CONSENT FOR TREATMENT AGREEMENT AND RECOMMENDATION RELEASE

I authorize Covell Care and Rehabilitation to render appropriate evaluation and therapy services, and/or licensed clinical social work and/or fitness training to the client named below in accordance with state and federal laws. I understand that care will be provided by a qualified, licensed and trained healthcare professional(s). I recognize, agree and understand that I have the right to refuse treatment or terminate services at any time. In addition, Covell Care and Rehabilitation may terminate services by notifying me. I also recognize the treatment I receive may involve the touching of my body by a therapist or other care provider and that full or partial disrobing may be required to facilitate such care, all of which is expressly consented to by me.

I understand treatment and equipment recommendations from Covell Care and Rehabilitation and contracted professionals are made in good faith and judgment. I understand that if I should not be successful in meeting my treatment goals, Covell Care and Rehabilitation and other contracted professionals are not responsible for my progress and my outcomes are not guaranteed. Should any equipment be ineffective, used inappropriately, or faulty in any manner, I understand that Covell Care and Rehabilitation and contracted professionals are not responsible for related outcomes or injury.

If you are a resident of a Senior Living Community we have permission to share your medical info with community contacts if it is in correlation to treatment planning and potential success.

I have read this agreement and I understand the above information. By signing below, I am hereby consenting to the care described.

_____ _____

Client/Legal Guardian/POA/Client Representative Signature **Date**

I permit the following individuals to receive information and provide communication-related to my care.

1.Name/Relationship/Contact info: _____

2.Name/Relationship/Contact info: _____

CLIENT NAME: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have privacy rights regarding my health information. I understand Covell Care and Rehabilitation originates and maintains health records. These records may describe my history, test results, diagnoses, treatments: past, present and future. Records may include the costs, payments and adjustments by myself and my health plan. I consent to the use, access and disclosure of my Private Health Information for the purposes of planning care or treatment, communicating with other appropriate professionals who contribute to my care, evaluating quality care practices, communicating balances on previously rendered and/or charged services for Covell Care and Rehabilitation and our agents, and assigns applicable diagnostic and procedural information to a third party for the processing of my services and bills related to my service. I have received a copy of Covell Care and Rehabilitation's HIPAA policy. I understand I may contact Covell Care and Rehabilitation to request a current copy of the Notice of Privacy Practices.

____ (Initial)

I understand and give my full consent to be contacted on the landline and/or cell phone numbers provided to Covell Care and Rehabilitation and their assigns. This also applies to any landline and/or cell phone I acquire in the future. Covell Care and Rehabilitation and their assigns may also contact me by text messages or emails, using an email address I provide. I understand the inherent risks in electronic transmission and its confidentiality may be vulnerable to access by unauthorized third parties. Covell Care and Rehabilitation shall not have liability with respect to any error, omission, claim, or loss arising from or in connection with the electronic communication of information by Covell Care and Rehabilitation to me. I authorize Covell Care and Rehabilitation to communicate electronically with me and my associated healthcare providers. This information may include appointment information, treatment plans, billing, and claim information. I may restrict the information shared by providing written notification to Covell Care and Rehabilitation. I may revoke this authorization by providing written notice to Covell Care and Rehabilitation.

Preferred email address for communication: _____

_____ (Initial)

NON-DISCRIMINATON POLICY

I understand that Covell Care complies with applicable Federal civil rights laws and does not, and shall not, discriminate on the basis of race, color, religion (creed), gender, gender identity, gender expression, transgender, age, national origin (ancestry), disability, marital status, sexual orientation, or military status, in any of its services or operations. Covell Care will make every reasonable effort to accommodate the needs of clients to participate in services in-person and through telehealth. Based on an individualized assessment of the client's circumstances, Covell Care will provide the best option for treatment. **_____ (Initial)**

CLIENT NAME: _____

COVID19 GLOBAL PANDEMIC ACKNOWLEDGEMENT

I will inform Covell Care and Rehabilitation prior to my next visit if I have symptoms, been diagnosed or exposed to COVID19 (including the status of household members). _____ **(Initial)**

TELEMEDICINE

Telemedicine is being offered to Covell Care clients. I understand that:

- Telemedicine involves transmission of video, photographs, and/or details of my medical record such as x-rays, home exercise programs and test results (collectively, "Data").
- I will be informed of any other people who are present at either end of the telemedicine encounter, and have the right to exclude anyone from either location.
- All confidentiality protections required by law or regulation will apply to my care.
- I have the right to refuse or stop participation in telemedicine services at any time and request alternate services such as an in-person appointment. However, I understand that equivalent in-person services might not be available at the same location or time as telemedicine services.
- If I do not want to receive health care services by telemedicine, it will not affect my right to future care or treatment, or any insurance/ program benefits to which I would otherwise be entitled.
- If an emergency occurs during a telemedicine encounter at a hospital or clinic, health care personnel at my location will manage the emergency. If an emergency occurs during a telemedicine encounter when I am at a non-health-care site, I should call 911 and stay on the video connection (if applicable) until help arrives.
- Technology malfunctions may occur on my end of the telemedicine visit and/or the provider's and may not be avoidable. Covell Care is not responsible for furnishing equipment to me to use for the purpose of telemedicine.

_____ **(Initial)**

PHOTO CONSENT

_____ **(Initial)** I hereby freely and voluntarily grant to **Covell Care and Rehabilitation** permission, in respect to the photographs that may be taken of me, my property, or including others in relation to my treatment.

☐ **YES or** ☐ **NO** **Photographs and case information can be used for marketing and promotional purposes.**

CLIENT NAME: _____

INSURANCE AND BILLING POLICY

Covell Care and Rehabilitation may submit a claim for my services to my insurance company.

I agree I am responsible for all deductibles and charges not covered by insurance.

- I understand I have the option to continue with therapies, or receive therapy and/or services that are not covered by my insurance. I will discuss this with my service provider prior to services or when deemed necessary.
- I agree to notify Covell Care and Rehabilitation timely of any changes to my insurance coverage.
- I understand that pre-authorization for therapy does not guarantee payment of benefits and/or payment by my insurance company. **I agree to be responsible for any balance owed to Covell Care and Rehabilitation.** If payment is not received within 60 days of invoice date, a late payment fee of 9% will be applied.
- Per § 149.610(b)(1)(iii)(A-C), I understand that Covell Care and Rehabilitation will inform an uninsured or self-pay individual of the availability of a good faith estimate of expected charges upon scheduling a service or upon request.
- I understand that Covell Care may keep my credit card information on file and that they may charge the card on file if there is an outstanding balance.

Out of Network Insurance Balance Billing Disclosure: Beginning January 1, 2020, Colorado state law protects you* from "surprise billing," also known as "balance billing." These protections apply when:

- You receive covered emergency services, other than ambulance services, from an out-of-network provider in Colorado, and/or
- You unintentionally receive covered services from an out-of-network provider at an in-network facility in Colorado

What is surprise/balance billing, and when does it happen?

If you are seen by a health care provider or use services in a facility or agency that is not in your health insurance plan's provider network, sometimes referred to as "out-of-network," you may receive a bill for additional costs associated with that care. Out-of-network health care providers often bill you for the difference between what your insurer decides is the eligible charge and what the out-of-network provider bills as the total charge. This is called "surprise" or "balance" billing.

If you receive services from an out-of-network provider or facility or agency OTHER situation, you may be balance billed, or you may be responsible for the entire bill. If you intentionally receive nonemergency services from an out-of-network provider or facility, you may also be balance billed.

*This law does NOT apply to ALL Colorado health plans. It only applies if you have a "CO-DOI" on your health insurance ID card.

I will notify Covell Care and Rehabilitation at least 24 hours in advance if I need to cancel an appointment. Failure to give this notice may result in a "No-Show Appointment Fee" of $65.00. I understand this fee cannot be billed to my insurance company and is my direct responsibility.

I have read the above and accept financial responsibility in full for this account.

_____ _____

Client/Legal Guardian/POA/Client Representative Signature **Date**

Billing Contact (if different from client):

Name: _____ **Phone**: _____

Email Address: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS TO COVELL CARE AND REHABILITATION, LLC

I hereby authorize the person, agency or organization named herein to release any and all information pertaining to my care to Covell Care and Rehabilitation, LLC.
Filled out by Covell Care representative:

1. _____
2. _____
3. _____

The following is requested in regards to my care:
Check only those that apply:

- ☐ History and Physical
- ☐ Recent Visit Summaries
- ☐ Discharge Summaries
- ☐ Height and Weight
- ☐ Current Medications
- ☐ PT/OT/SLP Evaluations and Notes
- ☐ Neurological Consultation
- ☐ Neuroimaging Results including CT Scans and/or MRI
- ☐ Copies of insurance cards and photo ID
- ☐ Other: _____

Client Name: _____ **Date of Birth**: _____

_____ _____

Client/Legal Guardian/POA/Client Representative Signature **Date**