IMPORTANT PHONE NUMBERS / INFORMATION

Thanks for being part of our family. We don't say this lightly as we strive to treat all our patients as if they were members of our family. Your privacy, dignity, and care are of utmost importance to us. We are a local therapist owned and operated organization and will do our very best to accommodate any of your needs and concerns. Should you have any needs please use the numbers below to contact us.

EVOLUTION REHAB GROUP	561-900-2423 ext 1
WEB/EMAIL	www.evolution.rehab info@evolution.rehab
BILLING QUESTIONS	**866-281-7636**
FAX	561-600-3011

We are accredited by Medicare and the State of Florida as a Rehabilitation Agency and can provide therapy care in your home or in our office. If your physician thinks you need therapy, and you want to be seen in your home, then have them fax us an order with your information to our main fax listed above.

	NAME	DIRECT PHONE
Physical Therapy (PT) Supervisor		
Physical Therapy Assistant		
Occupational Therapy (OT) Supervisor		
Occupational Therapy Assistant		
Speech and Language Pathologist (ST)		
Scheduling Questions Call therapists directly, or call main scheduling number at		
Billing Questions	**866-281-7636**	
Fax to send a new prescription or order	561-600-3011	
Questions about the therapy being provided	Call the therapy supervisors who evaluated you	
Questions about HIPAA, privacy, access to records, patient rights, complaints, kudos	Call:561-900-2423 Ext 2 Email: ben@evolution.rehab	
Overall questions about resources available to seniors	(561) 355-4746 or 211 PALM BEACH (954) 745-9567 BROWARD	
Questions about Medicare and Medicare plans call the SHINE network	866-684-5885	
Mailing Address	8135 Emerald Winds Cir Boynton Beach, FL 33473	

GENERAL INTAKE FORM

If possible, take scan of ID card, insurance cards (front and back) and MUST turn in a Rx if not already obtained prior to intake

First Name	Middle Initial	Last Name
Name on Insurance if Different First Name	Middle Initial	Last Name

Date of Birth	Gender on File with Insurance	Home Phone	Cell Phone
	❑ M ❑ F ❑ Other:	( ) -	( ) -

Mailing Address ❑ See ID card	City	State	Zip
Service Address ❑Same as Mailing❑ See ID card	City	State	Zip
		FL	

If ALF, ILF, or other neighborhood name please note here	

Address on File with Insurance			
❑Same as Mailing❑ See ID card	City	State	Zip

POA/HCS Name	POA/HCS Phone

Primary Physician	Practice Name	Phone
Referring Physician	Practice Name	Phone

Insurance Information ❑ **N/A** see ABN ❑ **Verified information from eligibility to card** (no need to add below then)

Primary ❑ See card	Responsible Party	ID/PLAN/PHONE
	❑ Patient ❑Other:	
Claim Address Information		
Secondary ❑ See card	Responsible Party	ID/PLAN/PHONE
	❑ Patient ❑Other:	
Claim Address Information		
Supplemental ❑ See card	Responsible Party	ID/PLAN/PHONE
	❑ Patient ❑Other:	
Claim Address Information		

A SCANNED COPY OF THESE FORMS WILL SUFFICE AS VALID AS AN ORIGINAL

DISCLOSURE OF LIABILITY

The **treatment** that will be provided is **NOT related** to any **third-party liability event** (car accident, slip and fall, etc) that there is not a claim open, or claim under litigation. If there is an open or under litigation claim, then I will need to provide the claim number, adjuster information, and any other pertinent information **before** beginning treatment.

X Date:

CONSENT FOR EVALUATION AND TREATMENT FOR THIS EPISODE OF CARE

By signing below, you hereby agree for the clinical staff of Evolution Rehab Group to render Physical, Occupational, or Speech therapy depending on your orders performed by one of our qualified licensed therapist or therapy assistants licensed in the state of Florida and in good standing (employee, contractor, or vendor). You will have your medical care documented in our system and kept on record for the state mandated time frame (currently 7 years). Consent will remain through successive treatment episodes. At the resumption of services any time after a discharge or at the onset of any changed episode, we will gather new consent at that time.

X Date:

evolution
REHAB GROUP

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENTS OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE. I irrevocably assign and convey directly to the above-named provider, as my designated authorized representative, all insurance benefits, if any, otherwise payable to me for services rendered by provider, regardless of its managed care network participation status. Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named provider any and all Plan documents, summary benefits description, insurance policy, and/or settlement information upon written request from the above-named provider or their attorneys in order to claim such benefits. I also assign and/or convey to the above-named provider, as my designated authorized representative, any legal or administrative claim or chosen action arising under any group health plan, employee benefits plan, health insurance or tortfeasor insurance concerning expenses incurred as a result of services received from the provider. This includes an assignment of ERISA breach of fiduciary duty claims. I intend by this assignment and designation of authorized representative to convey to the above-named provider all my rights to claim (or place a lien on) the medical benefits related to the services provided by the above-named provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The above-named provider or their representative is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or actions against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider, as my assignee and my designated authorized representative, may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense. This assignment is valid for all administrative and judicial reviews under PPACA, ERISA, Medicare and applicable federal and state laws. Any amount of co-pay, co-insurance, deductible or any amount not covered because patient elected to be under a different plan after verification or under a home care episode and did not call to cancel services will be patient responsibility for services rendered paid in master rate full amount. There are some insurance companies that pay the patient to then pay the provider. It is up to you to assign those checks or just deposit them and pay for the amount due.

X Date:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Federal law requires that we seek your acknowledgement of the Notice of Privacy Practices.
I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years. I can view them online at www.evolution.rehab in the Patient section on the bottom of the page labeled privacy notice.

X Date:

NOT RECEIVING MEDICARE HOME HEALTH CONCURRENTLY

I understand that if I am under an active episode of Home Health (Nurse, Therapist, Aide provided by Medicare) even if no one is coming to the house right now, that I am not eligible for outpatient services, even if provided at my home. It is ultimately my responsibility to acknowledge that I am not under an active episode of home care, and that all services have been officially discharged at least 1 calendar day prior to my first billable service otherwise I can be potentially liable for charges associated with my services performed by Evolution Rehab Group. Furthermore if at any time I sign with a Medicare Certified Home Health Agency between now and when I am discharged from Evolution Rehab Group, I MUST stop treatment with Evolution Rehab Group, and let them know, or any sessions financial obligations I have during this time can be transferred to me.

X Date:

PAYMENT

All claims will be submitted on patient's behalf through Evolution Rehab Group. Please note we submit claims typically once a month. Therefore, the date of claim and explanation of benefits and any notice of patient responsibility can be months after treatment. All claims will reflect Evolution Rehab Group as the provider. We do not collect money up front for insurance based cased. Any claims without our facility information are not from our organization. Notices of patient fiduciary responsibility will be for services rendered and any applicable co-pays, deductibles, co-insurance, or other charges that are not covered but not subject to an ABN (for example failure to disclose open liability or open home health case can transfer financial liability to the patient). Payment can be made via check or credit card (processing fee applies for credit card). If financial hardship applies, there will need to be a form filled out to validate and accept said hardship, this can be obtained by calling our facility.

X Date:

PATIENT EXPECTATION WITH TREATMENT

Therapy takes commitment from the patient as much as the therapist. We ask that you make yourself available for the recommended frequencies (typically 3 times per week). This means not cancelling just because you are sore, or don't feel 100%, or you have friends stopping by. We ask that you perform all the home program activities recommended and are attentive and available for treatment as directed. We also ask that you understand that most insurance plans ask for supervisory visits periodically to update progress, check on the plan of care, and make sure you are satisfied with care. The supervisor will also need to come out for a final discharge assessment. PLEASE, keep us informed if you have any changes to your medical condition, have been in the hospital/ER/Urgent care since your last session, have any new medications or diagnoses since your last session, or have changed insurance plans or coverage. If you are not seen for a period of 15 days or more, we reserve the right to terminate services and have you obtain a new prescription and begin the care episode all over again. If you do not cooperate with scheduling or our plan of care in this manner, we will notify you in writing of our intent to withdraw from your care and offer other options in the area for your therapy needs. If you elect to cancel services or self-discharge before the planned episode is over or before a planned progress or discharge assessment, please let us know. If we cannot accommodate your needs, if your environment is not safe for our therapists or your treatment sessions, we will not be able to provide care. If you need translation services or any assistance communicating with our office or our clinical staff please let us know and we will provide these services at no charge. We ask that you provide feedback at our website or by email at www.evolution.rehab or info@evolution.rehab both if you are happy with services or dissatisfied.

X Date:

PRIVACY PERMISSIONS

Initial All Below Applicable

_____**Evolution Rehab Group** may leave messages on my phone regarding appointment times
_____**Evolution Rehab Group** may leave messages on my phone regarding any fees I may owe
_____**Evolution Rehab Group** may leave messages on my phone as part of any check-up / marketing campaign (not a third party) even when therapy services are over
_____**Evolution Rehab Group** may contact me via email as part of any check-up / marketing campaign (not a third party) even when therapy services are over (will not include any personal health information)
_____**Evolution Rehab Group** may discuss the following with parties below until a written revocable request is obtained ***(if this item initialed then fill out below otherwise skip to signature line)***

Name:_____Relationship:_____
____Appointment times ____Therapy diagnosis, plan of care, prognosis
____My progress with therapy ____ Money owed/balance

Name:_____Relationship:_____
____Appointment times ____Therapy diagnosis, plan of care, prognosis
____My progress with therapy ____ Money owed/balance

Name:_____Relationship:_____
____Appointment times ____Therapy diagnosis, plan of care, prognosis
____My progress with therapy ____ Money owed/balance

Name:_____Relationship:_____
____Appointment times ____Therapy diagnosis, plan of care, prognosis
____My progress with therapy ____ Money owed/balance

X_____ Date_____

I can request my records at any time. I will have a copy of my records within 20 business days of written request via fax at 561-600-3011. The records will be $10 for the first 9 pages, and $1.00 a page thereafter if copied or $20 for a digital copy unlimited pages inclusive of the digital data drive and mailing.

I understand that my records can be audited by CMS (FirstCoast) or any of my insurance companies and any of its contracted auditors including but not limited to state surveyors and Accrediting Organization surveyors without explicit permission. My records may be seen by the billing entity, administrative staff, and treating therapists only as needed if it pertains to my treatment program or for auditing as needed.

I have read or waived the right to read a copy of HIPAA and privacy notices and know it is on www.evolution.rehab web site under patient section on bottom as downloadable PDF and have no questions regarding the aforementioned information.

PRIVACY OFFICER: Ben Galin, Administrator
561-900-2423 Ext 2
Ben@Evolution.Rehab

Patient SIGNATURE Log

Patient Name:_____
DOB:_____
Med Rec:_____
Vendor: _____
Therapist Name, Credential, License Number:_____

NOTE to THERAPIST: If no one is available who is competent to sign, then please do your best to call patient representative at each session to let them know your name, discipline, and quick update on progress if possible.

Representative Name(s) and Relationship(s) if Patient is Unable to Sign

Name	Relationship
_____	_____
_____	_____
_____	_____

DAY DATE	UNITS		THERAPIST SIGNATURE	PATIENT OR REPRESENTATIVE SIGNATURE
	Eval Codes	Tx Units		
SUN	❑Eval ❑Re-Eval		**X**	**X**
MON	❑Eval ❑Re-Eval		**X**	**X**
TUES	❑Eval ❑Re-Eval		**X**	**X**
WED	❑Eval ❑Re-Eval		**X**	**X**
THURS	❑Eval ❑Re-Eval		**X**	**X**
FRI	❑Eval ❑Re-Eval		**X**	**X**
SAT	❑Eval ❑Re-Eval		**X**	**X**