Resilience Maine
MOBILE REHABILITATION & WELLNESS

Thank you for choosing Resilience Maine as your provider for physical therapy services. We look forward to working with you to meet your goals.

Please keep this information handy while working with us:

How to contact us:

- **Office number:** 207-707-5300
  Please leave a message and we will return your call as soon as possible. If you are experiencing a medical emergency, please dial 911.

- **Email:** info@resiliencemaine.com
  We encrypt all our email communication. When we communicate through email you will receive a prompt to access our secure email server to retrieve messages from us. This helps to protect your privacy. Simply click the "Read the message" button when we send you an email and follow the instructions.

- **Text Message:**
  Let us know if this is your preferred method of communication and we can set this up when we meet.

Cancellation Policy

We require 24-hour notice for appointment cancellations. We charge a $50 fee if an appointment is cancelled with less than 24 hours' notice. Please refer to our cancellation policy for details.

Attire

Please wear comfortable clothing such as shorts and a t-shirt. If we are addressing a shoulder or spine, issue, please wear a sports bra, tank top, or t-shirt so we can perform a thorough examination.

For more information and FAQs please go to: www.resiliencemaine.com

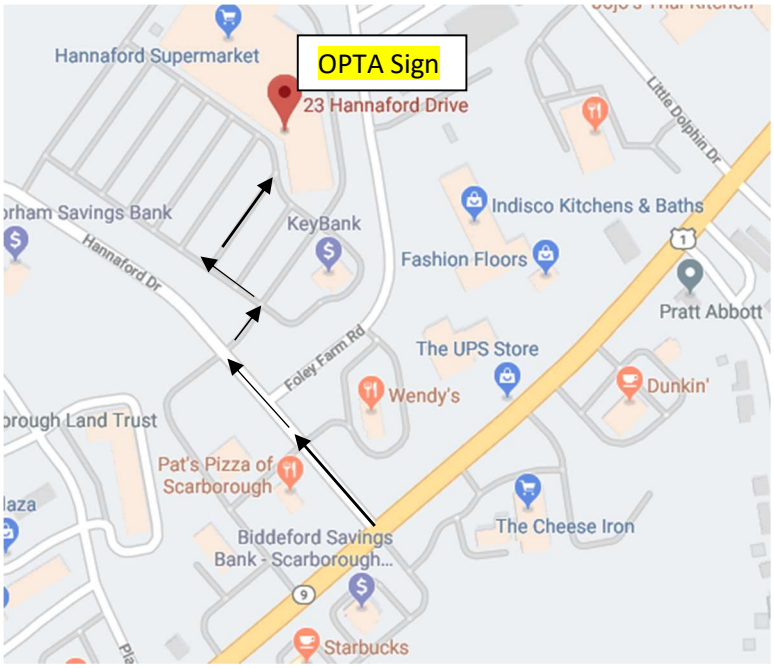
"Like" our Facebook and Instagram page *to have access to information from our blog that will cover a wide variety of topics related to physical therapy and wellness.*

For Patients Receiving Services At Our Scarborough Clinic:

Scarborough Clinic address:
23 HANNAFORD DR
OPTA OFFICE
SCARBOROUGH, ME
04074-9057

Directions:

From Rt. 1 South, make a right onto Hannaford Dr. Make a right into the Hannaford's parking lot and park near the "OPTA" sign (our colleague's clinic). There is handicapped accessible parking available. You will see "Resilience Maine" on the front door.



When you enter the building there will be a lobby and a place to hang up your coat. If there isn't someone at the receptionist's desk, please push the doorbell to let us know you have arrived.

Please arrive 15 mins before your first scheduled appointment to fill out our intake forms. Alternatively, we can email the forms to you in advance or you can download them from our website. You can either email them back or print and bring them with you to the clinic.

For Patients Receiving Services At Their Home:

Intake forms:

Please fill these out **in advance** of our arrival. We can mail or email the forms to you. You can also download them from our website.

Scheduled Visit Times

It is important to us to arrive promptly to our scheduled visit, but due to unforeseen delays (traffic/emergencies) we ask that you allow us a 30 min time frame to arrive. For example, if you are scheduled for an appointment at 1pm, please allow a range of 1-1:30pm for arrival. We will always call if something delays us beyond that time range.

Setup At Your Home

Please consider the following recommendations to have an effective physical therapy session at your home:

- Keep your therapy equipment (exercise bands), and exercise handouts together. This will make it easier to progress your program.
- Please wear proper exercise attire if possible.
- Please refrain from using strong perfumes. If smoking, please stop an hour before your scheduled appointment and open windows and doors. Some therapists have allergies and are very sensitive to these products.
- Except for service animals, consider keeping your dog/pets in another room. Some pets react strongly to new people coming into the home. However, if having your pet with you is helpful, have some treats available for us to use to help with the transition.
- Please have a clean surface (kitchen table) for us to put our equipment. When we come to a home we typically use barriers on surfaces for our equipment. This helps us avoid bringing germs to and from other people's homes. If you are currently being treated for an infectious disease, let us know in advance so we can accommodate.
- This is YOUR home so feel free to tell us if you have any special requests such as removing "outdoor" shoes to "indoor" shoes, and where to park our car to not interfere with your household.
- Feel free to have family or friends present to ask questions.
- Please turn off the TV during our session, but feel free to turn on music and have fun with therapy.

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Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices located at the clinic, with the therapist during a home visit, and on the website at www.resiliencemaine.com.

_____ _____

Patient's or Guardian's Signature Date

Payment Agreement

Thank you for choosing Resilience Maine as your rehab provider. To receive services from us, you agree to the following Payment Policies:

- **Payment Terms.** You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved. Payment for copays, coinsurance and deductibles is expected at the time of service or within 30 days of receiving our bill unless you have made other payment arrangements with us.
- **Medicare.** If you have Medicare and your services are medically necessary covered benefits, we will bill Medicare or your Medicare Advantage Plan on your behalf. You will only be responsible for your co-insurance or co-pay portion of the visit. If at any time we believe your services might not be covered by Medicare, we will discuss this with you and have you sign an "Advanced Beneficiary Notice" indicating whether you want to receive and pay for the services yourself if Medicare doesn't pay.
- **In-Network Claims**. If we are in-network with your health plan, we will submit the claims to your health plan on your behalf and your health plan will send payment directly to us. If your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless whether you have filed or plan to file an appeal. You hereby assign and convey directly to Resilience Maine all health plan benefits and/or insurance reimbursement benefits otherwise payable to us for medical services, treatments, therapies and/or examinations rendered or provided by us. You authorize Resilience Maine to release all medical information necessary to process your claims to the responsible Payor. You also agree that if any payments are sent to you despite your assignment of benefits to us, you will promptly forward the funds and explanation of benefits/payment to Resilience Maine.
- **Out-of-Network Claims.** If we are out-of-network, payment is expected in full at the time of service unless you have made other payment arrangements with us. We may, at our sole discretion, agree to set you up a payment plan or make other payment arrangements. We will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. We may agree to bill your health plan for our services directly and await payment from your health plan if you execute the assignment of benefits agreement below. You agree that if your health plan does not honor the assignment and sends payment to you, you will promptly forward the payments to us. You further agree that if your health plan denies payment of our claims, in whole or in part, you are responsible for paying any and all unpaid amounts within thirty (30) days of receiving our statement regardless whether you have filed or plan to file an appeal.
- **Prompt Payment Policy.** We offer a discounted cash payment rate when patients pay cash at the time of service in exchange for the prompt payment and the reduction in administrative work/time since we don't have to file claims or obtain pre-authorization. This cash payment discount is offered to patients who do not have insurance or who choose not to use their health plan benefits. If we are in-network with your health plan, we offer a 5% discount off our already discounted fee schedule in our agreement with your health plan if you choose to pay out of pocket for

your services. If you choose to take advantage of our discounted cash payment policy, you understand that we will not submit a claim to your health plan and agree that you will not submit our claims or statements to your health plan in an attempt to get reimbursed for our services. If you choose to pay cash initially and later want to switch to using your health plan, you understand that the fees for our services may be higher and you will no longer be entitled to our discounted cash price. Your ability to switch to using your health plan benefits may also be limited by your health plan's requirements for pre-authorization or other policy limitations.

- **Workers' Compensation.** If your injury is work-related, we will bill your company's workers' compensation carrier if you have filed an injury report with your employer and your right to workers' compensation benefits is not in dispute. If you are informed that a dispute about your right to workers' compensation benefits has arisen after you have begun treatment with us, you agree to inform us immediately. You will have a choice at that time to pay for your treatment out of pocket or allow us to bill your health insurance. In the event you do not have health insurance and cannot pay privately, we will discuss your options with you at that time.
- **Auto or other Liability Insurance.** If an auto or other liability insurer is responsible for paying your claims, you hereby assign your MedPay/Personal Injury Protection (PIP) or other applicable benefits to us for the payment of our claims. You further agree to give us a lien on any settlement, judgment or insurance proceeds you receive for payment of any and all unpaid claims, including late payment interest and authorize your attorney to pay us out of the settlement/verdict proceeds. In the event your auto insurer or other liable party denies our claims or refuses to honor the assignment, we may, at our sole discretion, bill your health plan. If we do, you will be responsible for refunding any fees owed to your health plan when you settle your case. We may also, at our discretion, agree to wait until your case settles before requiring payment. If we do, you understand that we are not obligated to discount any portion of our service or late payment penalty fees when your case settles regardless of the amount of your settlement or whether your settlement adequately covers your balance due to us.
- **Late Payment Penalty.** A late payment penalty in the amount of **1.5%** on unpaid claims will be added every month that your claims go unpaid after you are discharged from our care. You agree to be personally responsible for paying such penalties unless applicable law requires your health plan or other responsible Payor to pay it.
- **Appeals**. You understand that you are responsible for filing all appeals of adverse benefit determinations. We may be willing to file appeals on your behalf if you appoint us as your Authorized Representative (see below). By appointing us as your Authorized Representative, we are given the right by you to (1) obtain information regarding the claim to the same extent as you; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Our acceptance of the appointment as your Authorized Representative is no guarantee that your claims will be paid or alter your ultimate responsibility to pay our claims.
- **Collection Actions.** You understand that we are not required to obtain your written authorization to disclose protected health information to a collection agency or court of law that may be necessary to collect payment for services rendered. Should collection proceedings or other legal action become necessary to collect an overdue account, you will be responsible for paying the collection costs plus court costs and filing fees incurred by the practice.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative/Witness

Assignment of Benefits and Authorized Representative Appointment

- ☐ **Assignment of Benefits**. I hereby assign and convey directly to Resilience Maine all health plan benefits and/or insurance reimbursement benefits (including MedPay and/or Personal Injury Protection benefits), if any, otherwise payable to me for medical services, treatments, therapies and/or examinations rendered or provided by Provider regardless of its managed care network participation status. I hereby authorize Provider to release all medical information necessary to process my claims to the responsible Payor. I agree that if any payments are sent to me despite my assignment of benefits to Provider, I will promptly forward the funds and explanation of benefits/payment to Provider.
- ☐ **Appointment of Authorized Representative.** By checking this box, I hereby appoint Resilience Maine (hereinafter "Provider") as my designated Authorized Representative to act on my behalf in the filing or pursuance of claims and appeals with my health plan, auto liability insurance plan or other liable Payor or Payors in connection with medical services, treatments, therapies and/or examinations rendered or provided by Resilience Maine regardless of its managed care network participation status. I understand that as a result of this authorization, the Payor(s), plan administrator, fiduciary, insurer and/or attorney may disclose and release information concerning benefit eligibility, claim status, or claim approval or denial reasons in connection with the above referenced health care claims to the Provider. Further, I hereby authorize my health plan, plan administrator, fiduciary, insurer, and/or attorney to release to Provider any and all Plan documents, summary benefit description, insurance policy, and/or settlement information upon request from Provider or its attorneys in order to claim such medical benefits. As my Authorized Representative, Provider is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit or workers' compensation plan, health care benefit plan, or plan administrator. Provider, as my Authorized Representative, Provider may also bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at Provider's expense. This constitutes an express and knowing assignment of ERISA breach of fiduciary duty claims and other legal and/or administrative claims.

Right to Revoke Designation and/or Assignment. I acknowledge that Provider has not made the provision of my medical care contingent upon this designation of Provider as Authorized Representative. I understand that I may revoke this Authorized Representative appointment at any time by giving written notice to Provider and Payor(s) except to the extent that any party has taken action in reliance on this appointment before they knew of the revocation. I further understand that revocation of Provider as my Authorized Representative does not release me from my obligation to pay Provider's claims. Unless revoked, this Authorized Representative appointment is valid for all administrative and judicial reviews under the Affordable Care Act, ERISA, Medicare and applicable federal and state laws until Provider's claims are paid in full.

A photocopy of this assignment is to be considered valid, the same as if it was the original.

I HAVE READ AND FULLY UNDERSTAND THIS AGREEMENT.

X _____ Date: _____

Signature of Patient and/or Guardian

X_____ Date: _____

Signature of Provider Representative/Authorized Representative

Resilience Maine
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Patient's Legal Name:_____
First MI Last

Preferred Name/Nickname_____

Date of Birth: _____ **Age:**_____ **Sex:**_____

Preferred Pronoun:_____ **Email address:** _____

Mailing Address:_____
City State Zip Code

Phone Number **Circle One** **Circle One**
(_____)_____ OK to leave message? Yes / No Detailed Message? Yes / No
□ Home □ Cell □ Work

Emergency Contact Name:_____ **Relationship:**_____

Phone Number **Circle One** **Circle One**
(_____)_____ OK to leave message? Yes / No Detailed Message? Yes / No
□ Home □ Cell □ Work

I give Resilience Maine permission to communicate with the family/caregivers listed below who are actively involved in my care for the purposes of treatment and coordination as necessary:

Name(s)_____

Marital Status:_____

Who lives in your household?_____

Do you have family or friends who can provide assistance if needed? _____

Primary language_____

Do you need an interpreter? □ Yes □ No
If yes, please let us know so we can have an interpreter available at your appointment.

Hand Dominance: □ Right □ Left

Patient/Guardian signature_____ **Date**_____

Please list any past and present medical issues:_____2/7

_____

_____

_____

_____

Please list any surgeries and dates:_____

_____

List any implants (e.g. total joint, pacemaker, IUD)_____

_____

Please list any x-rays, MRI, bone scans or other imaging tests in the past year.

Test Result

_____

_____

_____

Please list any laboratory work (e.g. urinalysis, blood tests) in the past year.

Test Result

_____

_____

_____

Primary Physician:_____

Specialist Physician(s):_____

_____

Do you have Advanced Directives? □ Yes □ No □ I Would like Information

Patient/Guardian signature_____ **Date**_____

Allergies:_____ 3/7

Name any prescription and over-the-counter medications that you are taking.

Medication	Dose	How often	Reason for taking

Use of tobacco? Yes No Stopped using
If Yes, how often?_____

Use of alcohol? Yes No Stopped using
If Yes, how often?_____

Use of marijuana? Yes No Stopped using
If Yes, how often?_____

Use of caffine containing products (e.g. coffee, tea, soda)?
Yes No Stopped using
If Yes, how often?_____

Use of any other recreational drugs?_____

Are you on a special diet prescribed by a physician? _____

Patient/Guardian signature_____ Date_____

Reason for coming to physical therapy:_____4/7

_____

What goals do you want to meet in therapy?_____

Do you Work or Volunteer? □ **Yes** □ **No** **If yes, please describe**_____

_____

What hobbies/activites do you enjoy?_____

_____

Do you have a current exercise routine? □ **Yes** □ **No** **If yes, please describe:**_____

_____

Do you own any special equipment to help you get around (eg. walker, wheelchair, orthotics)?

□ No

□ Yes, please describe_____

Do you drive?	□ Yes	□ No
Home	□ Own	□ Rent
	□ 1 level	□ ≥ 2 levels
Do you feel safe at home?	□ Yes	□ No

If no, please explain_____

Do you feel unsteady when standing or walking?	□ Yes	□ No
Do you worry about falling?	□ Yes	□ No
Have you fallen in the past year?	□ Yes	□ No

If yes to above question,

How many times have you fallen in the past year?_____

Were you injured?_____

Recent travel outside of the US?	□ Yes	□ No
Do you <u>currently</u> have any infectious diseases such as: TB, C-Diff, MRSA, VRSA, VRE, CRE, Ebola, Hepatitis B?	□ Yes	□ No

Patient/Guardian signature_____ **Date**_____

Payment Information 5/7

Self Pay □ Yes □ No

IF SELF PAY, STOP HERE. NO NEED TO FILL OUT THE REST OF THE FORMS

If you are using commercial insurance please provide information below:

Primary Insurance

_____

Insurance Name Subscriber ID Group#

Name of insured party □ Self □Other _____

DOB of primary insured_____ **Relationship to patient**_____

Provider phone number (on back of card)_____

Secondary Insurance

_____

Insurance Name Subscriber ID Group#

Name of insured party □ Self □Other _____

DOB of primary insured_____ **Relationship to patient**_____

Provider phone number (on back of card)_____

Is a Home Health Agency nurse or therapist coming to your home? □ Yes □ No

Do you have Medicare?

□ Yes □ No

IF YES, PLEASE FILL OUT THE MEDICARE SECONDARY PAYER FORM

Is the reason you are coming to physical therapy related to an injury at work, automobile accident, or any other type of accident?

□ Yes □ No

IF YES PLEASE FILL OUT THE ACCIDENT INFORMATION FORM

Patient/Guardian signature_____ **Date**_____

MEDICARE SECONDARY PAYER FORM

Is the illness or injury due to an automobile accident, accident at work, or liability accident?

□ Yes □ No

Is the illness covered by the Black Lung Program or Veterans Administration program?

□ Yes □ No

If you or your spouse are still working and covered by an employer group plan, does the employer have 20 or more employees?

□ Yes □ No

If you are disabled and covered under an employer's group health plan, does the employer have more than 100 employees?

□ Yes □ No

If under 65, are you receiving renal dialysis in your first 30 months of Medicare entitlement?

□ Yes □ No

Are you currently an active duty military member enrolled in Medicare?

□ Yes □ No

(Internal Use- If answered "No" to the above questions, then Medicare is the Primary Payer

Conflicting services screening:

Have you received or are you currently receiving care from one of the following:

Skilled Nursing Facility □ Yes □ No

Home Health Agency nurse or therapist coming to your home □ Yes □ No

If yes, what was the date you were discharged?_____

Do you have a copy of your discharge letter? □ Yes □ No

Home Health Agency Name_____

Home Health Agency phone number_____

Note: Medicare will not cover Resilience Maine services while receiving care through a Skilled Nursing Facility or Home Health Agency.

Patient/Guardian signature_____ **Date**_____

ACCIDENT INFORMATION FORM 7/7

The questions below will help determine the primary insurer we should submit claims to:

1) Is it work related? □ Yes □ No

2) Is the injury Auto-related? □ Yes □ No

3) Do you plan to file a claim against a business or homeowner's insurance policy?
□ Yes □ No

IF YOU ANSWERED "NO" TO ALL THREE QUESTIONS, YOU CAN STOP HERE
If 1, 2, or 3 are yes, please fill out the rest of the Accident Information Form

Date of injury_____

How did the injury occur?_____

Where did it happen (eg. city, intersection, business)?_____

Who is responsible for the accident?
□ Self □ Another party

Insurance of Responsible Party_____

Claim #_____

Address_____

Adjuster name_____

Adjuster phone_____

Patient/Guardian signature_____ **Date**_____

OSPRO Review of Systems Screening Tool

Have you recently experienced any of the following?	Yes	No
1. Abnormal sensations (eg. numbness, pins, and needles)?		
2. Headaches?		
3. Night pain?		
4. Sustained morning stiffness?		
5. Lightheadedness?		
6. Trauma (e.g., a motor vehicle accident, a fall)?		
7. Night sweats?		
8. Constipation?		
9. Easy bruising?		
10. Changes in vision?		
11. Changes in menstruation patterns?		
12. Gait or balance disturbances?		
13. Chest pain with rest?		
14. Shortness of breath?		
15. Muscle weakness?		
16. A failure of conservative intervention (failure to improve within 30 days)?		
17. Excessive sweating?		
18. Edema or weight gain?		
19. A heartbeat in your abdomen when you lie down?		
20. Cramps in your legs when you walk for several blocks?		
21. Abdominal pain?		
22. Changes in the integrity of your nails?		
23. Prolonged use of corticosteroids?		

94% accuracy for review of systems tool comprised of the first 10 items
100% accuracy for review of systems tool comprised of all 23 items

Patient/Guardian signature_____ Date_____

Resilience Maine
MOBILE REHABILITATION & WELLNESS

Consent for Email and Text Messaging Communication

Patients/Clients frequently request that we communicate with them by email or text message. Resilience Maine respects your right to confidential communications about your protected health information (PHI) as well as your right to direct how those communications occur. Since email or text messages can be inherently insecure as a method of communication, we will only communicate with you by email or text message with your written consent at the email address/phone number you provide to us below. Please be aware that if you have an email account or cell phone through your employer, your employer may have access to your email or text messages.

When you consent to communicating with us by email or text message, you are consenting to email or text message communications that may not be encrypted. Therefore, you are agreeing to accept the risk that your protected health information may be intercepted by persons not authorized to receive such information when you consent to communicating with us through email or text message. Resilience Maine will not be responsible for any privacy or security breaches that may occur through email or text message communications that you have consented to.

You may choose to limit the type of email or text message communication you have with us if you wish to limit your risk of exposing your protected health information to unauthorized persons. Please indicate below what types of correspondence you consent to receive by email or text message.

- ☐ I do not consent to any email or text message communication.
- ☐ I consent to receiving communication **only about the scheduling of appointments or other communications that do not reveal my protected health information by**:
  □ Email □ Text Message
- ☐ I consent to **all communication by email, including but not limited to communication about my medical condition and advice from my health care providers**.
  □ Email □ Text Message

E-mail address you are consenting to communicate through: _____

Phone number you are consenting to receive text messages through: _____

Patient Signature: _____ Date_____

Authorized Representative/Guardian Signature:_____ Date_____

Resilience Maine
MOBILE REHABILITATION & WELLNESS

Resilience Maine Cancellation Policy

We require 24-hour notice for any cancellations. We do this in order to ensure all our patients receive timely care.

In order to cancel an existing appointment, please call our office number at 207-707-5300 and leave a message at least 24 hours before a scheduled appointment.

A cancellation fee of **$50** will be charged if an appointment is cancelled with less than 24 hrs notice, or if the patient is not at their home/place of treatment for a scheduled appointment.

Three documented violations of this policy may result in dismissal from care from Resilience Maine.

Patient's Name (Printed) _____

Patient's Signature _____ Date_____

Parent/Guardian Signature_____ Date_____