REHABNEEDS, LLC
2401 Research Blvd #101
Rockville MD 2850
Tel | 240.480.4553
Fax | 301.972.1068
Website | www.rehabneeds.com
Email | info@rehabneeds.com

REHABNEEDS
Physical Therapy
& Rehabilitation

Patient's Name: _____

1. **CONSENT FOR TREATMENT**. I hereby understand that I am under the care of my attending or treating physician. I have been informed of the nature and purpose of medical treatment, procedures and services to be provided to me at my residence and of the risk involved. I have also been informed about alternative treatment, procedures and services. I have had the opportunity to ask questions of my physician and of the staff of REHABNEEDS, LLC. I voluntarily consent to receive outpatient rehab services in my home.
2. **STATEMENT TO PATIENT**. I acknowledge I have been provided and have had explained to me "A Statement to You" which describes my rights and responsibilities as a patient of REHABNEEDS, LLC.
3. DECISION ABOUT CARE. I have received information and instructions concerning my rights to make decisions about my health case, including the right to accept or refuse treatment.
4. **AUTHORIZATION FOR RELEASE OF INFORMATION.** I understand that all information concerning my care is confidential. I authorize REHABNEEDS, LLC. to release to my physician, other healthcare providers, and to my payer any information related to the provision of service that may have any effect on the continuation of plan of care or on the benefits payable for services rendered. This may include photographs/other personal data. I also authorize the release of information for purposes of utilization, review, medical records audits, quality improvement, accreditation or similar reviews.
5. **ASSIGNMENT OF BENEFITS**. I authorize payment directly to REHABNEEDS, LLC. of health insurance benefits otherwise payable to me, but not to exceed the balance due to the outpatient rehab services provided to me. As a patient or guarantor I am responsible for any charges billed for products or services provided to me and are not reimbursed by my insurance carrier. This may include non-covered services/supplies deductibles, co-pays or balances stipulated by my insurance plan. I will pay outstanding accounts balances in accordance with rates and terms of REHABNEEDS, LLC. I will be responsible for any attorney/collection fees incurred by REHABNEEDS, LLC. in an attempt to collect a delinquent balance due. I certify all information provided by me in applying for Medicare programs payment or any other Payer information is correct.
6. **FINANCIAL RESPONSIBILITY**. I will be responsible for informing REHABNEEDS, LLC. of any insurance/payer information changes occurring while services are being rendered. **I understand that failure to do so may result in my insurance/payer to deny coverage of service, products, medications or equipment of which I could ultimately be responsible.**

Patient's Signature: _____ **Date:** _____

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REHABNEEDS Patient Rights and Responsibilities

The patient has the following rights:

1. Know the names of the therapists and other staff members who take care of you.
2. Be involved in the planning of your care and treatment, including pain management, in collaboration with your physician and treatment team.
3. Have the information necessary to enable you to make treatment decisions that reflect your wishes.
4. Accept medical care or to refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
5. Have all records concerning your care or illness treated confidentially, with personal privacy respected. You have the right to access information contained in your clinical records within a reasonable time period and in accordance with federal HIPAA policies and procedures.
6. Participate or refuse to participate in any experimentation or research projects related to your care or treatment.
7. Receive prompt and reasonable responses to your requests for service.
8. Considerate, safe and respectful care; to be free from abuse or harassment.
9. Have impartial access to care regardless of race, sex, sexual orientation, age, physical or mental disability, culture, ethnicity, gender identity, expressions, religion, language or source of payment.
10. Request a consultation or second opinion from another provider.
11. Change provider or facility.
12. Review your REHABNEEDS bill and received an explanation of charges.
13. Participate in the consideration of ethical issues that may arise in your care and treatment.
14. Have your legal guardian, next of kin, or legally authorized person exercise your rights, to the extent permitted by law, if you are a minor; have been deemed incompetent in accordance with the law; are found by your physician to be medically incapable of understanding the proposed care or treatment; are unable to communicate your wishes regarding treatment.
15. Have a family member or person of your choice and your family physician notified of your treatment, as well as to exclude any or all family members from participating in your care decisions.
16. Maintain communication with family and friends, i.e., send and receive mail and phone calls.
17. Maintain your legal rights as a citizen, i.e., voting in elections, as provided by state and federal law.
18. Have a confidential clinical record.
19. Informed of the HHA's policies for transfer and discharge
20. Express a compliment and/or complaint pertaining to your care or treatment. Your compliments/complaints may be directed to your clinical director. A Patient Relations phone line is also available Monday through Friday from 9:00-4:00 PM at 240-480-4553 Ext 5. Voicemail is available during non-business hours. You may also email your complaint to info@rehabneeds.com.

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Patient Responsibilities:

1. Providing accurate and complete information about your illness and medical history including present complaints, past illnesses and hospitalizations, medications, and other matters related to your health.
2. Knowing and following hospital rules and regulations, i.e., no tobacco use.
3. Following your provider's prescribed plan of treatment, care and services.
4. Notifying your provider or staff if you do not understand your diagnosis, treatment, or prognosis.
5. Any consequences and other adverse outcomes if you refuse treatments or do not follow the provider's prescribed treatment plan.
6. Being considerate of other patient's rights, privacy, and property, and in assisting with noise control.
7. Fulfilling your financial obligations associated with your health care.
8. Advising our staff nurse or your clinician of any concern, dissatisfaction, or safety issues you may have in regard to your care while in the clinic.
9. Safeguarding any valuables or personal belongings retained by you at the bedside, including eyeglasses, hearing aids, dentures, cell phones, clothing, etc.
10. Cooperating with your REHABNEEDS team to maintain your and your family's safety, i.e. calling for assistance when needed or as instructed.
11. Being knowledgeable of your medical insurance benefits plan and your obligations regarding deductibles, co-payments, pre-authorization requirements, etc.

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REHABNEEDS 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

REHABNEEDS CORP. and its affiliated companies (the "Provider") (collectively, an "Affiliated Covered Entity"), may use and disclose your protected health information for treatment, payment, health care operations and as required by law in accordance with the Health Insurance Portability and Accountability Act ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH Act), and the HIPAA Omnibus Rule (Collectively, the **"HIP**AA Rules"). The use of "you" or "your" below, also refers to your authorized representative(s).

CONSENTS: In accordance with the HIPAA Rules, the Provider exercises its option to obtain your consent regarding the use and disclosure of your information at the start of care or within a reasonable amount of time afterwards. The Provider retains the right not to provide treatment if you refuse to sign the consent form.

AUTHORIZATIONS: Your written authorization is required for the disclosure of your protected health information when the disclosure is not for treatment purposes, health care operations or payment, or required by law.

YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED WITHOUT PATIENT AUTHORIZATION:

To Provide Treatment. The Provider and others involved with treatment (such as your attending physician, family members, pharmacists, suppliers of medical equipment or other health care professionals) may disclose your health information to each other in order to provide appropriate treatment to you. For example, your attending physician needs information about your symptoms in order to prescribe appropriate medications. Where applicable, any documents containing protected health information given to you or left in your home/place of service by one of our caregivers for the purpose of treatment and/or continued care, is your responsibility to safeguard.

To Obtain Payment. The Provider may disclose your health information to collect payment from third parties. For example, the Provider may be required by your health insurer to disclose information regarding your health care status to obtain prior approval for treatment.

To Conduct Health Care Operations. The Provider may disclose your health information as necessary to facilitate the Provider's health care operations and to provide quality care to all of the Provider' s patients, including such activities as:

- Quality assessment and improvement
- Activities designed to improve health or reduce health care costs
- Protocol development, case management and care coordination
- Contacting providers and patients about treatment alternatives and other related functions
- Professional review and performance evaluation
- Supervised professional training programs
- Accreditation, certification, licensing or credentialing
- Reviews and auditing (includes compliance, medical, and legal services)
- Business planning and development (includes cost management, analyses, formularies)
- Business management and general administration
- Patient safety activities

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For example, the Provider may use your health information to evaluate its staff performance, combine your health information with other Provider patients in evaluating how to more effectively serve all Provider patients, disclose your health information to Provider staff and contracted personnel for training purposes, use your health information to contact you as a reminder regarding a visit to you, or contact you via information mailings (unless you tell us you do not want to be contacted for such).

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To an Affiliated Covered Entity: The Provider may disclose information to other affiliated entities that are part of the Affiliated Covered Entity to carry out treatment, payment and health care operations as described above, which may include assisting to identify and provide appropriate care for you or to assist in administrative functions related to your care.

To Business Associates. We may enter into contracts with entitles knows as Business Associates that provide services to, or perform functions on behalf of, the Provider. For example, we may disclose your protected health information to a Business Associate to administer claims. Business Associates and their subcontractors are required by law to safeguard your protected health information.

As Required by Law. There are federal and state regulations that require certain reporting, including population-based activities relating to improving health or reducing health care costs. For example, your health information may be required for public health activities, abuse, neglect or domestic violence investigations, law enforcement purposes, specialized government functions, death related functions/purposes, to avert a serious threat to health or safety, judicial and administrative proceedings, disaster relief and workers compensation. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law overrides the federal law.

Other than as stated above, the Provider will not disclose your health information without your written authorization, which you may revoke in writing at any time.

WRITTEN AUTHORIZATION IS REQUIRED OUTSIDE OF TREATMENT, PAYMENT, HEALTH CARE OPERATIONS, OR AS REQUIRED BYLAW FOR THE FOLLOWING

- Litigation
- Long term care/Life insurance
- Fundraising/Marketing
- Psychotherapy notes/ records
- Disability
- Research

WITH RESPECT TO YOUR HEALTH INFORMATION, YOU HAVE THE RIGHT:

- **To request restrictions** on certain uses and disclosures of your health information, including disclosure to individuals involved in your care or payment. However, the Provider is not required to agree to your request except when PHI is for payment to a health plan to carry out payment, and is not otherwise required by law, and you have, or someone on your behalf has, paid the Provider in full.

- **To receive confidential communications** in **a certain way.** For example, you may request that the Provider only communicate with you privately with no other family members present. The Provider will not request any reasons for your request and will attempt to honor any reasonable requests.

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- **To inspect and receive a copy your health information** including billing records. To request an inspection or copy of your records containing your health information, please directly notify your Provider. You may request to receive this information in electronic or paper format. The Provider may charge a reasonable fee for copying and assembling costs associated with your request.

- **To request amendments to your health care information** (including corrections or other opinions) for any health information in question for as long as it is maintained by the Provider. This right does not include the deletion, removal, or erasure of health information. All such requests must be made in writing. The Provider may deny the request if: (a) the request is not in writing; (b) the request does not include a reason; (c) the health information was not created by the Provider nor pa rt of the Provider's records; (d) if you are not otherwise permitted by the Regulations to inspect or copy the health information in question; or, (e) if after considering your request, the Provider finds that your health information is already accurate and complete.

- **To an accounting of disclosures** of your health information made by the Provider for reasons other than for treatment, payment or health care operations. All such requests must be made in writing and should specify the time period for the accounting not to exceed six (6) year or the normal record retention policy of the Provider, whichever is longer. The Provider will provide the first accounting requested during any twelve (12) month period without charge. Subsequent requests may be subject to a reasonable cost-based fee.

- **To a paper copy of this Notice** at any time even if you have received this Notice previously. A copy of the current version of this Notice is available at the Provider location and at www.rehabneeds.com

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DUTIES OF THE PROVIDER (AS REQUIRED BYLAW):

- to maintain the privacy of your health information.
- to provide to you or your representative this Notice of its duties and privacy practices.
- to abide by the terms of this Notice as may be amended from time to time; and
- to notify you in the event that we or one of our Business Associates discover a breach of your unsecured protected health information, in a manner not permitted under the HIPAA Rules, which compromises the security or privacy of your protected health information, unless after assessment it is determined that there is a low probability that the protected health information was compromised.

CHANGES TO THIS NOTICE: The Provider reserves the right to change the terms of this Notice and to make such changes effective for all health information that it maintains. If the Provider changes this Notice, the Provider will provide a copy of the revised Notice to you via your Provider location (and at www.rehabneeds.com).

COMPLAINTS: You have the right to express complaints to the Provider or the Secretary of DHHS if you believe that your privacy rights have been violated. You will not be retaliated against in any way for filing a complaint.

TO CONTACT US: Privacy and security concerns related to your patient information can be addressed directly to your Provider, or our designated **HIPAA Privacy Officer at 240-480-4553 ext. 5, or by the direct mailing address below:**

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