CUSTOMER RECEIVED A COPY OF: ☐ INTAKE PAPERWORK ☐ PAYMENT PLAN

Gottsche Therapy and Wellness
Patient Benefit Information

Patient Full Name:_____ Age:_____ Today's Date:_____/_____/_____

Primary Insurance Name: _____ Policyholder Name:_____

SSN:_____ Relationship to Policyholder: self/spouse/child/other

DOB of Policyholder:_____/_____/_____ ID#_____ Group #_____

Effective date: From:_____ To:_____

Ind. Deductible:_____ Ded. paid to date:_____ Max OOP:_____ Max OOP Met:_____

Family Deductible:_____ Ded. paid to date:_____ Max OOP:_____ Max OOP Met:_____

		Visits Allowed	Maximum/Year	Met to Date
Physical Therapy:	Yes____ No____	_____	_____	_____
Occupational Therapy:	Yes____ No____	_____	_____	_____

Co-Pay amount: $_____ Authorization #_____

Notes: _____

_____

_____

_____Reference #_____

* * * * * * * * * * *

Secondary Insurance Name: _____ Policyholder Name:_____

Primary Policyholder:_____

SSN:_____ Relationship to Policyholder: self/spouse/child/other

DOB of Policyholder:_____/_____/_____ ID#_____ Group #_____

Effective date: From:_____ To:_____

Ind. Deductible:_____ Ded. paid to date:_____ Max OOP:_____ Max OOP Met:_____

Family Deductible:_____ Ded. paid to date:_____ Max OOP:_____ Max OOP Met:_____

		Visits Allowed	Maximum/Year	Met to Date
Physical Therapy:	Yes____ No____	_____	_____	_____
Occupational Therapy:	Yes____ No____	_____	_____	_____

Co-Pay amount: $_____ Authorization #_____

Notes: _____

_____

_____

_____Reference #_____

***** Please be aware that this is not a guarantee of payment and is based on your benefits only.***

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

Pre Admit Completed By:_____ Date:_____/_____/_____

Therapist Signature:_____ Date:_____/_____/_____

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Gottsche Therapy and Wellness
Patient Registration Form

PRIMARY CARE DOCTOR:_____

PATIENT INFORMATION

Patient Full Name:_____ Date of Birth:_____/_____/_____
Social Security Number:_____/_____/_____ ____Male ____Female Single, Separated, Married, Widowed, Divorced
Mailing and Street Address:_____
City:_____ State: _____ Zip Code:_____
Home Phone:_____ Cell Phone:_____Work Phone:_____
Do you want a reminder call for your appointments? ____Yes ____No
May we send you an email: ____Yes ____No Email Address:_____
If the patient is a minor, do you have a custody agreement for medical responsibility: ____Yes ____No

RESPONSIBLE PARTY

____ Same as above. Otherwise, please fill out below.
Responsible Party Name:_____ Date of Birth: _____/_____/_____
Social Security Number:_____/_____/_____ ____Male ____Female Single, Separated, Married, Widowed, Divorced
Mailing and Street Address:_____
City:_____ State: _____ Zip Code:_____
Home Phone:_____ Cell Phone:_____ Work Phone:_____

EMERGENCY CONTACT INFORMATION

In case of emergency notify:_____Relationship:_____Phone Number:_____

PATIENT PAYMENT POLICIES AND PAYMENT PLAN

We collect upfront for patient co-pays, deductibles, and co-insurance amounts at time of service. These are items that we are required to collect from patients per your insurance requirements. Every patient is required to have a payment plan on file as part of the intake process.

All patient accounts will be paid off within 6 months. If the balance cannot be paid off by the patient within 6 months, the patient will be sent to Receivable Solutions, which is an outside company that will collect the payments from you. This is NOT a collection agency. if payments are not made, you will be sent to collections.

The following is the schedule of payments which is based on your account balance. This payment amount could change monthly based on your account balance. If you are paying the highest payment plan amount and will not pay off the balance in 6 months, you will be sent to Receivable Solutions. It is understood that Gottsche expects payment for therapy services rendered regardless of litigation.

If your balance is:
$0-$500 your monthly payment will be $85
$501-$1,000 your monthly payment will be $167
$1001-$1,500 your monthly payment will be $250
$1,500 and above your monthly payment will be $300

You will receive a monthly statement. The amount due may change as you receive treatments and start making payments. Please contact our office to arrange for this payment plan, or call our office for more information. We reserve the right to change the payment amount.

GOTTSCHE LOCATIONS

Thermopolis	864-2146
Worland	347-2535
Basin	568-9399
Cody	578-1970
Powell	754-9262

Signature_____ **Date:** _____/_____/_____
** please see second page for further information regarding Gottsche's financial agreement.

REVISED 8/19

AUTHORIZATION AND SIGNATURES

CONSENT FOR TREATMENT
I voluntarily consent to treatment for myself/child/dependent from the healthcare providers at Gottsche Rehabilitation Center ('Gottsche'). I consent to rehabilitation and related services at Gottsche. In so doing, I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature.

WAIVER AND RELEASE
I hereby release, discharge and acquit Gottsche, its agents, representatives, affiliates, employees, or assigns, of and from any and all liability, claim demand, damage, cause of action, or loss of any kind arising out of or resulting from my refusal to accept, receive or allow emergency and or medical services.

LIABILITY
I know and agree that Gottsche is not responsible for loss or damage to personal valuables.

LITIGATION
Our services are provided in good faith. The bill is between you and this office. Gottsche expects payment for therapy services rendered regardless of litigation.

MEDICAL RECORDS
Gottsche charges a minimum of $50 for copies of medical records, and may charge more depending on the number of pages being made. Records will be mailed within 30 days of receipt of payment.

TREATMENT AND BILLING OF MINORS
I, as a parent/guardian of a minor receiving treatment hereunder, do herby agree and understand that I have been advised to remain on the premises during any such treatment and waive any claim I may have resulting from failure to do so. Also, I will be liable for the cost of treatment unless there is a custody agreement (a copy of which must be filed with Gottsche) that covers medical responsibility.

FINANCIAL AGREEMENT
PATIENT RESPONSIBILITY: If you do not have insurance, the full self-pay rate will be due at the time of service. This will be applied toward your visit. All patients with insurance coverage are expected to pay deductibles, co-insurance, co-payments or any balance not covered by insurance at the time service is rendered. Gottsche will file your claims as a courtesy to you one time. After 60 days, if your insurance has not been resolved, it is the responsibility of the patient to contact their insurance company to remedy the situation or the remaining balance could become the responsibility of the patient.
AUTHORIZATION OF PAYMENT: I hereby assign all benefits directly to and also authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. I understand fully that in the event my insurance company or financially responsible party does not pay for the service I receive, I will be financially responsible for payment. A Finance charge of 1.5% of the outstanding balance will accrue after 60 days.
INSURANCE: Gottsche may or may not participate as in network with your insurance company. It is the patient's responsibility to know the terms of their own plan. Gottsche will abide by signed insurance contracts as a participating provider. It is very important to advise us of your insurance carrier's pre-authorization requirements regarding therapy or durable medical supplies. We need to be aware of any specific requirements, according to your insurance carrier's plan, and Gottsche will not be responsible for non-payment obtained from not having correct authorization.
COLLECTIONS: Should it be necessary to turn your account over for collection, you will be held responsible for any additional collection, court costs, or attorney fees. Account balances that are delinquent will accrue interest at the rate of 20%.

NON-SUFFICIENT FUNDS: Returned checks are subject to a minimum fee of $15 with a maximum fee of $30.

FAILURE TO SHOW: If at any time you do not appear for your appointment, there will be a $15 fee collected at your next appointment. You can avoid this fee by calling our office in advance to cancel. We understand extenuating circumstances.

_____ _____/_____/_____
Signature of Patient/Parent/Guardian Relationship Date

REVISED 8/19

Gottsche Therapy and Wellness
Medical History Questionnaire

Patient Full Name:_____ Date:_____/_____/_____

Height:_____ Weight:_____ Occupation:_____

Reason for therapy:_____ Date of injury/or onset:_____

Surgery:_____ Date of surgery:_____

Are you receiving Home Health Services: ____Yes ____No

Have you received therapy in the past for this condition: ____Yes ____No When:_____

Previous treatment received:_____

Previous treatment was ____ successful ____ unsuccessful

Do you have allergies: ____Yes ____No Please list:_____

_____

_____

Are you currently using any tobacco products: ____Yes ____No Amount:_____

Are you currently consuming alcohol products: ____Yes ____No Type/Amount:_____

Have you had any falls in the past year: ____Yes ____No Please explain:_____

Please rate and circle your pain on the following 0-10 scale:

0 - No pain at all
1- Very weak pain
2 - Weak pain
3 - Moderate pain
4 - Somewhat strong pain
5 - Strong pain
6 - Stronger pain
7 - Very strong pain
8 - Very, very strong pain
9 - Very, very strong pain, unable to function
10 - Emergency room

Please list any medications (prescribed or over-the-counter) or supplements you are currently taking. Include dose and when you take them. If you have a list we can scan it into our system.

MEDICATION	DOSAGE	FREQUENCY/TIME TAKEN	MEDICATION ROUTE ORAL, INHALE, INJECTION

At the present time, would you say your health is ____Excellent ____Very Good ____Good ____Fair ____Poor

REVISED 8/19

MEDICAL HISTORY QUESTIONNAIRE PAGE TWO

Do you now, or have you ever had, any of the following conditions? (Mark all that apply.)

Medication		Chest Pain/Angina		Coronary Artery Disease	
Congestive Heart Failure		Heart Surgery/Pacemaker		Heart Attack	
Osteoarthritis		Osteoporosis		Back Injury/Pain	
Neck Injury/Pain		Rheumatoid Arthritis		Fracture/Broken Bones	
Bowel/Bladder Problems		Kidney Disease		Liver Disease	
Seizures/Epilepsy		Stroke/TIA		Headaches/Migraines	
Head Injury		Spinal Cord Injury		Peripheral Neuropathy	
Multiple Sclerosis		Parkinsons		Polio	
Asthma		COPD/Emphysema		Shortness of Breath	
Diabetes		Thyroid Disease		Sleep Apnea	
Hepatitis		Lupus		HIV/AIDS	
Anemia		Blood Clot/Emboli		Fibromyalgia/Chronic Fatigue	
Cancer		Hearing Problems		Bleeding Disorders	
Depression		Bipolar Disorder		Vision Problems	
PTSD		Previous Surgery		Anxiety	
GERD		IBS		Currently Pregnant	

Please provide details for any condition marked above: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

The information is correct to the best of my knowledge.

_____ _____/_____/_____

Signature of Patient/Parent/Guardian Relationship Date

REVISED 8/19

Notice of Privacy Practices (HIPAA)

This notice describes your rights regarding your medical information and informs you of how medical information about you may be used. Please review it carefully.

This notice applies to all Gottsche Rehabilitation Center facilities listed below (hereinafter referred to as "Gottsche").

Gottsche's Duties

By law, Gottsche must keep **protected health information ("PHI")** private. PHI is any information, including verbal, electronic and on paper that is created or received by Gottsche for purposes of providing health care to patients and for purposes of billing and payment for those services. PHI includes test results, notes written by therapists, doctors, nurses and other clinical staff, and general information such as your name, address and telephone number that is included in your health care records and your billing records.

Gottsche is required by law to give you this notice and to follow the notice that is currently in effect.

The Health Care Providers Covered By This Notice

This notice covers Gottsche and Gottsche co-workers, volunteers, students and trainees. The notice also covers other health care providers that come to Gottsche's facilities to care for patients (such as physicians, physician assistants, therapists and other health care providers not employed by Gottsche), unless these other health care providers give you their own notice of privacy practices.

Use and Disclosure of PHI without your Permission

Below is a list of ways in which Gottsche may use or share your PHI without your advance permission:

- **For Treatment:** We may share PHI about you with people involved in your care. For example, a doctor may need to look at your medical history before treating you.
- **For Payment:** We may use and disclose your PHI for billing purposes. For example, we may share your PHI with your insurance company to receive payment for services Gottsche provides to you, and we may share information with an ambulance company so that it may bill for services provided to bring you to Gottsche for treatment.
- **For Health Care Operations:** We may use and disclose PHI about you for our operations. For example, we may share PHI about you to evaluate our doctors' and nurses' performance in caring for you.
- **For Research:** We may share your PHI with researchers when their research has been approved by an institutional review board (IRB) and found by the IRB not to require patient permission. Your permission is required for other types of research.

Other Uses and Disclosures of PHI without your permission

Gottsche may also use or share PHI without your permission for the following purposes:

- Public health activities such as to report the occurrence of communicable diseases.

- To report information about victims of abuse, neglect or domestic violence.
- Health oversight activities, such as Medicare and Medicaid program activities.
- Legal proceedings, such as in response to a subpoena or court order.
- Law enforcement purposes, such as with the police or other law enforcement officials who are pursuing a criminal suspect.
- With medical examiners, coroners, and funeral directors.
- For organ and tissue donation purposes.
- To avert a serious health or safety threat.
- To comply with workers' compensation laws, military activity, and national security
- With an entity legally authorized to assist in disaster relief efforts such as the American Red Cross.
- For other purposes as required by law.

Permissive Uses or Disclosures

Gottsche may use or share your PHI for any of the purposes described in this section *unless you specifically request in writing that we do not*. Your written request must be given to your care provider or to the Health Information Management Office listed below.

- We may contact you to remind you of an appointment.
- We may contact you to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
- We may contact you about Gottsche-sponsored activities including fundraising programs and events. If you do not want your information to be used for fundraising purposes, please contact the Gottsche Foundation office listed below. We will care for you regardless of your decision to participate in fundraising activities.
- We may share PHI about you with a friend, family member, personal representative, or any individual you identify who is involved in your care or is paying for some or all of your care.

Uses and Disclosures Requiring Your Written Permission

For any purpose other than the ones listed earlier in this notice, we may use or share your PHI only when you give us written permission.

- **Psychotherapy Notes.** We must obtain your written permission for most uses and disclosures of psychotherapy notes.
- **Marketing.** Before we receive financial payment for marketing activities using your PHI, we must obtain your written permission. We may, however, communicate with you about products or services related to your treatment, case management, care coordination, or alternative treatments, therapies, health care providers or care settings without your permission. Your permission is also not needed for small promotional items and face-to-face communications.
- **Sale of PHI.** We may not sell your PHI without your written permission, except that we may be paid our cost to provide PHI for certain purposes such as public health purposes and other purposes permitted by HIPAA.

Revoking Your Authorization

If you give us written permission to use and share your PHI, you can take back your permission at any time, as long as you tell us in writing. If you take back your permission, we will stop using or sharing your information, but we will not be able to take back any information that we have already shared.

You have the following rights

- **Right to Request Restrictions:** If you pay cash for your health care item or service in full and request that Gottsche not to share the PHI about that service with your health plan, we will not disclose the PHI about that service to the health plan unless we are required to do so by law.

- **Right to Request Confidential Communication:** You have the right to request PHI in a certain form or at a specific location. Your request must be in writing. For example, you can request that we not contact you at work, and you can tell us how and/or where you want to receive PHI. We will agree to reasonable requests. If we agree to your request, we will honor your request until you tell us in writing that you have changed your mind and no longer want the confidential communication.
- **Right to Inspect and Receive a Copy Your PHI:** You have the right to review your PHI and to receive a paper or electronic copy of your PHI. Your request must be in writing. We may charge a fee for the cost of providing you with copies. We may deny your request to access and receive a copy of your PHI in rare situations when doing so is determined by a licensed health care professional to pose a serious risk of harm.
- **Right to Request a Change to Your PHI:** You have a right to request that your PHI be corrected if you believe that it contains a mistake or is missing information. You must tell us the reasons for the change in writing. Gottsche can deny your request if: (1) it is not in writing or does not include a reason for the change; (2) the information you want to change was not created by Gottsche; (3) the information is not part of the medical record kept by Gottsche; (4) the information is not part of the information that you are permitted to inspect or copy; or (5) the information contained in the record is accurate and complete.
- **Right to Notice of a Breach:** We are required by law to tell you if there is a breach of your PHI. A breach can occur when safeguards to protect your PHI fail.
- **Right to an Accounting of Disclosures:** You have the right to request an accounting of disclosures of your PHI that we have made, with some exceptions. Your request must be in writing and must state the time period for the requested information. Gottsche will not provide this information for a time period greater than six (6) years from the date of your request. You have the right to receive one (1) free accounting every twelve (12) months. If you request more than one (1) accounting in any twelve (12) month period, we may charge you a reasonable fee for the costs of providing that list.
- **Right to Receive a Copy of this Notice:** You have the right to a copy of this Notice. If you want a paper copy of this notice mailed to you, or to exercise any of your rights outlined above, please send a written request to the Gottsche Location where you received your health care services, listed below.

We hope you will tell us if you have a concern so we can try to fix it, but you also have the right to file a complaint with the Office for Civil Rights (OCR). If you decide to report a complaint to Gottsche or to the OCR this will not affect your ability to obtain care and treatment at Gottsche.

Changes to This Notice

We have the right to change this notice at any time. If we change this notice, we may make the new terms effective for all PHI that we maintain. Any changes that we make will comply with federal, state and other laws. You can also call or write to the Gottsche location where you received your health care services to receive a copy of this notice.

Privacy Contacts for Concerns or Questions

If you have any questions about this Notice, or any concern about the privacy of your PHI, please contact the Gottsche provider where you obtained health care services listed below.

GOTTSCHE REHABILITATION CENTER LOCATIONS

Thermopolis	**Basin**	**Worland**	**Cody**	**Powell**
148 E. Arapahoe 82443	890 Hwy 20 South 82410	1125 Charles St 82401	1526 Rumsey Ave 82414	639 Coulter Ave 82435
307.864.2146	307.568.9399	307.347.2535	307.578.1970	307.754.9262

Receipt of Notice of Privacy Practices

Patient Full Name:_____

May we leave a message with anyone at your household when we are unable to reach you by phone?

☐ Yes ☐ No If yes, who? _____ Phone:_____
_____ Phone:_____
_____ Phone:_____

May we talk to anyone else about your healthcare and treatment?

☐ Yes ☐ No If yes, who? _____ Phone:_____
_____ Phone:_____
_____ Phone:_____

My signature below acknowledges that I have been provided, or was offered, a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Guardian Date

_____
Print Name

_____
Personal Representative's Title (Guardian, Health Care Power of Attorney, Parent, etc.)

For office use: Complete this section if you are unable to obtain a signature

1. If the patient or representative is unable or unwilling to sign this acknowledgement, or the acknowledgment is not signed for any other reason, state reason: _____
_____
_____

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the acknowledgement: _____
_____
_____

Completed by: _____ Date: _____

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