Gulf Coast Rehabilitation, P.C.

PO Box 3666 Victoria, Texas 77903
www.gcrexcel.com
Administrator: Michelle Hochdorf

OFFICE LOCATIONS

Victoria
Jay Babcock, PT, DPT
Grace Rees, OT
5205 John Stockbauer
Victoria, Texas 77904
PH: 361-572-4246
Fax: 361-572-9490

Cuero
Jay Babcock, PT, DPT
2550 N. Esplanade
Cuero, Texas 77954
Ph: 361-277-6527
Ph: 361-275-0532
Fax: 361-275-8389

Goliad
Jay Babcock, PT, DPT
Ross Mansker, PT
310 E. Pearl, Ste. B
Goliad, Texas 77963
PH: 361-645-1560
Fax: 361-645-8528

Port Lavaca
Kendra Bunurai, PT, DPT
128 N. Commerce
Port Lavaca, Texas 77979
Ph: 361-552-1977
Fax: 361-552-7686

Edna
Kara McCain, MPT,PT
1013 S. Wells St
Edna, Texas 77957
PH: 361-782-7898
Fax: 361-782-6317

REGISTRATION FORM

Patient Information (please print):

Patient Name: _____ **Are you currently receiving Home Health?** _____

S.S. #: _____ DOB: _____ Referring Doctor: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Please list the phone numbers for which we have permission to contact you at:

Cell #: _____ Home #: _____ Work #: _____

We have the right to leave a message at the above phone numbers *(circle one):* YES NO

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

e-mail address: _____

Employer: _____ Occupation: _____

Spouse/Parent Information:

Spouse/Parent Name: _____ DOB: _____

Employer: _____ Occupation: _____

Phone #: _____ (circle one) Home Cell Work

Insurance Information:

Primary Insurance: _____ Group #: _____

Subscriber Name: _____ ID #: _____

Secondary Insurance: _____ Group #: _____

Subscriber Name: _____ ID #: _____

In Case of Emergency Please Notify:

Name: _____

Relationship to Patient: _____ Phone #: _____

MEDICAL RELEASE FORM

I, _____, give my permission to Gulf Coast Rehab, PC to obtain any and all medical records currently in your possession which are needed to assist in my care and treatment.

_____
Patient Name

_____
Signature and Date

AUTHORIZATION FOR CARE, ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I give my consent to receive physical/occupational therapy treatment to be performed by the staff of Gulf Coast Rehabilitation, PC for all services described on the attached clam or statement. I further hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further agree and acknowledge that my signature on this document authorizes my therapist to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.
I acknowledge and understand that I am responsible for all the charges and service rendered to me or any member of my family.

Signed: _____ Date: _____

GULF COAST REHABILITATION, P.C.

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

Gulf Coast Rehabilitation, P.C.'s LEGAL DUTY

Gulf Coast Rehabilitation, P.C. is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Gulf Coast Rehabilitation, P.C. used your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example: Gulf Coast Rehabilitation, P.C. may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Gulf Coast Rehabilitation, P.C. may also use or disclose your personal health information without prior authorization for public health purposes, auditing purposes, or for research studies and for emergencies. We also provide information when required by law.

In any other situation, Gulf Coast Rehabilitation, P.C.'s Policy is to obtain your written authorization before disclosing your personal health information, If you provide us with a written authorization to release your information for any reason you may later revoke that authorization to stop future disclosures at any time.

Gulf Coast Rehabilitation, P.C. reserves the right to change its policy at any time. When changes are made, a new NOTICE OF INFORMATION PRACTICES will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our NOTICE OF INFORMATION PRACTICES at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed our personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Gulf Coast Rehabilitation, P.C. will consider all such request on a case-by-case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Gulf Coast Rehabilitation, P.C. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Gulf Coast Rehabilitation, P.C.'s health information practices or if you have a complaint, please contact the following person:

GULF COAST REHABILITATION, P.C.
Michelle Hochdorf – Privacy Officer
P.O. Box 3666, Victoria, Texas 77903
Phone: 361-277-6527 Fax: 361-275-8389

Patient Signature: _____ Date: _____

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Michelle Hochdorf administrator mhochdorf@gcrexcel.com Ph 361-275-0532 Fax: 361-275-8389

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Please list all medications including; prescriptions, herbals, over-the counter, & vitamins.

DRUG NAME	DOSAGE	FREQUENCY

Patient Signature: _____ Date: _____

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HIPAA PRIVACY ARTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA")

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION however, Gulf Coast Rehabilitation, P.C., ("Covered Entity") may decline to provide treatment to me if I do not sign this consent or later revoke this consent.

By signing this authorization, you acknowledge and agree that Covered Entity may use or disclose your personal health information in order to provide you with services and the treatment you require or request, or to collect payment for those services and to conduct other related health care operations otherwise permitted or required by law.

By signing this authorization, you agree that Covered Entity or its business associates may disclose your personal health care information to coordinate care within the Covered Entity and with others involved in your care, such as your attending physicians and other health care professionals who have agreed to assist the Covered Entity in coordination of my care. The Covered Entity also may disclose your health care information to individuals outside of the Covered Entity involved in your care including family members, pharmacist, suppliers of medical equipment or other health care professionals.

Further, by signing this authorization you acknowledge that you have been provided a copy of, have heard and understand Covered Entity's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Covered Entity has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Covered Entity at any of its offices, or by sending a written request with return address to: Michelle Hochdorf-Privacy Officer—P.O. Box 3666 Victoria, Texas 77903

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by Covered Entity for as long as the PHI is maintained in the designated record set.

You have the right to revoke or limit this authorization, in writing at any time, except to the extent that Covered Entity has taken action in reliance on it. A revocation is effective upon receipt by Covered Entity of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: (a) revocation of the authorizations, (b) a finding by the Secretary of the U.S. Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, (c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Covered Entity, or (d) six years from the date this authorization was executed.

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By signing this authorization, you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Acknowledged and agreed to by:

Patient:

Signature: _____ Date: _____

Printed Name: _____

Address: _____

_____

_____

Or ON BEHALF OF PATIENT:

Signature: _____ Date: _____

Printed Name: _____

Address: _____

_____

_____

Pre-Exam Form

Patient Name: _____ Age: _____

Occupation: _____ Are you working now: _____

1. Where is your pain/problem? _____
2. What caused your pain/problem? _____
3. Approximately when did it start? _____
4. Have you ever had this pain/problem before? _____
5. In your understanding, what do you think will make it better?
   _____
6. How optimistic are you that you will get better? (circle one)
   Not at all mildly optimistic Fairly Very optimistic Extremely
7. What are some potential obstacles to getting you better:
   _____
8. Over the next month, how many hours per week will you commit to getting better:
   _____
9. What are you expecting from your physical therapy program?
   _____
10. Circle your worst pain level in the past couple of days:
    0 1 2 3 4 5 6 7 8 9 10
11. Are any of your everyday activities affected? _____Yes _____No
12. List all past surgeries with dates/years if known
13. List all Medical conditions you have (or were told you have)

I understand that my candidacy for a rehabilitation program will be dependent upon my ability and willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for rehabilitation program and that my activation in to their system is not guaranteed.

Signature: _____Date: _____

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Benefit Notification Agreement

PATIENT NAME: _____

ACCOUNT #_____

INSURANCE: _____

Co-pay: _____ Max dollar amount allowed: _____

Percentage of payment: _____ / _____

Deductible: _____ Deductible met: _____

Out of pocket: _____ out of pocket met: _____

Is prior authorization required? YES NO After _____ visits

Authorized visits: _____

Additional Comments: _____

_____

_____

Insurance Benefits and Financial Responsibility Agreement

I acknowledge that Gulf Coast Rehabilitation, P.C. has informed me of my insurance benefits. I understand that verification of insurance eligibility and benefits is not a guarantee of payment by my insurance company. I accept financial responsibility for any charges not covered or paid by my insurance, including any remaining balance.

I agree to pay all applicable co-payments at each visit.

I further agree to make payments toward any outstanding balance at each visit, as applicable, and to pay any remaining balance promptly upon notification or receipt of a statement. I understand that I am responsible for ensuring that all amounts owed for services rendered are paid in a timely manner, regardless of my insurance coverage or reimbursement.

Patient / Guardian Signature: _____

Date: _____

Verified By: _____ Date Verified: _____