



Frisbie Memorial Hospital    Marsh Brook Rehabilitation Service    Wentworth-Douglass Hospital    Durham: Rehab and Sports Therapy Center

Dear Patient:

*Welcome to Rehab 3 at Marsh Brook. We are a division of Strafford Health Alliance, which is a joint venture of both Frisbie Memorial Hospital in Rochester and Wentworth-Douglass Hospital in Dover. Although we work closely with Seacoast Orthopedics and Sports Medicine (SOSM), we are two completely separate companies without financial or ownership relationship. We handle all billing, documentation, and any other patient information independent of SOSM. As part of our registration procedure, we would like to inform you of our current billing policies. If you would like a list of our current therapy charges, please request one at registration.*

**INSURANCE INFORMATION AND BILLING POLICY:**

In order to properly and efficiently process your therapy claim(s), accurate insurance information is needed at your initial visit. While most insurance companies cover physical and occupational therapy charges, **IT IS YOUR RESPONSIBILITY TO CERTIFY COVERAGE FOR PHYSICAL AND/ OR OCCUPATIONAL THERAPY OUTPATIENT SERVICES** in a freestanding clinic. While we are a participating provider with many insurance companies, please ask our front office staff if we are in your network.

**PAYMENT POLICY:**

Patients with health insurance coverage (other than NH Medicaid or Worker's Compensation) will be expected to make a co-payment consistent with their policy at each visit. If deductibles have not been met, patients are responsible for payments at time of service unless other arrangements are made. After final payment has been received from the insurance company, the patient will be billed for any remaining balance. Please note **that Financial Assistance is available if applicant meets income guidelines. Please ask our receptionist for more information.**

All SELF-PAY patients are expected to pay weekly balance in FULL, unless other arrangements are made with us prior to treatment.

**CANCELLATION POLICY:**

Please be sure to notify Rehab 3 at Marsh Brook 24 hours in advance at (603) 749-6686 if you cannot make your scheduled appointment. Failure to do so may generate a charge to your account. This will be your responsibility, because it is not covered by any type of insurance coverage. **TWO CANCELLATIONS OR NO-SHOWS WITHIN A 30-DAY PERIOD WILL TERMINATE ALL THERAPY SESSIONS**, unless otherwise approved by the treating clinician.

Any billing questions should be directed to the Patient Accounts Manager.

Any returned checks will result in a \$15.00 charge to your account.

Thank you for choosing us to help meet your rehabilitation needs. We are pleased to serve you and welcome your feedback at all times.

## **CONSUMER BILL OF RIGHTS AND RESPONSIBILITIES AT REHAB 3 AT MARSH BROOK (MBRS)**

**As a person who makes use of the services available at our clinic, you have the RIGHT:**

- To receive considerate and respectful care at MBRS without discrimination based on your race, creed, color, national origin, religion, sex, sexual preference, handicap, or age;
- To be given the information you need to give informed consent for treatment prior to your treatment being started and to consider use of alternative services which may be available to you;
- To receive complete information about and/ or participate in the development of your plan of care and the updating or reassessment of that plan;
- To refuse medical treatment or other services provided and to be informed of the possible results or consequences of your refusal;
- To know that information about your health, social, and financial circumstances and about what takes place during your care is considered private and confidential;
- To know that all verbal communications and written records pertaining to the services you receive will be handled confidentially;
- To expect that all clinic staff employed by MBRS will, within the limits of your plan of care, respond in good faith to your requests for assistance in any way;
- To receive information about the clinic's operations, policies and procedures, such as information on service costs, qualifications of staff, supervision of staff, and your eligibility for third-party payment(s);
- To receive services as is needed and available to meet your health care needs;
- To examine all bills for services regardless of whether they are paid for by you or by other sources;
- To be given information about any anticipated transfer of your health care to another facility and/ or ending of the care provided to you;
- To voice a grievance and/ or suggest a change in what service is provided and/ or the staff that provides it without fear of being threatened, discriminated, or otherwise retaliated against.

**As a MBRS consumer, you have the RESPONSIBILITY:**

- To give accurate and complete health care information concerning past illnesses, prior hospitalizations, medications used, allergies, and other subjects related to your health care;
- To inform the clinic when you will not be able to keep an appointment for a scheduled visit;
- To follow your current plan of treatment;
- To request further information concerning anything which you do not understand;
- To sign a Fee Agreement informing you of your financial responsibility for payment of services not covered by your insurance company; and
- To give information, preferably to someone who has a supervisory role at the clinic, regarding concerns or problems you have about clinic services or staff.



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PATIENT INFORMATION SHEET			
<b>For Office Use Only</b>		Date:	
Account Number:		Chart Number:	
Last Name:	First Name:	M.I.:	
Street Address:		P.O. Box (if applicable)	
City:	State:	Zip:	
Home Telephone Number:	Cell Phone Number:	Email Address:	
Date of Birth: (mm/dd/yyyy):	Social Security:	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Other	Sex: M ___ F ___
Employer:			
Employer's Address:			Work Telephone:
Referring Physician:	Telephone:	Primary Care Physician:	Telephone:
Date of onset of injury:			

MEDICAL INSURANCE INFORMATION			
<i>Please check one below:</i>			
<input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Motor Vehicle Accident   State: _____ <input type="checkbox"/> Health Insurance <input type="checkbox"/> Self (If this is a Workers' Compensation claim, please put the proper insurance carrier information below, otherwise please provide your primary health insurance information)			
<b>Primary Insurance Company:</b>			Telephone:
Street Address:			P.O. Box (if applicable)
City:		State:	Zip:
**Subscriber's Name:		Relationship to Patient:	Subscriber's Date of Birth:
Insurance Group Number:		Insurance I.D. Number:	Subscriber's Social Security Number:
Subscriber's Employer:			
<b>Secondary Insurance Company:</b>			Telephone:
Street Address:			P.O. Box (if applicable)
City:		State:	Zip:
**Subscriber's Name:		Relationship to Patient:	Subscriber's Date of Birth:
Insurance Group Number:		Insurance I.D. Number:	Subscriber's Social Security Number:
Subscriber's Employer:			
<b>For Workers' Compensation claims only:</b> Claim or Case Number:			
Claim Adjuster's Name:			Telephone:

\*\*If you have this policy through your spouse, parents or other sources, he or she will be the subscriber.



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**PLEASE ARRIVE 15 MINUTES EARLY FOR YOUR APPOINTMENT TO ALLOW FOR REGISTRATION TIME.**

As a courtesy our staff will contact each patient’s insurance carrier to verify therapy coverage. We also encourage all patients to call their insurance carrier and verify Physical Therapy and/ or Occupational Therapy coverage prior to their first appointment. This will allow patients to verify if Rehab 3 at Marsh Brook is in network, and will ensure that any insurance information given to our office is correct. All patients are expected to come prepared with referrals from their Primary Care Physician (if applicable) and Referring Physician orders. Patients are also responsible for making any necessary deductible, co-payments or co-insurance payments each visit, based on their policy. Financial Assistance is available; please ask our front office staff for more information.

**Patients should use the questions below as a guideline when calling their Insurance Company.**

- Am I covered to receive outpatient Physical Therapy and/ or Occupational Therapy at Rehab 3 at Marsh Brook?
- Do I need to obtain a referral from my Primary Care Physician?
- Do I need to obtain authorization or pre-certification for therapy from my insurance company?
- Do I have a deductible to meet? Amount: \$ \_\_\_\_\_
- How much of my deductible has been met this year? Amount: \$ \_\_\_\_\_
- Do I have any visit limitations? \_\_\_\_\_
- Am I responsible for a percentage or a co-payment each visit? Amount: \$ \_\_\_\_\_
- If Occupational Therapy, will splints be covered? Yes \_\_\_\_\_ No \_\_\_\_\_

**Please contact your Primary Care Physician for your referral if required.**

**Workers’ Compensation Information**

**If this is a work-related injury, patients should use the questions below as a guideline when obtaining Workers’ Compensation information from employers. Patients arriving without their information will be responsible for payment in full each visit.**

- Date of Injury: \_\_\_\_\_ (must be date used on first report of injury filed with employer)
- State where injury occurred: \_\_\_\_\_
- Employer Workers’ Compensation Carrier information:

Insurance Name: \_\_\_\_\_

Address: \_\_\_\_\_ P.O Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Adjustor (if known): \_\_\_\_\_

File Claim Number: \_\_\_\_\_

**Please bring this form completed with your insurance information to your first therapy appointment.**



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Rehab 3 at Marsh Brook

Date: \_\_\_\_\_

**For Office Use: COPY ONTO RED PAPER AND PLACE IN CHART** Reviewed with patient: \_\_\_\_\_

PATIENT NAME (Please Print): \_\_\_\_\_ Telephone #: \_\_\_\_\_

(May we leave a message at the number above? Yes \_\_\_ No \_\_\_)

EMERGENCY CONTACT PERSON: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ Primary Care MD: \_\_\_\_\_ Telephone #: \_\_\_\_\_

**EMERGENCY DATA**

**Medical History:**

	Have Now		Had in the Past	
	Yes	No	Yes	No
Heart Problems (angina)	_____	_____	_____	_____
Lung Disease (asthma, COPD)	_____	_____	_____	_____
Liver Disease (hepatitis, cirrhosis)	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____
Blood Clots, Circulation Problems	_____	_____	_____	_____
Depression	_____	_____	_____	_____
Seizures, Fainting (syncope)	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____
Numbness or Tingling (arms/ legs)	_____	_____	_____	_____
Unexpected Weight Loss or Gain	_____	_____	_____	_____
Cancer (location: _____)	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____
Bruises Easily (anemia)	_____	_____	_____	_____
Multiple Sclerosis	_____	_____	_____	_____
Thyroid Disease	_____	_____	_____	_____

**FOR OFFICE USE ONLY**

Precautions (i.e. pacemaker, THR): \_\_\_\_\_

What medications are you currently taking? Please include herbs and vitamins. \_\_\_\_\_

Please list surgeries (i.e. tonsillectomy): \_\_\_\_\_

Other Medical Problems: \_\_\_\_\_

**ALLERGIES** (Please list): \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Current Age: \_\_\_\_\_ DOB: \_\_\_\_\_

Do you smoke? Yes \_\_\_ No \_\_\_ If so, how many packs per week? \_\_\_\_\_

Do you drink? Yes \_\_\_ No \_\_\_ If so, how much per day? \_\_\_\_\_

Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_

Children? Yes \_\_\_ No \_\_\_ How many? \_\_\_\_\_ Women: Are you currently pregnant? Yes \_\_\_ No \_\_\_

Type of work: \_\_\_\_\_ Retired? Yes \_\_\_ No \_\_\_

Is there anything else you would like your therapist to know about? \_\_\_\_\_