BEYOND LIMITS REHABILITATION

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HIPAA Release Form

Release of information: (Initials Required)

_____ I authorize the release of information including any diagnosis, records, examination notes and claim information. This information may be released to the following:

Name:___________________________ Relationship_______________
Name:___________________________ Relationship_______________

Or

_____ Do not release to anyone

This release will remain in effect until terminated by me in writing.

Messages:

Please call: _____ Home _____ Cell _____Work _____ Other

If unable to reach me:
_____ You may leave a detailed message
_____ Leave a message asking me to return your call
_____ Do not leave a Message

Patient Name (Please Print) ______________________________
Patient/Guardian Signature:____________________ Date:_______
Employee Signature:__________________________ Date:_______

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REHABILITATION

Did this condition result from a work injury? _____Yes _____ No
If yes date of accident _______________
Did this condition result from a motor vehicle accident? _____ Yes _____ No
If yes date of accident _______________
Are you currently receiving Home Health? _____ Yes _____ No
If yes from whom? ______________________________________
(i.e. any healthcare worker/aide assisting
Or doing to or for you at home)
Do you live in a nursing home? _____ Yes _____ No
If yes what is the name? _________________________________
Are you covered:

a. Under Black Lung Disease? _____ Yes _____ No
b. End Stage Renal Disease? _____ Yes _____ No
c. Large Group Insurance? _____ Yes _____ No
d. Veterans Affairs? _____ Yes _____ No

Please list your primary care doctor:________________________________
Phone Number: ___________________________

Payment Authorization: (Initials required for all 3 statements)

_____ **Assignment of insurance benefits**

I authorize that the payment of my insurance benefits be made directly to Beyond Limits Rehabilitation for all series delivered; paid directly, I will promptly pay Beyond Limits Rehabilitation all the monies paid to me.

_____ **Guarantee of Payment**

I understand that all payments designated as "the patient's responsibility" such as co-pays and deductibles are due and payable at the time of service. I guarantee I will pay the amount deemed "my responsibility" by my insurer by the statement due date.

_______ **Certification of Information**

I certify that the information I have provided Beyond Limits Rehabilitation for payment including, but nit limited to, related accidents, illnesses or other insurer is accurate and truthful.

I attest to the best of my knowledge; the above information is accurate and true.

Signature/Date:
Patient's Name: ______________________________
Patient's or Legal Representative's Signature: ______________________________
Today's Date: ____________________