

SWAN Rehab

1190 East Missouri Avenue, Suite 100 Phoenix, AZ 85014
Phone: (602) 393-0520 Fax: (602) 393-0523 www.swanrehab.com

Southwest Advanced Neurological Rehabilitation
Breaking Barriers in Recovery

Today's Date _____

Patient Information

Patient Name _____ Height _____ Weight _____
Last First Middle

Gender: ___ Male ___ Female Date of Birth _____ Age _____ Social Security # _____

Marital Status (circle one): Single Married Widowed Divorced Separated

Name of Spouse / Guardian / Caregiver (circle one) _____

Address _____

Phone#(____) _____ Cell #(____) _____ Email _____

May we leave messages for you at: **Home:** Yes No **Cell:** Yes No **Email:** Yes No

Would you like text or e mail reminders: If yes, what address/phone # _____

Emergency Contact: _____ Relationship _____

Emergency Contact Home# _____ Emergency Contact Cell# _____

May we speak with your Emergency Contact about your medical condition, needs and account? Yes No

Date of Seating Evaluation:

Primary reason requesting wheelchair? _____

Do you currently use a wheelchair? Yes No

If so, what type is it? Manual Electric Scooter

Why does it need to be replaced?

___ It is more than 5 years old If so, how old _____

___ It is in poor repair. Explain: _____

___ It cannot be fixed (explain) _____

Other: _____

Past Medical History:

Turn Page Over

Home Environment:

Do you live in a house or apartment? _____

Do you live alone? _____

If not, who do you live with? _____

Transportation:

Do you drive? yes no

If not what type of transportation do you use?

_____ Dial a Ride/ Public Transportation _____ Insurance provides wheelchair van _____ I have my own van

_____ Other: _____

Are you: right handed left handed

Sensation and Skin Issues:

Have you had a history of wounds or ulcers on your feet, legs, buttocks?

If so explain:

Did you go to a wound clinic? _____

Did you have surgery? _____

Bladder Management: Continent / Incontinent

Bowel Management: Continent / Incontinent

Activity of Daily Living Status:

What do you need help with?

_____ Toileting. Explain: _____

_____ Dressing, Explain: _____

_____ Grooming. Explain: _____

_____ Bathing. Explain: _____

_____ Cooking. Explain: _____

_____ Transferring. Explain: _____

Do you have pain? Explain _____

On a scale of 1 to 10 how much is your pain at best? _____ / 10. At worst? _____ /10. Now? _____ /10.

Have you had any Falls within the last year? Yes No How Many? _____

Were you hurt? _____

INFORMED CONSENT AGREEMENT

Thank you for choosing to use the facilities, services, or programs of SWAN Rehab. We request your understanding and cooperation in maintaining both your and our safety and health by reading and signing the following informed consent agreement.

I, the undersigned, declare that I intend to use some or all of the activities, facilities, programs, and services offered by SWAN Rehab and I understand that each person, (myself included), has a different capacity for participation in such activities, facilities, programs, and services. I am aware that all activities, services, and programs offered are educational, recreational, or self-directed in nature. I assume full responsibility, during and after my participation, for my choices to use or apply, at my own risk, any portion of the information or instruction I receive.

I understand that part of the risk involved in undertaking any activity or program is relative to my own state of fitness or health (physical, mental, or emotional) and to the awareness, care and skill with which I conduct myself in that activity or program. I acknowledge that my choice to participate in any activity, services, and program of SWAN Rehab brings with it my assumption of those risks or results stemming from this choice and the fitness, health, and awareness, care, and skill that I possess and use.

I further understand that personnel, who may not be licensed, certified, or registered instructors or professionals sometimes conduct the activities, programs, and services offered by SWAN Rehab. I accept that fact that the skills and competencies of some employees and/or volunteers will vary according to their training and experience and that no claim is made to offered assessment or treatment of any mental or physical disease or condition by those who are not duly licensed, certifier, or registered and herein employed to provide such professional services. I recognize that by participating in the activities, facilities, programs, and services offered by SWAN Rehab, that I may experience potential health risks such as transient light-headedness, fainting, abnormal blood pressure, chest discomfort, leg cramps, and nausea and that I assume willfully those risks. I acknowledge my obligation to immediately inform the nearest supervising employee of any pain, discomfort, fatigue, or any other symptoms that I may suffer during and immediately after my participation. I understand that I may stop or delay my participation in any activity or procedure if I so desire and that I may also be requested to stop and rest by a supervising employee who observes any symptoms of distress or abnormal response.

I understand that I may ask any questions or request further explanation or information about the activities, facilities, programs, and services offered by SWAN Rehab at any time before, during, or after my participation. I declare that I have read, understood and agree to the contents of this informed consent agreement in its entirety.

x _____ / ____ / ____
Patient/Responsible Party Relationship to patient Date

PHOTO AND VIDEO AUTHORIZATION

At times we take photos or video to monitor and record your progress. At other times we may use video for teaching or marketing purposes. I hereby consent without further consideration or compensation, to give SWAN Rehab, the absolute right and permission to use my photograph or video in its promotional materials, publicity efforts, advertisements and social media. I hereby grant permission to SWAN Rehabilitation to crop, screen or alter the photograph or video as necessary for use on materials produced by and on behalf of SWAN Rehabilitation. I understand that these images may be used alone or in conjunction with other photographs or videos for educational purposes, still or moving, sketches, advertising and publication in any manner and in any medium whatsoever without limitation or reservation. *I release all claims against SWAN Rehabilitation, their employees, agents and designees from liability for any violation of any personal or proprietary right I may have in connection with such use.*

x _____ / ____ / ____
Patient/Responsible Party Relationship to patient Date

NOTICE OF PRIVACY POLICIES

In this document, "we, us and our" refers to RWW Outpatient Rehab Services, LLC d.b.a. SWAN Rehab. "you" or "yours" refers to individual patients. We are required by federal law to protect the privacy of your individual health information (referred to in this notice as "Protected Health Information" or PHI). We are also required to provide you with this notice regarding our legal duties and privacy practices with respect to your PHI, and to abide by the terms of this notice. We maintain medical information about you in the course of providing health services to you. We also hire business associates, such as billing service and a transportation service, and bill third party payers, such as Medicare, in the process of providing and billing these services. These business associates also receive and maintain medical information about you.

We may use and disclose medical information about you with our consent for the following purposes:

- **Health Care Providers' Treatment Purposes.** For example, to communicate with your doctor we may disclose medical information about you.
- **Payment.** For example, we may use or disclose medical information about you to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment.
- **Health Care Operations.** For example, we may use or disclose medical information about you for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of contracts or previous contract(s).
- **Health services.** For example, we may use medical information about you to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **As Required by Law.** For example, we must allow the U.S Department of Health and Human Services to audit our records. We may also disclose medical information about you as authorized by and to the extent necessary to comply with worker's compensation or other similar laws.
- **To Business Associates.** We may disclose medical information about you to business associates we hire to assist us in your care. Each business associate must agree in writing to ensure the continuing confidentiality and security of medical information about you.

We may also use and disclose medical information about you as follows; to comply with legal proceedings, such as a court or administrative order or subpoena, to law enforcement officials for limited law enforcement purposes, to your personal representatives appointed by you or designated by the applicable law, for research purposes, as long as certain privacy-related standards are satisfied, to a government agency authorized to oversee the health care system or government programs, we may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person's involvement with your care or payment related to your care.

Authorizations: Uses and Disclosures with Your Permission

We will not use or disclose medical information about you for any other purposes unless you give us your written authorization to do so. If you give us written authorization to use or disclose medical information about you for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all medical information about you that we maintain, except for information we have already released based on your authorization.

Your Rights

You may make a written request to SWAN Rehab to do one or more of the following concerning medical info about you to put additional restrictions on our disclosure of medical information about you we do not have to agree to your request, to communicate with you in confidence about medical information about you by a different means or location, to see and get copies of medical information about you, we do not have to agree to your request, to amend medical information about you, in some cases we do not have to agree to your request.

Complaints

If you believe your privacy rights have been violated, you may notify us in writing or The Secretary of The Department Of Health Services. You will not be retaliated against for filing a complaint.

PHI use and disclosure by SWAN Rehab is regulated by federal law known as HIPPA. You may find these rules at 45 Code of Federal Regulations part 160 and 164. This Notice attempts to summarize the Privacy standards. The Privacy Standards will supersede any discrepancy between the information in the Notice and Privacy Standards. I hereby acknowledge that I have been provided and have reviewed SWAN Rehab's Notice Of Privacy Practice

X _____ / /
Patient/Responsible Party Relationship to patient Date

FINANCIAL POLICIES AND PROCEDURES

Patient Name _____ Date of Birth _____ Today's Date _____

I authorize payment of my insurance benefits directly to SWAN Rehab and authorize SWAN Rehab to disclose my protected health information to assist with the processing of my claim(s); carry out my treatment; and for health care operations like quality reviews. I understand I am personally responsible for balances not paid by my insurance. I understand I will be notified by invoice of the amount charged to either my insurance/bank account/or credit card. Claims are submitted by SWAN within 48 hours of the date of service.

BILLING PROCEDURE: You will receive a statement with your remainder balance once a reply is received from your insurance company from our billing company until paid in full.

MEDICARE PATIENTS: If you have Medicare as your primary insurance carrier, but you do not have a secondary insurance, you are responsible for the 20 percent. A Payment plan can be set up for special circumstances.

BALANCES DUE AFTER INSURANCE PAYS: If there is a remaining balance due after your insurance carrier pays, you have 30 days to make payment on the invoice. Payment arrangements can be made for special circumstances by contacting the office manager within 30 days of the receipt of the invoice. It is your responsibility to make contact with our office to make special arrangements.

PAYMENT AT THE TIME OF SERVICE:
I or my Guarantor will be paying for service by Check

SELF PAY: If insurance does not cover your therapy and you are a self-paying, all payments will be due at the time services are rendered unless you have made arrangements with the office manager.

Patient or Guarantor Initials:

DELINQUENT ACCOUNTS: We urge you to keep your account current to avoid any misunderstandings with our office. All account balances past due over 180 days will be sent to an outside agency for collections. Delinquent accounts will be reported to our collection's agency, KEA Recovery, after normal collections procedures. Please contact our billing company at 864-679-1600, if temporary financial problems will affect timely payment of your account or if a payment plan is required to prevent your account from going to collections. Patient/Guarantor agrees to pay all cost of collection, including attorney fees, collection fees, and contingent fees to collection agencies which may be more than 35% of the delinquent balance, such contingency fee to be added by the provider and collected by the collection agency immediately upon our referral of your account to the collection agency of our choice.

PAYMENT ARRANGEMENTS: Under special circumstances, payment arrangements can be made. These arrangements are made with the Office Manager. Our office can set this up for you as a courtesy. You will be sent a monthly statement. However, it is your responsibility to know your monthly due date, which will be determined at the time of your payment arrangement is set up. After the second missed payment, the account will be sent to an outside agency for collections.

COMMUNICATIONS CONSENT: You agree, in order for us to service your account or to collect any amounts you may owe, that we, or any third-party vendor authorized by us, may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We, or any third-party vendor authorized by SWAN Rehab, may also contact you by sending text messages or emails you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

X _____ / ____ / ____

Patient/Responsible Party

Relationship to patient

Date