Notice of Patient Privacy

We are committed to preserving the privacy of your personal health information. In fact, we are required by law to protect the privacy of your medical information and to provide you with Notice describing:

How Medical Information About You May Be Used and Disclosed and How You Can Access This Information

We may require your written consent before we use or disclose to others your medical information for purposes of providing or arranging for your health care, the payment or reimbursement of the care that we provide to you, and the related administrative activities supporting your treatment.

We may be required or permitted by certain laws to use and disclose your medical information for other purposes without your consent or authorization.

As our patient, you have important rights relating to inspection and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and complaining if you think your rights have been violated.

We have available a detailed Notice of Privacy Practices which fully explains your rights and our obligations under the law. We may revise our Notice from time to time. You have the right to receive a copy of our most current Notice in effect. If you have not yet reserved a copy of our current Notice, please ask us and we will provide you with a copy. If you have any questions, concerns, or complaints about the Notice or your medical information, please contact the company listed above.

Release of Medical Information Necessary to Process Claims

I authorize the release of all medical or other information needed to process this medical claim. I also request payment of government benefits to the party who accepts the assignment below.

Authorization of Payment of Benefits to Provider

I authorize payment of medical benefits to this Health Care Provider for the physical and/or occupational services given to me or dependent.

Consent for Physical Therapy/ Occupational Therapy

I, the undersigned due hereby agree and give my consent for the company listed above to furnish physical and or occupational therapy to myself or dependent, which is considered necessary and proper in evaluating and treating myself or dependent for my/their physical condition.

I have read and fully understand the above information.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ **Date:** _____

Certification that no benefits under Medicare Part A are being received

(Please read carefully)

Services through our company are billed through Medicare part B. If you are currently receiving any services through Medicare part A, Medicare will not cover our services. By signing below, you certify that you are not currently receiving Part A services. If you are currently receiving services through part A, **or begin to receive services through part A and do not inform us**, you will be responsible for any costs associated with our services. Part A services include any service provided by a certified home health agency that bills Medicare, and include but are not limited to nursing, physical therapy, occupational therapy, home health aide, social worker.

Services not billed through Medicare part A include private duty home health aides, services that are being covered by long term care insurance, services that are being paid for out of pocket. You may have these services while receiving our services.

If you are unsure if any services you are receiving are covered under Medicare part A please call our office to discuss the situation.

Name: _____ **Date:** _____

Cancellation/No show Policy

Dear Valued Patient,

Please be advised that if for any reason you must cancel your appointment with us, it is our company policy that **RMM Therapy and Rehabilitation** receives notification by 9AM the morning of your scheduled visit. Further, the first cancellation will be recorded without a fee. However, upon the second cancellation, if this prior notification is not received and your therapist is in transit or your therapist arrives at your home, a cancellation fee in the amount of one session will be charged to your account. In the event that you are hospitalized, please make every effort to contact us at 786-253-8818.

If you have insurance, it will not cover the penalty amount and you will be responsible for this charge. Missed/late cancelled appointments prevent other patients the opportunity for an appointment and affect the consistency of your own rehabilitation program. The therapist will not be able to reschedule on short notices and must accommodate for lost work time and travel. A Millage fee may be applied in the amount of $1 per mile from the location of the therapist's home.

Name_____

Date_____

Signature_____

Telehealth Consent Form

In the event that patient opts to use an iPad that is supplied by **RMM Therapy and Rehabilitation**, there will be a $500 deductible fee to issue the device and a charger cord. The device will be delivered to you with setup and instructions provided. The charge will only be issued if the device is damaged in the care during services. Upon return of the device in the same condition as provided, the money will be returned to the account from which it was originally deducted. If damages occur, Apple Care will be used for the repair and the remaining balance will be returned. A data plan will be provided upon request.

If there are any questions, please do not hesitate to ask! We are here to serve you!

Name_____

Date_____

Signature_____

RMM Therapy and Rehabilitation Patient Sign-in Sheet

Patient Name: _____Therapist: _____

Visit#	Date	Time	
1			
2			
3			
4			
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25			

A. Notifier: RMM Therapy and Rehabilitation
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.OT/PT** below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D. OT/PT** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical/Occupational Therapy Services	Not skilled and/ or Medically necessary	$130-$200

WHAT YOU NEED TO DO NOW:
• Read this notice, so you can make an informed decision about your care.
• Ask us any questions that you may have after you finish reading.
• Choose an option below about whether to receive the **D. OT/PT** listed above.
Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

□ **OPTION 1.** I want the **D.** listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.
□ **OPTION 2.** I want the **D.** OT/PT listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.
□ **OPTION 3.** I don't want the **D.** listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

CMS does not discriminate the programs or activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

I. Signature:	J. Date: