Maher Rehab Solutions, LLC.

New Patient Paperwork

Patient Demographic Information

First Name: MI: Last Name: Sex: M F

Address: City: State: Zip:

Home Phone: Work Phone: Cell Phone:

Email SSN#: Date of Birth:

Referring Physician: Attorney (if applicable):

Preferred Pharmacy: Pharmacy Phone#:

Primary Insurance (Subscribers Information)

First Name: MI: Last Name: Sex: M F DOB:

Insurance Carrier: Member ID: Group No:

Address: City: State: Zip:

Relationship to Patient: Employer: SSN#:

Insurance Adjuster: Claim#: Date of Injury:

Adjuster's Phone# Adjuster's Fax# Work Related? Y N

Secondary Insurance (Subscribers Information)

First Name: MI: Last Name: Sex: M F DOB:

Insurance Carrier: Member ID: Group No:

Address: City: State: Zip:

Relationship to Patient: Employer: SSN#:

Insurance Adjuster: Claim#: Date of Injury:

Adjuster's Phone# Adjuster's Fax# Work Related? Y N

Emergency Contact

First Name: Last Name: Telephone Number:

Home Phone: Cell Phone: Work Phone:

Communication Consent

☐ **Option A**: I give Dr. Maher's office permission to leave detailed phone messages regarding my medical and/or billing information on:

Home# _____ ☐ Medical ☐ Billing

Cell# _____ ☐ Medical ☐ Billing

Work# _____ ☐ Medical ☐ Billing

I also authorize Dr. Maher's office to release ☐medical and/or ☐billing information to: _____

☐ **Option B**: I wish to be contacted personally and do not authorize Dr. Maher's office to leave detailed messages or discuss my care or billing account with anyone other than myself.

Patient/Responsible Party Signature: Date:

Patient Name:_____

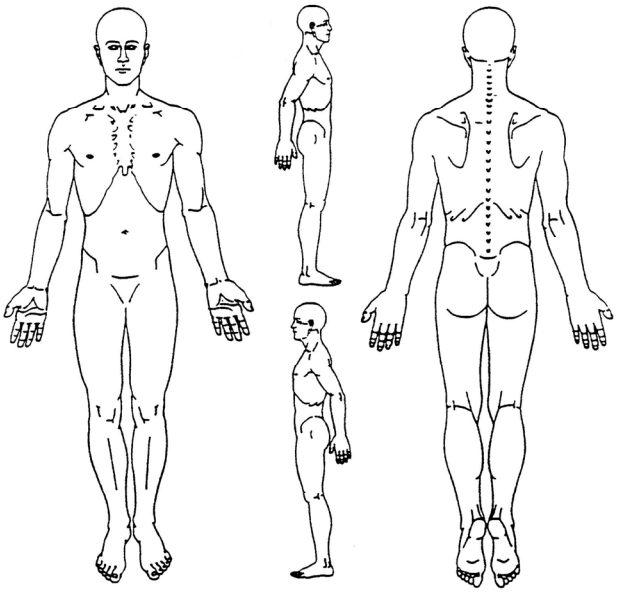
SYMPTOM DETAILS

Diagnosis (if you know or have been told) _____

_____

_____

Body part effected? (please indicate below)



Shoulder Elbow Wrist Neck Mid-back Low-back

Hip Knee Ankle Other:_____

Which side(s)? ☐ Right ☐ Left ☐ Both

Dominant arm? ☐ Right ☐ Left

Problem(s) (please check all that apply)

☐ Pain

☐ Weakness

☐ Instability/Giving way/Dislocation

☐ Stiffness

☐ Swelling

☐*Other*_____

How severe is your pain? (0=none & 10=severe)

Currently?	0	1	2	3	4	5	6	7	8	9	10
At rest?	0	1	2	3	4	5	6	7	8	9	10
When active?	0	1	2	3	4	5	6	7	8	9	10
At it's worst?	0	1	2	3	4	5	6	7	8	9	10
At it's best?	0	1	2	3	4	5	6	7	8	9	10

Do you have pain at night? ☐YES ☐NO

Does the pain awaken you from sleep? ☐YES ☐NO

Have you <u>ever</u> been seen <u>for this issue</u> by any other provider (ie. chiropractor, physician)? ☐YES ☐NO

Within <u>this year</u> have you received any of the following treatments:

☐ Physical Therapy ☐ Home Health

☐ Occupational Therapy ☐ Chiropractic

☐ None

Have you received any injections? ☐YES ☐NO

Are you post surgical? ☐YES ☐NO

Date of Surgery:_____

Type of Surgery:_____

List any additional surgeries you've received for this problem:_____

_____

Other unrelated surgeries:_____

_____

_____

_____

_____

This is a result of... (mark all that apply)

☐ No injury – just started hurting

Date of Onset_____

☐ Sports Injury (which sport?) _____

☐ Motor Vehicle Related (☐My Fault ☐Not at Fault)

☐ Fall Related

☐ Work/Job Related

☐ 3rd Party Accident (involving insurance other than your own)

Injury :☐Current ☐Old (greater than 1 year)

Date of Injury:_____

Please briefly describe your injury (if applicable):

_____

_____

Please tell us your goals for this visit:

_____

Are you currently pregnant? ☐YES ☐NO

Patient Signature **Date**

Patient Name:_____

MEDICAL HISTORY

Please mark “yes” to any condition you currently have or have had in the past.

Arthritis	Y / N	Anemia	Y / N	Allergies	Y / N
Cancer	Y / N	Asthma	Y / N	Bladder Incontinence	Y / N
Chronic Fatigue	Y / N	Blood Clots/Phlebitis	Y / N	Concussion/TBI	Y / N
Falls	Y / N	Circulation Problems	Y / N	Depression	Y / N
Fibromyalgia	Y / N	COPD	Y / N	Eczema/Psoriasis	Y / N
Fractures	Y / N	Cystic Fibrosis	Y / N	Epilepsy/Seizure	Y / N
Headaches/Migraines	Y / N	Bronchitis	Y / N	Diabetes	Y / N
Herniated Disc	Y / N	Heart Arrhythmia	Y / N	Gallbladder Issues	Y / N
Jaw Pain/ TMJ	Y / N	Heart Attack	Y / N	Hepatitis	Y / N
Leg Cramps	Y / N	High/Low Blood Pressure	Y / N	HIV	Y / N
Lupus	Y / N	High/Low Cholesterol	Y / N	Hearing Issues	Y / N
Metal Implants	Y / N	Pacemaker	Y / N	Kidney Problems	Y / N
Osteoarthritis	Y / N	Pneumonia	Y / N	Liver	Y / N
Osteoporosis	Y / N	Shortness of Breath	Y / N	MRSA	Y / N
Polymyalgia	Y / N	Wheezing	Y / N	Multiple Sclerosis	Y / N
Rheumatoid Arthritis	Y / N	Fever/Flu	Y / N	Parkinson’s Disease	Y / N
Use of Assistive Device	Y / N	Shingles	Y / N	Stroke/TIA	Y / N

If answered “yes” to any of the above questions, please provide details below:_____

_____

_____

CURRENT MEDICATIONS

Drug Name	Dosage	Frequency	Administration	Reason Taking

ALLERGIES

Drug Name	Reaction/Side Effect

Patient Name:_____

HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day to day healthcare operations of Maher Rehab Solutions, LLC.

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Signed this _____day of _____, 20_____.

Print Patient Name:_____

Relationship to Patient:_____

Signature:_____

Practice Name: Maher Rehab Solutions, LLC.
Address: 1880 Office Club Pointe Ste #100
City/State/Zip: Colorado Springs, CO 80920
Phone: 719-471-0727

NO SHOW/ RESCHEDULING POLICY

Late Arrivals

I understand if I arrive later than 10 minutes for my appointment(s) I will be asked to reschedule my appointment(s) regardless of the reasoning for being late. This is as a courtesy to our other patients and to keep our doctor on time.

Cancellations/No Shows

We understand there will be times you will not be able to attend your appointment. To allow other patients, the opportunity to be seen we ask you give at least 24 hours notice. Messages left within 24 hours will count as sufficient notice. If you are unable to cancel your appointment within the 24-hour time frame or just do not show up for an appointment the following fee will be applied:

- **New Evaluation/1st Appointment = $75 Fee**
- **Established Patients = $40 Fee**

I understand that I will be charged these fees if I do not show up for my appointment.

Discharging Patients

I also understand that if I do not show (or fail to cancel within 24 hours) for *three* consecutive appointments I will be discharged from care. When this occurs, any remaining appointments will be cancelled, and Maher Rehab Solutions, LLC will notify your referring physician, workers compensation case manager, and/or adjuster. It is at the discretion of Maher Rehab Solutions, LLC to discharge patients, due to failure to keep appointments, failure to pay or for any other reason.

Appointment Reminders

As a courtesy we will make every effort to call you and remind you of your upcoming appointment however sometimes circumstances don't allow for these calls to take place. Therefore, you are ultimately responsible for these appointments whether you receive a reminder call or not.

Trial Testimony and Depositions

I understand that due to the nature of this practice there will be times when Dr. Michael Maher, DO may need to reschedule my appointment due to being subpoenaed to testify in trials and depositions at the last minute. Dr. Michael Maher, DO will make every effort to give patients as much notice as possible.

Signature:_____ **Date:**_____

Patient Name:_____

PATIENT BILLING AGREEMENT

Consent to Treatment
I hereby authorize Dr. Michael Maher, DO to deliver treatment to me.

Filing Claims
I understand Maher Rehab Solutions, LLC files claims to my primary and secondary health insurance as a courtesy to me, but any tertiary claims will need to be filed independently by me.

Contracted Insurances
I understand it is my responsibility to contact my insurance and verify they are in network with Maher Rehab Solutions, LLC. If my insurance is not in network, I understand that I will have a higher out of pocket cost and agree to pay that cost.

Authorization to Pay Benefits
I authorize payment for services provided to be made directly to Maher Rehab Solutions, LLC./Dr. Michael Maher, DO. If I accidently receive payment from my insurance for services received at Maher Rehab Solutions, LLC. I will either sign the check over to Maher Rehab Solutions, LLC. or cash the check and immediately pay the balance due regardless of if I have received an invoice from Maher Rehab Solutions, LLC. or not.

Benefits
I understand it is my responsibility to know my benefits available within my health insurance plan. Maher Rehab Solutions, LLC. may check my benefits as a courtesy to me, but it is ultimately my responsibility to know and understand my benefits and what my insurance will and will not pay for.

Authorization/ Precertification
I understand it is my responsibility to make sure that my insurance doesn't require authorization/precertification. If authorization or precertification is required, it is my responsibility to make sure it is obtained prior to services being performed or being seen by Maher Rehab Solutions, LLC. / Dr. Michael Maher, DO. If authorization is not obtained and my claim is denied I understand I will be financially responsible for the entire balance due.

Collecting Payment Upfront
I understand it is the policy of Maher Rehab Solutions, LLC. to collect co-pays, co-insurance, and deductible amounts prior to being seen for my appointment. I understand this policy and agree to pay my respective co-pay, co-insurance, and deductible under the terms of my insurance plan.

Insurance Denials/ Unable to File to Insurance
I understand that Maher Rehab Solutions, LLC. files my claims as a courtesy to me and if there is any reason my claims deny (for lack of medical necessity or can't be filed due to incorrect/lack of information provided) I will be responsible for full payment of the charges. I also understand that I am responsible for resolving any disputes with my insurance over denied claims.

No Insurance
I understand that if I don't have insurance or wish to not use my insurance, I will be billed at a high out of pocket rate. I also agree to pay all out of pocket costs at the time service is provided. ***Please note: Medicare patients must sign a waiver if they wish to not use their insurance.***

Statements/Collection Process
I understand that should there be a balance due on my account I will have a period of 30 days to pay any balance. After 30 days my account will become past due, and steps will be taken to turn my account to a collection agency. I understand that if my account becomes past due Maher Rehab Solutions LLC. will take necessary steps to collect the debt including sending my account to a collection agency. I will be responsible for all associated fees, including collection fees, attorney fees, and court costs.

Medical Records
I understand that medical records are the property of Maher Rehab Solutions.; however, I may request copies with sufficient advanced notice. There may be a charge for medical copies.

Special Forms
I understand that Maher Rehab Solutions, LLC. charges fees for completion of special forms (such as FMLA, disability…etc.).

Signature:_____ **Date:**_____

Patient Name:_____

CONSENT FOR PAIN RELIEVING MEDICATION

Taking Medication as Prescribed
I understand it is vital to adhere to Dr. Michael Maher's orders on how I take pain medication. I agree to never take more than the prescribed dose without first consulting Dr. Michael Maher, DO. I agree to not abruptly decrease or stop my pain medication, since "withdrawal" symptoms may occur (anxiety, insomnia, diarrhea, abdominal cramping) that in rare cases may be dangerous.

Responsible for Medications
I understand I am solely responsible for my medications. If the prescription or medication is lost, misplaced, or stolen, I understand that it may not be replaced. If the medication was stolen and I can provide legitimate police reports to substantiate the circumstances surrounding the medication theft, special exceptions may be made.

Against Physician Advise
I understand that if I choose to use more of the medication(s) than prescribed by Dr. Michael Maher, DO that I VOLUNTARILY have chosen to go through withdrawal (I in fact may make myself have diarrhea, nausea, shakes, lack of sleep, or other consequences). By my actions, I am responsible solely for all consequences and will not hold Dr. Michael Maher, DO. responsible, knowing that I have not followed my physician's instructions. **I understand my prescriptions will not be refilled early because I have voluntarily chosen to take more medication than was prescribed.**

Not Obtaining Controlled Substances Elsewhere
I will not request, seek, or accept any controlled substance from any other physician, physician's assistant, or nurse practitioner, while I am receiving such medication from Dr. Michael Maher, DO. I understand that seeking or obtaining controlled substances from other physicians or persons is illegal and can endanger my health.

Refills
I understand refills of controlled substances will ONLY be made during normal off hours. Refills will not be made at night or on holidays or weekends. I realize that if I do not follow through with my end of this agreement, I will go through medication withdrawal, which can cause anxiety, nausea, vomiting, diarrhea, or other side effects. In addition, my pain will increase.

Selling Medications
Selling medications or sharing medication with family, friends or any other person is illegal and will not be tolerated. You should protect and care for your medication as you would any extremely valuable possession. Care should be taken to prevent inadvertent consumption of your medication by any other person as this could be dangerous.

Problems with Law Enforcement
I understand that if I'm involved in any problems with law enforcement agencies this may be grounds for dismissal from Maher Rehab Solution's pain management practice.

Violation of Terms
I understand and agree that if I violate any of the above, my controlled substance agreement and treatment will be terminated immediately without any recourse by me.

Signature:_____ **Date:**_____

PATIENT RESPONSIBILITIES

This agreement is between Maher Rehab Solutions and the patient (as shown above). In an effort to better care for Maher Rehab Solution's patients, the following expectations are required to maintain an effective provider-patient relationship.

Expectations
I will treat Dr. Maher and staff with respect and dignity whether in the clinic, via email, text, or on the phone.

Violation of Terms
I have read and understand the above-listed expectations and agree that failure to meet these expectations will result in immediate termination of this relationship between me and Maher Rehab Solutions.

Signature:_____ **Date:**_____