Boston Brain Center
Neurological Rehabilitation

Authorization and Consent to Treatment

Assignment of Benefits and Authorization to Release Medical Information. I hereby certify that the insurance information I have provided is accurate, complete and current and that I have no other insurance coverage. I assign my right to receive payment of authorized benefits under Medicare, Medicaid, and/or any of my insurance carriers to the facility or supplier of any services furnished to me by that facility or supplier. I authorize my facility to file an appeal on my behalf for any denial of payment and/or adverse benefit determination related to services and care provided. If my health insurance plan does not pay my provider directly, I agree to forward to my provider all health insurance payments which I receive for the services rendered by my provider and its health care providers. I authorize my provider or any holder of medical information about me or the patient named below to release to my health insurance plan such information needed to determine these benefits or the benefits payable for related services. I understand that if my provider does not participate in my insurance plan's network, or if I am a self-pay patient, this assignment of benefits may not apply.

Guarantee of Payment & Pre-Certification. In consideration of the services provided by my provider, I agree that I am responsible for all charges for services I receive that are not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I agree to pay all charges not covered by my health insurance plan or for which I am responsible for payment under my health insurance plan. I further agree that, to the extent permitted by law, I will reimburse my provider for all costs, expenses and attorney's fees incurred by my provider to collect those charges.

If my insurance has a pre-certification or authorization requirement, I understand that it is my responsibility to obtain authorization for services rendered according to the plan's provisions. I understand that my failure to do so may result in reduction or denial of benefit payments and that I will be responsible for all balances due.

Consent to Treatment. I voluntarily consent to the rendering of such care and treatment as my providers, in their professional judgment, deem necessary for my health and well-being; however I may refuse any particular treatment or procedure.

If I request or initiate a Telehealth visit (a "virtual visit'), I hereby consent to participate in such Telehealth visit and its recording and I understand I may terminate such visit at any time.

My consent shall cover medical examinations and diagnostic testing (including testing for sexually transmitted infections and/or HIV, if separate consent is not required by law), including, but not limited to, minor surgical procedures (including suturing), cast application/ removals and vaccine administration. My consent shall also cover the carrying out of the

orders of my treating provider by care center staff. I acknowledge that neither my provider nor any of his or her staff have made any guarantee or promise as to the results that I will obtain.

Consent to Call, Email & Text. I understand and agree that my provider may contact me using automated calls, emails and/or text messaging sent to my landline and/or mobile device. These communications may notify me of preventative care, test results, treatment recommendations, outstanding balances, or any other communications from my provider. I understand that I may opt-out of receiving all such communications from my provider by notifying my facility's staff, by visiting "My Profile" on my Boston Brain Center Patient Portal, or by emailing the Privacy Officer at **contact@bostonbriancenter.org**

HIPAA. I understand that my facility's Privacy Notice is available on my facility's website and at **www.bostonbraincenter.org/about/** and that I may request a paper copy at my facility's reception desk.

I hereby acknowledge that I have received my provider's Financial Policy as well as my provider's Notice of Privacy Practices. I agree to the terms of my provider's Financial Policy, the sharing of my information via HIE,* and consent to my treatment by my provider. This form and my assignment of benefits applies and extends to subsequent visits and appointments with all

Printed Name of Patient: _____

Email: _____

Signature: _____

Date: _____

To be signed by the patient's parent or legal guardian if the patient is a minor or otherwise not competent.

Name and Relationship of Person signing, if not Patient:

_____

*Note: If you do not want to participate in Health Information Exchange (HIE), it is your responsibility to follow the instructions outlined on the provider HIE Opt-Out Request Form and/or contact the HIE directly.

Boston Brain Center
Neurological Rehabilitation

HEALTH HISTORY QUESTIONNAIRE

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Name _____Preferred Name:_____
Title: _____Date of Birth:_____Gender: _____
Contact Number:_____ Email: _____
Address:_____ City/State/Zip Code:_____

Emergency Contact Information:

Name:	Name:
_____	_____
Relationship to patient:	Relationship to patient:
_____	_____
Contact Number:	Contact Number:
_____	_____
Email:	Email:
_____	_____

Main reason for today's visit:

_____
_____
_____
_____

Other concerns:

_____
_____
_____

MEDICATIONS

Please list all the medications you are taking. Include prescribed drugs and over-the-counter drugs, such as vitamins and inhalers.

DRUG NAME STRENGTH FREQUENCY TAKEN

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

PAST MEDICAL HISTORY

Please check all that apply:

☐ Anxiety Disorder	☐ Diverticulitis	☐ Kidney Disease
☐ Arthritis	☐ Fibromyalgia	☐ Kidney Stones
☐ Asthma	☐ Gout	☐ Leg/Foot Ulcers
☐ Bleeding Disorder	☐ Has Pacemaker	☐ Liver Disease
☐ Blood Clots (or DVT)	☐ Heart Attack	☐ Osteoporosis
☐ Cancer	☐ Heart Murmur	☐ Polio
☐ Coronary Artery Disease	☐ Hiatal Hernia or Reflux Disease	☐ Dialysis
☐ Pulmonary Embolism	☐ Claustrophobic	☐ HIV or AIDS
☐ Reflux or Ulcers	☐ Diabetes - Insulin	☐ High Cholesterol
☐ Stroke	☐ Diabetes - Non-Insulin	☐ Tuberculosis
☐ High Blood Pressure	☐ Overactive Thyroid	☐ Other

Specify: _____

_____

PAST SURGICAL HISTORY

SURGERY	REASON	YEAR	HOSPITAL
1.			
2.			
3.			
4.			
5.			
6.			

REHABILITATION HISTORY

1. Have you previously undergone any rehabilitation treatments? If yes, please describe:

_____

_____

2. Are you currently receiving any rehabilitation services? If yes, please specify:

_____

_____

3. What are your goals for rehabilitation? (e.g., pain management, improved mobility, etc.)

_____

_____

4. Do you have any specific concerns or limitations regarding rehabilitation?

_____

_____

GENERAL HEALTH AND LIFESTYLE

1. How would you describe your overall health? (e.g., excellent, good, fair, poor)

_____

_____

2. Do you smoke or use tobacco products? If yes, please specify:

_____

_____

3. How would you rate your level of physical activity? (e.g., sedentary, moderately active, highly active)

_____

_____

4. Do you consume alcohol? If yes, please specify frequency and amount:

_____

_____

Additional Information:

Is there any other information you believe would be important for us to know before beginning your rehabilitation treatment?

_____

_____

_____

_____

Have you had the following procedures or services:

- ◻ Alzheimer's
- ◻ Peripheral neuropathy
- ◻ Concussion
- ◻ Stroke
- ◻ Spinal cord injury
- ◻ TBI
- ◻ Brain tumor
- ◻ Cerebral palsy
- ◻ Multiple sclerosis
- ◻ Muscular dystrophy
- ◻ Neuromuscular disorder
- ◻ Adaptive sports and recreation
- ◻ Balance activities
- ◻ Bracing
- ◻ Compensatory techniques and strategies
- ◻ Gait training with cutting-edge assistive equipment/devices.
- ◻ Language, swallowing therapies, and cognitive therapy.
- ◻ Neurological re-education of movement patterns and functional activities
- ◻ Specialized therapy equipment
- ◻ Splinting
- ◻ Therapeutic exercise
- ◻ Wheelchair services and seating assessments

SOCIAL HISTORY

Education: ☐ Less than 8th grade ☐ High school ☐ 2 year college ☐ 4 year college ☐ Post graduate ☐ Other: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Domestic partner

Caffeine: ☐ None ☐ Occasional ☐ Moderate ☐ Heavy # of cups/cans per day?_____

Tobacco: Do you use tobacco? ☐ Yes ☐ No ☐ Cigarettes -____pks./day ☐ Chew - ____/day

If so, how often? ☐ Occasionally ☐ < 3 times a week ☐ Cigars - _____/day

If not currently, did you ever use tobacco? ☐ Yes ☐ No ☐ # of years____ Or year quit _____

Drugs: Do you currently use recreational or street drugs? ☐ Yes ☐ No If yes, list:_____

_____

Alcohol: Do you drink alcohol?☐ Yes ☐ No - How many drinks per week? _____

Exercise Level: ☐ > 3 times a week ☐ No exercise ☐ Occasional exercise ☐ Moderate exercise ☐ High level exercise

REVIEW OF SYSTEMS

Please check all that apply:

Allergic/Immunologic

☐ Frequent Sneezing

☐ Hives

☐ Itching

☐ Runny Nose

☐ Sinus Pressure Cardiovascular

☐ Arm Pain on Exertion

☐ Chest Pain on Exertion

☐ Chest Heaviness/Pressure on Exertion

☐ Irregular Heart Beats (Palpitations)

☐ Known Heart Murmur

☐ Light-headed on Standing

☐ Shortness of Breath When Lying Down

☐ Shortness of Breath When Walking

☐ Swelling (edema)

Constitutional

☐ Exercise Intolerance

☐ Weight Gain (____lbs)

☐ Weight Loss (____lbs) Eyes

☐ Dry Eyes

☐ Irritation

☐Vision Change Date of Last Exam:_____

Musculoskeletal

☐ Back Pain

☐ Joint Pain

☐ Muscle Aches

Ears/Nose/Mouth/Throat

☐ Bleeding Gums

☐ Difficulty Hearing

☐ Dizziness

☐ Dry Mouth

☐ Ear Pain

☐ Frequent Infections

☐ Frequent Nosebleeds

☐ Hoarseness

☐ Mouth Breathing

☐ Mouth Ulcers

☐ Nose/Sinus Problems

☐ Ringing in Ears

Endocrine

☐ Fatigue

☐ Increased Thirst/Hunger/ Urination Gastrointestinal

☐ Abdominal Pain

☐ Black or Tarry Stool

☐ Blood in Stool

☐ Change in Appetite

☐ Frequent Indigestion

☐ Hemorrhoids

☐ Trouble Swallowing

☐ Vomiting

☐ Vomiting Blood

☐ Fatigue

Genitourinary

☐ Blood in Urine

☐ Difficulty Urinating

☐ Incomplete Emptying

☐ Increased Urinary Frequency

☐ Rash

☐ Easy Bruising/Bleeding

☐ Swollen Glands

Integumentary (Skin)

☐ Changes in Moles

☐ Dry Skin

☐ Eczema

☐ Growth/Lesions

☐ Itching

☐ Jaundice (Yellow Skin/Eyes)

☐ Urinary Loss of Control Hematologic/Lymphatic

Neurological

☐ Dizziness

☐ Fainting

☐ Headaches

☐ Memory Loss

☐ Migraines

☐ Numbness

☐ Restless Legs

☐ Seizures

☐ Weakness

☐ Muscle Weakness	☐ Fever	**Other: (please specify)**
Respiratory	**Psychiatric**	_____
☐ Cough	☐ Alcohol Overuse	_____
☐ Coughing Up Blood	☐ Anxiety/Stress	_____
☐ Shortness of Breath	☐ Depression	_____
☐ Sleep Apnea	☐ Do Not Feel Safe in Relationship	_____
☐ Snoring	☐ Sleep Problems	_____
☐ Wheezing		

Please add any other information about your health that you would like your provider to know here:

_____

_____

_____

_____

_____

_____ _____

Patient Signature Date

_____ _____

Parent, Guardian, or Caregiver Signature Date

Thank you for taking the time to complete this questionnaire. Your responses will help us tailor our rehabilitation services to best meet your needs. If you have any questions or concerns, please don't hesitate to contact us.

Boston Brain Center
Neurological Rehabilitation

HIPAA AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient's Full Name _____
Date of Birth _____**Patient's Telephone Number**_____
Address _____**City/State/Zip Code** _____
Any Other Names Used_____

I request that my provider share my protected health information (PHI) as directed below. Specifically, I request that my PHI:

1. From the following Care Center locations and/or providers (list all locations):

   _____

   _____

2. Be sent to the following person / entity at the address listed below:

Name:_____ Telephone: _____
Address_____City/State: _____Zip Code:_____
Fax or Email Address for Delivery_____

Name:_____ Telephone: _____
Address_____City/State: _____Zip Code:_____
Fax or Email Address for Delivery_____

3. I hereby authorize disclosure of the following information: ☐ My entire medical record
   ☐ Immunization Records Only ☐ Service Dates Only:_____ to _____
   ☐ Specific Information Only: _____

NOTES

1. INFORMATION ABOUT ALCOHOL/SUBSTANCE USE, HIV/AIDS AND MENTAL HEALTH ISSUES IS INCLUDED UNLESS YOU SPECIFICALLY REQUEST THAT IT BE EXCLUDED IN THE SPACE BELOW. PSYCHOTHERAPY NOTES, HOWEVER, ARE NEVER INCLUDED.

2. IF YOU REQUEST WE SEND ONLY A PORTION OF YOUR RECORDS TO A TREATING PROVIDER, WE WILL SEND YOUR RECORDS TO YOU TO GIVE TO YOUR PROVIDER; WE WILL NOT SEND INCOMPLETE RECORDS DIRECTLY TO A TREATING PROVIDER. ☐ PLEASE ***EXCLUDE*** THE FOLLOWING INFORMATION:

_____

Signature: _____

3. I understand that I have the right to receive a copy of my PHI in the form and format and manner I request, if readily producible in that way, or as I may otherwise agree. If I do not specify a format below, I understand that my PHI will be mailed to at the address listed above in

hard copy/paper format. I hereby request that my PHI be provided in the following format: ☐ via secure electronic delivery; or ☐ other (please specify): _____

4. If I have requested records be sent unencrypted, I understand and acknowledge the risk of sending my PHI in an insecure manner.

5. If I requested records be mailed to me, I understand I will be charged for the cost of paper and postage; if I request my records on a USB drive or similar, I will be charged the cost of that device.

6. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or entity receiving it and will then no longer be protected by federal privacy regulations.

7. I understand I may revoke this authorization by notifying my provider OR **contact@bostonbraincenter.org in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.**

8. I understand that my care and treatment may not be conditioned on providing this authorization, if such conditioning is prohibited by the HIPAA Privacy Rule.

9. My purpose/use of the information is for ☐ personal use; or ☐ other (please specify):

_____

10. This authorization expires on _____ ____, 20___, OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of information about me: (please describe/specify event). If no expiration date is provided, this authorization will expire one year from the date signed.

NOTE: FEES FOR COPIES: When a patient requests a copy of his/her PHI for personal use, federal law permits a reasonable, cost-based fee that includes only labor for copying the PHI, costs for supplies, labor for creating a summary/explanation of the PHI if a summary or explanation was requested, and postage. If these charges are expected to exceed $25, we will attempt to inform you prior to your request being filled.

THIS FORM MUST BE FULLY COMPLETED BEFORE SIGNING; INCOMPLETE FORMS WILL NOT BE PROCESSED.

Signature of Patient_____

Patient's Date of Birth_____**Date of Patient's Signature**_____

If Patient is unable to sign, signature of Patient's Legal Guardian or Personal Representative of Patient's Estate

Representative's Signature _____**Date**_____

Description of Authority to Act for the Individual _____

Boston Brain Center
Neurological Rehabilitation

FINANCIAL POLICY

We are pleased that you have chosen us as your healthcare provider. To avoid any misunderstandings and ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your health care. We require all patients to sign our Authorization and Consent To Treatment Form before receiving medical services. That form confirms that you understand that the healthcare services provided are necessary and appropriate and explains your financial responsibility with respect to services received as set forth in this policy.

PATIENT RESPONSIBILITY

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit as well as any prior balance. When the insurance plan provides immediate information regarding patient responsibility, we may request payment for your share when you schedule and/or when you present for your appointment. As a convenience to you, we can save a credit card on file to settle your account when you check in or out. You may receive an estimate for your patient responsibility prior to or at the time of your service. If there is a difference in the estimated patient responsibility, we will send you a statement for any balance due. If a credit balance results after insurance pays, we will apply the credit to any open balance on your account. If there are no open balances, we will issue a refund.

If you have an Annual Wellness Visit or Physical/Preventative Exam, but need or request additional services, we may bill you for those additional services. All services for patients who are minors will be billed to the custodial parent or legal guardian. If you are uninsured and demonstrate financial need and complete the required paperwork, financial assistance may be available. If you have a large balance, a payment plan may be available.

INSURANCE AND BILLING INFORMATION

To ensure you have a good understanding of your specific insurance plan and benefits, we recommend that you call your insurance company to let them know you will be attending outpatient physical, occupational, or speech therapy at a specialty outpatient-based clinic. **You are responsible for understanding the limitations of your insurance policy.** Your insurance company can then confirm your benefits and provide information on the anticipated cost of your appointments. You may be responsible for co-pays each visit and/or meeting a deductible and/or co-insurance costs. Co-pays are due at the time of service. Please inform our front desk staff or any changes to your current insurance policy or contact information (including address, phone number, or email address).

You can obtain an estimate for a specific service. It is your responsibility to consult with your primary insurance company to determine whether Boston Brain Center's bill will be covered in whole or in part or what portion of the bill will be your personal financial responsibility. You may contact us for information on service estimates at (781)757-0577.

INSURANCE

We ask all patients to provide their insurance card (if applicable) and proof of identification (such as a photo ID or driver's license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e., self-pay). We accept assignment of benefits for many third party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient's responsibility. Keep in mind that our fees are for physician services only; you may receive additional bills from laboratory, radiology or other diagnostic related providers.

NO SURPRISES ACT / GOOD FAITH ESTIMATE OF CHARGES

If you do not have insurance or are not using insurance to pay for your care, you have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost. Under the NO SURPRISES ACT, health care providers must give patients who don't have insurance or who are not using insurance an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item.
- You can also ask your healthcare provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate. For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call 1-888-774-8428.

CARD-ON-FILE PROCESS

You may be requested to provide a credit card when you check-in for your visit. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of the notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. Your statements will be available via your patient portal and our Customer Support line is available to answer any questions about the balance due. If you have any questions about the card-on-file payment method, please let us know.

YOUR RESPONSIBILITIES

Outstanding Balances. After your visit, we will send you a statement for any outstanding balances. We send out statements when the balance becomes the patient's responsibility.

All outstanding balances are due on receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balances can be paid conveniently via our patient portal.

We may add a finance charge of 1.33% of your outstanding account balance every month if you do not pay your account in full.

If you have an outstanding balance for more than ninety (90) days, you may be referred to an outside collection agency and charged a collection fee of 23% of the balance owed, or whatever amount is permitted by applicable state law, in addition to the balance owed. In addition, if you have unpaid delinquent accounts, we may discharge you as a patient and/or you may not be allowed to schedule any additional services unless special arrangements have been made.

No-shows. If you miss your appointment or cancel with less than 24 hours notice, you may be charged a $50.00 fee for a routine appointment or a $100.00 fee for a missed consultation/ evaluation. This fee will need to be paid before you are allowed to schedule another appointment. This fee cannot be billed to insurance.

Interpreter and Translation Services. If you have requested interpreter or translation services for your visit and you miss your appointment without canceling at least forty-eight (48) hours prior to your scheduled appointment, you may be charged the amount that the translation or interpreter service charges your care center for such missed appointment.

Patient Signature: _____

Printed Name of Patient: _____Date: _____

(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

Thank you for choosing us as your healthcare provider!

Do you have any questions about your billing statement?
If you have specific questions about your statement, call us
Monday-Friday from 9AM- 5PM at (781)757-0577

Boston Brain Center
Neurological Rehabilitation

Preferred Communication

The HIPAA Privacy Rule gives individuals the right to direct how and where their healthcare provider communicates with them. This could, for example, include sending correspondence to your office instead of your home. Please tell us your preferred place and manner of communication. You may update or change this information at any time; please do so in writing.

Patient Name:

I prefer to be contacted in the following manner (check all that apply):

☐ **Send all communication through my Patient Portal**.

☐ **Home Telephone:**_____☐ **Cell Phone:**_____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐ **Written Communication:**_____

☐ OK to leave message with detailed information

☐ Leave message with call-back number only

☐**Other:** _____

My Preferred Contacts:

We respect your right to tell us who you want involved in your treatment or to help you with payment issues. Our secure patient portal is our primary means of patient communication, such as to share your test results. **You** have the ability to control access to your patient portal. Please indicate the person(s) with whom you prefer we share your information below.
Please update this information in writing promptly if your preferences change.

Please note that in some situations, it may be necessary and appropriate for us to share your information with other individuals. This may include information about your general medical condition and diagnosis (including information about your care and treatment), billing and payment information, prescription information and scheduling appointments.

Name:_____**Telephone:**_____
Relationship:_____**Email:** _____
Name:_____**Telephone:**_____
Relationship:_____**Email:** _____

ACKNOWLEDGMENT: I understand that HIPAA may permit my provider to share my information with other persons not named on this form as needed for my care or treatment or to obtain payment for services provided.

Patient Signature: _____
Printed Name of Patient: _____Date: _____
(To be signed by patient's parent or legal guardian if patient is a minor or otherwise not competent)

MEDIA RELEASE FORM

I, _____-- (the "Releasor") grant permission and consent to Boston Brain Center (the "Releasee") for the use of my MEDIA taken at the Boston Brain Center facilities and events for presentation under any legal condition, including but not limited to: publicity, copyright purposes, illustration, advertising, and web content.

Payment

I understand that there shall be no payment for this release.

Royalties

I understand that no royalty, fee, or other compensation shall become payable to me by reason of such use.

Revocation

I understand that I may revoke this authorization at any time by notifying the Releasee in writing. The revocation will not affect any actions taken before the receipt of this written notification. Media will be stored in a secure location and only authorized staff will have access to them. They will be kept as long as they are relevant and after that time destroyed or archived.

I, the Releasor, understand and agree to the aforementioned terms and conditions.

Releasor's Signature: _____ **Date** _____