



GENERAL INFORMATION

PATIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Is this your legal name? ☐ - Yes ☐ - No

If no, what is your legal name? _____

Date of Birth: _____ Age: _____ ☐ - Male ☐ - Female Marital Status: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ SSN: _____

Referring Physician: _____

Diagnosis: _____

INSURANCE INFORMATION:

Person Responsible for bill: _____ Date of Birth: _____

☐ Check if address information is same as above.

Address: _____ City: _____ State: _____ Zip: _____

Name of Employer: _____ Employer Phone: _____

Do you have Medicare? ☐ Yes | No ☐

Policy #: _____

Do you have Medicaid? ☐ Yes | No ☐

Policy #: _____

Are you covered by Insurance? ☐ Yes | No ☐

Name of Insurance: _____

Subscribers Name: _____ SSN: _____ DOB: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy #: _____

Subscribers Name: _____ SSN: _____ DOB: _____

Patient's Relationship to Subscriber: ☐ - Self ☐ - Spouse ☐ - Child ☐ - Other

IN CASE OF EMERGENCY:

Name and relation of **LOCAL** friend or relative: _____

Phone #: _____ Alternate #: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Arkansas Complete Care (dba Complete Pulmonary Rehab). I understand that I am financially responsible for any balance. I also authorize Arkansas Complete Care (dba Complete Pulmonary Rehab) or insurance company to release any information required to process my claims. I have been informed of cancellation policy notice.

Patient Signature

Date



PATIENT MEDICATION LIST

Patient Name

Date of Birth

Medication Name and Strength	Amount and Frequency Taken on a Daily Basis	Time of Day Taken	Purpose of Medication	Any Additional Comments

Medication Allergies: _____

Vitamins You Take: _____

Food Allergies: _____

Patient Signature

Date



Complete Pulmonary Rehab

5905 Forest Place Suite 200

Little Rock, AR 72207

Phone: (501) 566.1011 Fax: (501) 501.232.4693

RELEASE OF INFORMATION

PATIENT NAME

DATE OF BIRTH

INFORMATION REQUESTED

I hereby authorize Complete Pulmonary Rehab to release or obtain information contained in my medical records.

I authorize the release of the information requested relating to my general medical treatment and/or any treatment. I further authorize the information to be faxed or electronically sent. I understand this authorization may be revoked at any time, providing the information has not already been disclosed. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department. I also understand that once the above information has been disclosed per my instruction, the information may no longer be protected by the confidentiality laws.

I hereby state that I have read and fully understand the above statements.

Patient/Legal Representative Signature

Date

Relationship to Patient, if signed by Legal Representative



Complete Pulmonary Rehab

5905 Forest Place, Suite 200

Little Rock, AR 72207

Phone: (501) 566.1011 Fax: (501) 232.4693

HIPAA CONSENT

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

I consent to the disclosure of my protected health information by Complete Pulmonary Rehab for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations. I understand that treatment of me by Complete Pulmonary Rehab may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or healthcare operations of the practice. Complete Pulmonary Rehab is not required to agree to the request. However, if Complete Pulmonary Rehab agrees to a restriction that I request, the restriction is binding by Complete Pulmonary Rehab and all its clinicians who practice there.

My protected health information means health information, including my demographic information, collected from me and created by my physician, another healthcare provider, a health plan, my employer, or a healthcare clearinghouse. This protected information relates to my past, present, future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

Patient or Legal Representative Signature

Date



Complete Pulmonary Rehab

INFORMED CONSENT

AUTHORIZATION TO TREAT

Patient Name

Date of Birth

I hereby give my consent and authorize treatment for therapy.

The care provider has explained my condition to me, treatment procedure(s) and alternative methods of treating my condition.

The care provider has discussed with me foreseeable risks of the above stated treatment and there may be undesirable results.

I authorize the care provider to perform any additional or different treatment which is thought necessary, should, during treatment, a condition be discovered which was not known previously.

I have carefully read and fully understand this Informed Consent Form and have had the opportunity to discuss my condition and the procedure(s) with the care provider. All of my questions have been adequately answered.

Patient Signature

Date

Care Provider Signature

Date



Complete Pulmonary Rehab

ACKNOWLEDGEMENT OF MEDICAL DIRECTOR

Arkansas Complete Care LLC, dba Complete Pulmonary Rehab has a Physician who serves as Medical Director. The Medical Director's name, **Dr. Ladly Abraham**, will appear on correspondence sent to you from Medicare, such as on an EOB or Explanation of Benefits.

I have read the above information and acknowledged the Medical Director.

Patient Signature

Date



ARKANSAS HIPAA PRIVACY AUTHORIZATION FORM

**** Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act,
C.F.R. Parts 160 and 164) ****

**** 1. Authorization ****

I authorize Complete Pulmonary Rehab (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

**** 2. Effective Period ****

This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

****OR****

b. ☐ all past, present and future periods.

**** 3. Extent of Authorization ****

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and the treatment of alcohol or drug abuse).

****OR****

b. ☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obligated as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

Date



Notice of Medicare Provider Non-Coverage

Patient Name: _____

Medicare#: _____

The effective date coverage of your CORF will end: _____

Your provider has determined that Medicare probably will not pay your current rehab services after the effective date indicated above. You may have to pay for any rehab services you receive after that date.

YOUR RIGHT TO APPEAL THIS DECISION

You have the right to an immediate, independent, medical review (appeal), while your services continue, of the decision to end Medicare coverage of these services.

If you choose to appeal, the independent reviewer will ask your opinion and you should be available to answer or supply information. You do not have to prepare anything in writing, but you have the right to do so if you wish.

If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.

If you choose to appeal, and the independent reviewer agrees that services should no longer be covered after the effective date indicated above, Medicare will not pay for services after that date.

HOW TO ASK FOR AN IMMEDIATE APPEAL:

You must make your request to your Quality Improvement organization (also known as a Q10). A Q10 is the independent reviewer authorized by Medicare to review the decision to end these services.

Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective end date listed above.

The Q10 will notify you of its decision as soon as possible, generally by no later than two days after the effective date of this notice.

Call your Q10 at AR foundation for Medical Care to appeal, or if you have questions: 479.649.8501

OTHER APPEAL RIGHTS:

If you miss the deadline for filing an immediate appeal, you may still be able to file an appeal with Q10, but the Q10 will take more time to make its decision.

Contact 1800-Medicare (1800-633-4227) to TTY/TDD (1877-486-2048) for more information.

Please sign below to indicate that you have received this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my Q10.

Patient Signature

Date



ATTENDANCE POLICY

PATIENT NAME

DATE OF BIRTH

Complete Pulmonary prides itself on patient satisfaction. Results of a rehabilitation program are determined in large part by the consistency of patient participation which means keeping appointment times and attending your scheduled appointments. We realize that emergencies do occur and we will work with the best of our ability to reschedule you as necessary.

If for any reason you cannot make your appointment:

- ☐ We require 24 hours' notice in advance to reschedule or cancel your appointment unless there is a family/medical emergency. If we are closed for the day please leave a message. This allows us to staff appropriately.
- ☐ Please be aware that if you come in early, you may have to wait until staff can work you in, patients more than 15 minutes late will be rescheduled.
- ☐ Under Medicare Guidelines, missing consecutive visits could result in Medicare non-payment in which you would be responsible along with discharge from the program.
- ☐ **Complete Pulmonary Rehab's policy is missing 2 or more consecutive visits could result in discharge unless patient is on medical hold.** Two or more no call-no shows will result in immediate discharge from the program. If you have a conflicting medical appointment, documentation must be provided to Complete Pulmonary Rehab upon the patient's next visit.
- ☐ Beginning January 1, 2021 Complete Pulmonary Rehab will charge a \$40 fee for no call-no shows and not giving 24 hours' notice for cancellations unless due to a family or medical emergency.
- ☐ If you travel out of state or country while participating in our program, you must notify our staff beforehand. (COVID-19 PROTOCOL)

Patient Signature

Date

Your Pulmonary Program will consist of at least 2 visits per week and are based on the results of your evaluations and stated in your plan of care.