:_____ Claim/Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

B. Are you entitled to any Black Lung Benefits? ☐ Yes ☐ No
Black Lung Policy Name:_____ Claim/Policy #:_____
Address:_____ City:_____ State:_____ Zip: _____

SECTION V (End Stage Renal Disease (ESRD))

A. Are you entitled to Medicare ONLY because of End Stage Renal Disease (ESRD)? ☐ Yes ☐ No
If yes, did you have self dialysis training or a kidney transplant 3 months prior to Medicare Entitlement?
☐ Yes ☐ No
Date of first dialysis or kidney transplant:_____

B. Are the services to be paid by a program such as a government research grant? ☐ Yes ☐ No

OBTAIN BENEFICIARY OR OTHER REPRESENTATIVES' SIGNATURE IF POSSIBLE. IF UNABLE TO OBTAIN A SIGNATURE, PLEASE INDICATE HOW THE INFORMATION WAS OBTAINED.

Beneficiary/Resp. Party Signature (Optional):_____ Date: _____

Facility Witness Signature:_____ Date: _____

Patient Name: _____

Shawnee PARC
Post Acute & Rehabilitation Center

Application for Outpatient Therapy

Date of Application: _____ Date of 1st Visit: _____

Suffix: ___ Mr. ___ Ms. ___ Mrs. Marital Status: ___ Married ___ Single ___ Divorced ___ Widowed

Applicant's Name: _____
First Middle Last Nickname

Current Address: _____
Street City, State Zip

Phone Number: _____ (h) _____ (m)

ARE YOU CURRENTLY USING A HOME HEALTH AGENCY: ___ NO ___ YES; the Home Health Agency is: _____ phone # _____

Patient Demographics

Social Security Number: _____ Date of Birth: _____

Gender: ___ Male ___ Female

Race: ___ Hispanic ___ Asian/Pacific Islander ___ White/Not Hispanic ___ Black/Not Hispanic ___ Other

Occupation: _____ Employer: _____

Work Phone: _____

Insurance Information

Medicare HIC: _____ Medicaid ID: _____

Secondary Carrier: _____

Group: _____ Policy Number: _____

Mailing Address: _____

Phone Number: _____

Tertiary Carrier: _____

Group: _____ Policy Number: _____

Mailing Address: _____

Phone Number: _____

Patient Name:_____

Contact and Billing Information

Guarantor: _____ Relationship to Patient: _____

Address: _____
Street City, State Zip

Phone Number: _____ (h) _____ (m)

Power of Attorney: _____ ___ Durable ___ Medical

Relationship to Patient: _____

Address: _____
Street City, State Zip

Phone Number: _____ (h) _____ (m)

Emergency Contact: _____ Relationship to Patient: _____

Address: _____
Street City, State Zip

Phone Number: _____ (h) _____ (m)

Billing Statement: ___ Send to Resident Room ___ Send to Guarantor

Physician Information

Primary Care Physician: _____ Phone: _____

Address: _____
Street City, State Zip

NPI: _____

Ordering Physician: _____ Phone: _____

Address: _____
Street City, State Zip

NPI: _____

Please Provide Copies of the Following:

___ Private Insurance Card(s) ___ Medicare Card ___Driver's License/ID Card

The information I have provided in this application is current and correct to the best of my knowledge.

_____ _____
Signature of Guarantor Date

Patient Name:_____

Shawnee PARC
Post Acute & Rehabilitation Center

Outpatient Therapy Patient Information and Brief Medical History

Applicant's Name: _____

Date of Birth: _____ Phone Number: _____

Reason for Therapy Referral: _____

Date of Onset/Injury/Surgery: _____ Physician: _____

Medical History

Do you have/or have you had any of the following?

	YES	NO		YES	NO
Diabetes	____	____	Sensitivity to Heat	____	____
High Blood Pressure	____	____	Sensitivity to Cold	____	____
Circulatory Disorders	____	____	Dizziness	____	____
Heart Disease	____	____	Seizures	____	____
Heart Attack	____	____	Headaches	____	____
Pacemaker	____	____	Visual Problems	____	____
Metal Implants	____	____	Allergies	____	____
Kidney Problems	____	____	Previous Surgeries	____	____
Hernia	____	____	Back Injuries	____	____
Nervous Disorders	____	____	Other Injuries	____	____
Are you Pregnant	____	____	Other Illnesses	____	____

If yes to any of the above, please explain and give approximate dates: _____

_____

Medications

Are you currently taking medications? ____ Yes ____ No

If yes, please list what medications, dosages and for what condition: _____

_____

_____

Patient Name: _____

Shawnee PARC
Post Acute & Rehabilitation Center

Other Information:

____ Yes ____ No Have you had previous therapy for the present condition?

____ Yes ____ No Is this a work related injury or condition?

____ Yes ____ No Has this injury been reported to your employer?

I acknowledge that the information provided is true and correct to the best of my knowledge.

_____ _____

Patient Signature Date