IMPORTANT PATIENT INFORMATION

Welcome to the Main Street Physical Rehabilitation Center. In order that all of our patients and visitors are safe while they are in our facility, we would like to provide you with the following guidelines:

1. Patient's need to check-in at the Main Scheduling desk.

2. All co-payments need to be paid upon check-in, prior to treatment.

3. An adult must accompany all pediatric/adolescent patients; the adult must remain in the facility until treatment is completed.

4. If a child must accompany a patient to the facility for treatment, they must remain in the company of a supervising adult, in a waiting area.

5. We ask that your family member (s) remain in the waiting area until your treatment is finished. If the Clinician feels that a family member needs to be present during treatment they will notify you.

6. No pets are allowed in the facility or on the grounds unless they are a service animal specifically used to assist a patient or family member.

7. Do not, under any circumstances, begin using any equipment unless a staff person supervises you.

8. Do not enter the pool area unless staff is present. Specific pool rules are posted and a written copy is reviewed with aquatics patients and members.

9. We periodically have fire drills in the facility; please take your therapists' lead during these drills. We do not routinely evacuate the building.

If you have any questions regarding these guidelines, please discuss them with your therapist.

Thank you.

Western Connecticut Health Network
Danbury Hospital · New Milford Hospital · Norwalk Hospital

NAME: _____

MED REC. # _____

DATE OF BIRTH: _____

Main Street Physical Rehabilitation Center
235 Main Street -- Danbury, CT 06810
Phone (203) 730-5900 Fax (203) 730-5905

TO OUR PATIENTS:

Welcome to the ***Main Street Physical Rehabilitation Center***. We are pleased that you have chosen Danbury Hospital for your rehabilitation care. We strive to provide the highest quality care to enable you or your family member to gain functional independence.

As an important member of our team, you will work closely with your health care specialist(s) to develop a treatment plan specific to your needs. **Your active participation in therapy is necessary. Keeping each appointment is vital to the progress you will make**. In an effort to accommodate all of our patients, advance notice is required if you need to change or cancel an appointment.

Attendance policy:

Our policy regarding appointments that must be canceled or changed is as follows:

- **No Shows**: **These are appointments missed without calling prior to your appointment.**
  Two (2) No Shows will result in immediate discontinuation from all services.
- **Cancellations: These are appointments that are canceled with advance notice.**
  Adult: If you miss or cancel 50% of appointments over a two-week period of time, services will be discontinued.
  Pediatric: If you miss or cancel 50% of appointments over a 2 month period of time, services will be discontinued.

Our staff will work closely with you to reschedule your appointments whenever possible. If treatment is discontinued, a new prescription is required in order to resume treatment. We are committed to providing quality services to all our patients and must enforce this policy due to frequent cancels and no shows.

Prescription Policy:

In order for you to start or receive therapy, a current prescription is required. We are required to obtain a new prescription from your physician every 30 to 60 days during the course of your treatment (varies depending on insurance carrier). Our staff will work with your physician's office to keep your prescriptions up to date; however, therapy may be postponed if there is a delay in receiving the required documentation.

Billing Policy:

Each patient is personally responsible for all charges. We will be happy to submit claims to your insurance company when coverage has been verified. It is your responsibility to be familiar with your individual insurance plan and coverage. If co-pay is required by your plan, please stop at the front desk to make the payment before each visit.
If you are paying privately for your services, payment in full is due at time of each service. After services are rendered, you will receive a Private Pay bill from your therapist. These payments are accepted at the scheduling desk. If you are unable to remit payment in full, we require ½ the payment and you will be billed for the balance.

Should you have any questions regarding your insurance for therapy services, a patient service representative will be available to speak with you between 8:00 a.m. and 4:30 p.m., Monday through Friday.

Contact Information:

Communication with our patients is very important to us. In order to maintain confidentiality of your personal information, we need your permission for our telephone communications. Please read the options below and choose the most appropriate for you.
You may leave information about my care received at Main Street Physical Rehabilitation Center with a voicemail or a family member.

_____(Initials) Date _____ Main Contact Phone Number: _____

-OR-

If you **do not wish** information to be left on your voicemail or with a family member, please initial and date below.

_____ (initials) _____ date. Please **do not leave** any personal information with regards to my care received at Main Street Physical Rehabilitation Center on my voicemail or with a family member.

Thank you for your cooperation.

Signature (Patient / Parent / Legal Guardian) _____ Date: _____

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Acceptance of Payment Responsibility For Non-covered Services
Commercial and Managed Care Insurance or Self Pay Patients

Patient Name: **Account Number:**

I understand that my medical/health insurance may not/does not cover the service requested for the following reason:
☐ Danbury Hospital does not participate in my plan; or my physician/provider is Out of Network.
☐ Services provided require a referral from my primary care or other physician. I did not obtain/receive the required referral.
☐ Services provided require prior authorization from my insurance plan. I did not obtain/receive the required authorization.
☒ Services provided are not covered by my insurance plan, or may not be covered for my diagnosis or frequency of treatment.

Requested service(s):

- ☐ Screening services, including screening colonoscopy, laboratory services, etc.
- ☐ Cosmetic services
- ☐ Nutritional counseling
- ☐ Smoking cessation
- ☐ Cardiac Rehabilitation services
- ☐ Lactation Consultation
- ☐ Non-Therapy Pool Exercise or Fitness Programs
- ☐ Other _____

Check and sign the applicable section below:

☒ **Participating Plans**: I understand that, for the reason checked above, the service I have requested may not be covered by my insurance plan. I request that I receive the service and agree to pay for all services rendered should my insurance plan refuse to pay. If my insurance plan allows self-referral for the service rendered, I agree to pay the required co-payment, deductible and coinsurance at the time the service is rendered.
I understand that Danbury Hospital will not submit claims to my insurance company for certain non-covered services, such as Exercise or Fitness Programs, cosmetic services, or those provided for my personal convenience.

_____ _____
Patient/Responsible Party Signature Date

☐ **Non-Participating Plans or Self Pay**: I understand that Danbury Hospital does not participate in my health insurance plan: _____. Nevertheless, I request that I receive the service and agree to pay for the cost of treatment for all services rendered. I understand that Danbury Hospital will submit claims to my insurance company as a courtesy unless I request otherwise, however I understand that I will be responsible for all unpaid balances.

_____ _____
Patient/Responsible Party Signature Date

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NOTICE FOR OUTPATIENT TREATMENT

Note: Please read this form. It provides important information about your treatment as an outpatient of the Hospital. It also contains certain agreements in connection with your testing and/or treatment. In this form, reference to the "patient" or "you" also means, as appropriate, the patient's personal representative or parent where the patient is either a minor or is otherwise incapable of accepting or signing this form.

No Alterations/Failure to Sign:
This form may not be altered by the patient in any manner. Please understand that we cannot track individual changes, and therefore cannot honor cross-outs or new language. If you have questions about this form, please discuss them with the hospital staff, who will answer them to the best of their ability. Please also be aware that, if you do not sign this authorization, and this results in a refusal of your insurance company, managed care organization or any other third party payor to provide coverage and/or pay your Hospital bill, you will be personally responsible for the entire unpaid portion of your bill.

OUR RIGHT TO EXAMINE YOU, PROVIDE YOU WITH ROUTINE TREATMENT AND CARE AND PERFORM DIAGNOSTIC PROCEDURES, OTHER THAN TREATMENT, CARE OR PROCEDURES REQUIRING YOUR SPECIFIC INFORMED CONSENT
By presenting yourself as an outpatient, you are deemed to agree, without any specific written authorization by you, that we may perform routine examinations, and provide treatment, which does not require a separate informed consent, under the general or specific instructions or direction of your physician(s) or Hospital Staff. As part of this general consent to medical procedures or tests, you may be tested for human immunodeficiency virus ("HIV"). However, such testing is voluntary and you can chose not to be tested for HIV or antibodies to HIV if you so inform us. If medically appropriate, your physician and/or Hospital Staff may use various forms of photography such as digital imaging, standard photography, videotaping, *etc*. Such photography is strictly limited to the purposes of diagnosis and treatment. The use of photography for any other purpose, such as teaching or research, requires your specific authorization

INFORMED CONSENT
If you require an operation or any procedure involving a degree of risk requiring an informed consent, except in the event of emergency, your physician will discuss the risks, benefits, and alternatives, answer your questions, and otherwise obtain your informed consent.

Communications Via Telephone By providing a contact number to WCHN, I hereby authorize WCHN, along with their respective employees, agents, and business associates, to contact me via land line, cellular phone or text message for any reason, including, without limitation, automated notifications, appointment reminders, and collections. You are not required to agree to this section in order to receive services from WCHN.

STUDENTS RESIDENT PHYSICIANS, and RESEARCHERS
I understand that medical, nursing and other health care students as well as resident physicians and medical researchers provide or observe services provided to Hospital outpatients, and may be present during treatment, operations, and special procedures as part of their training and learning experiences.

AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION
The Hospital will keep your health care information confidential. It should be noted, however, that there are a number of circumstances where the Hospital is permitted to use and disclose medical records and other treatment information without your authorization for the purposes of treatment or payment, or health care operations, or because we are required by law to disclose. For example, we can use your protected health information for purposes of providing you with treatment, and for purposes of our obtaining payment for the services we provide to you. In addition, the Hospital is committed to improving the quality of health care by encouraging the use of electronic health records and the exchange of health information electronically between health care providers such as doctors and hospitals. We have established and participate in an electronic exchange program (the "Exchange") that provides a data base of electronic medical records that can be accessed by your health care providers. Upon your agreeing to having your health information included in the Exchange (by means of a separate authorization), your health information will be included in the Exchange's data base. Danbury Hospital utilizes an ePrescribe system to facilitate your treatment. This includes receiving prescription history from third parties, such as other healthcare providers and pharmacies, as well as submitting prescriptions. This information will support clinical staff in avoiding drug duplication and drug interactions.

Assignment of Benefits-Authorization to Third Party payment Sources to make Payments Directly to the Hospital.
State law and HIPAA require that the release of additional information be specifically authorized by the patient. In addition, state law provides that certain disclosures of records and communications concerning psychiatric conditions, substance abuse, genetic testing and HIV-related testing and treatment are subject to special authorization requirements. Finally, if you were treated on an outpatient basis in our dual diagnosis program, federal law also has certain special authorization requirements. This section is your authorization to release such additional information to specific persons/entities for the purposes identified below. I authorize Danbury Hospital/New Milford Hospital to release outpatient records of treatment for substance abuse, which are referred to collectively in this authorization as "Confidential Information," to the following persons/entities for the stated purposes:

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- third-party payors (which for purposes of this authorization includes insurance companies, managed care organizations & Medicare or Medicaid and other governmental payors), hospital agents or governmental agencies for purposes of payment of my bill.
- any utilization, managed care, and/or quality review organization affiliated with my insurance company/managed care organization (as defined above) for purposes of utilization management and quality review and/or improvement.
- other health providers for the purpose of providing continuing care or for their health care operations.
- state or federal agencies or accreditation bodies for auditing, licensure/regulatory, and/or accreditation purposes.

I also authorize the disclosure to the Hospital of Confidential Information that may be in the possession of any of my physicians for the same purposes. I have been informed that my refusal to authorize the release of Confidential Information will not jeopardize my right to obtain present or future treatment except where disclosure or use of the information is necessary for treatment. I understand that I may withdraw my authorization to release Confidential Information at any time in writing, except to the extent that action already has been taken in reliance on such authorization. This authorization expires three years from the date of the patient's discharge (inpatient), or three years from the last date of treatment (outpatient), or, with respect to information in the Exchange, until the Exchange stops operating or you revoke your Exchange authorization).

Physicians are Independent Contractors Responsible for the Patient's Care Your Physicians are independent contractors Responsible for your Care

Your physicians are not employees of the Hospital. While the Hospital periodically reviews the credentials of all of its physicians, your physicians, not the Hospital, are responsible for the care that they provide to you while you are an outpatient. They and not the Hospital are responsible for obtaining your informed consent to operations or procedures when it is required. If you have any questions for your physicians, including questions about the nature or risks and benefits of or the alternatives to any intended operation or procedure, or questions about the physician's charges or bills, you should address those questions to your physician since he/she is solely responsible for answering such questions.

Personal Valuables.

If you are staying overnight in the Hospital, The Hospital maintains a safe for the safekeeping of money and valuables. If you choose not to place valuables in the Hospital safe, the Hospital will not be responsible for the loss of or damage to your valuables. The Hospital shall not be responsible for loss or damage to items including documents, cash, dental work/dental prosthetics, eyeglasses, credit cards, hearing aids and items of unusual value or size that have not or cannot be placed in the Hospital safe. Any personal valuables should be given to a family member or friend for safekeeping.

RIGHT TO RECEIVE A COPY OF HOSPITAL CHARGES

Upon request, patients may receive copies of their hospital charge. A Patient Financial Service Representative is available at 203-730-5800 should assistance be needed.

VETERANS

Please indicate if you or your spouse is a veteran of the US Armed Forces. State the name of your spouse if he/she is a veteran. Please identify the branch of the Armed Forces and state the approximate dates of service:

_____

PATIENT RIGHTS AND RESPONSIBILITIES AND NOTICE OF PRIVACY PRACTICES

I acknowledge that the Hospital's Policy on Patient Rights and Responsibilities is posted and is available to me. I agree to comply with this Policy. I acknowledge that I have a right to receive a copy of Western Connecticut Health Network's Notice of Privacy Practices upon request.

I HAVE READ AND UNDERSTAND THE AUTHORIZATIONS, AGREEMENTS AND NOTICES SET FORTH IN THIS FORM, AND AGREE TO SUCH AUTHORIZATIONS AGREEMENTS AND NOTICES.

Date: _____Time:_____Signature:_____

Witness:_____ Relationship: _____

If this form has not been signed by the patient, please specify the signer's relationship to the patient, and, if necessary, explain why the patient did not sign. If signed by the Patient's Representative, please print name and describe relationship to patient.

Name: _____ Relationship: _____

COMPLETE THE FOLLOWING DOCUMENTATION OF GOOD FAITH EFFORTS IF IT IS NOT POSSIBLE TO OBTAIN A SIGNATURE:

The following good faith efforts were made to obtain a signature: _____

A signature could not be obtained for the following reasons: _____

Documented by: Signature_____ Print Name_____

Date_____ Time_____

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PEDIATRIC CASE HISTORY QUESTIONNAIRE

Today's Date: _____

Form Completed by: ☐ Mother/Father/Caregiver ☐ Therapist ☐ _____

General Information

Child's Name _____ Date of Birth:_____ Gender ____

Address: _____ Home Phone: _____

City: _____ State:_____ Zip: _____

Mother's Name: _____ Age: _____

Mother's Occupation:_____ Business Phone:_____

Father's Name: _____ Age: _____

Father's Occupation: _____ Business Phone:_____

Does the child live with both parents? ☐ Yes ☐ No

If no, with whom does the child live? _____

Brothers and Sisters (include names and ages): _____

Diagnosis/Reason for referral: _____

Is there any pain associated with this problem? ☐ Yes ☐ No

If yes, please describe: _____

_____

Pediatrician: _____ Phone: _____

Address: _____

Referring Physician: _____ Phone: _____

Address: _____

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Prenatal and Birth History

Describe mother's general health and any complications (illnesses, accidents, etc.) during pregnancy: _____

_____

Please list any medications taken during pregnancy (prescription and non-prescription): _____

_____

Length of pregnancy: _____

If your child was born prematurely, what was the expected due date? _____

Place of Birth: _____ Birth weight: _____

Child's length of stay in hospital:_____

Circle type of delivery: Cesarean or NSVD

Please describe any complications during delivery:_____

_____

Please describe any post-natal complications (i.e., oxygen, ventilation, surgeries, NICU stay): _____

_____

_____

Medical History

Child's general health is: ☐ Good ☐ Fair ☐ Poor

Provide the approximate ages/dates at which your child experienced the following illnesses and conditions.

Asthma _____ Pneumonia _____ Sinusitis _____

High fever_____ Influenza _____ Reflux_____

Visual/Glasses _____ Tonsillectomy _____ Adenoidectomy _____

Ear infections _____ Hearing loss _____

Seizures_____ Heart Problems _____

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Other Problems: _____

_____

List any allergies: _____

_____

Describe any major accidents, surgeries, or hospitalizations your child has had (with dates): _____

_____

_____

Please list any specialists that your child has seen and when:

Specialist's Name	Specialty Area	Date Seen
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has your child been diagnosed with a specific problem or disability? _____

By Whom? _____

When? _____

List child's current medications, dosages, frequency of administration, and what they are taken for: _____

_____

_____

Developmental History

Did your child exhibit delays with developmental milestones as a baby (i.e. rolling, crawling, talking, walking, etc.)? please circle Yes No

Current concerns or comments (if any) regarding your child's fine and gross motor development (e.g., writing, running, climbing)? _____

_____

_____

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Educational History

With whom does your child spend most of the day? _____

Current School or Daycare: _____ Grade: _____

Address: _____ Phone: _____

Teacher (s): _____

Please describe any special education services received through Birth to Three, school, or private therapy. List frequency of services on the Individualized Educational Plan (IEP) or Individual Family Service Plan (IFSP). __

_____

_____

Are there any customs or religious beliefs that might affect your care? ☐ Yes ☐ No

If yes, please describe: _____

_____

Please add any additional information not reported on this form that you feel is important for us to know and/or might be helpful in evaluating or treating your child: _____

_____

_____

Person completing the form (print): _____

Signature: _____ Date: _____

PLEASE ATTACH ANY REPORTS YOU HAVE FROM ANOTHER AGENCY, SCHOOL, OR DOCTOR.

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Communication (only if applicable)

What language(s) is your child exposed to in the home? _____

How does your child usually communicate? (circle all that apply)

Gestures Sign Language Single Words Short Phrases Sentences

How many words can your child say? ☐ 1-10, ☐ 10-50, ☐ 50-100, ☐ 100-300, ☐ 300-500, ☐ Over 500

Give a few examples of phrases and/or sentences that your child typically uses at this time: _____

_____

_____

What percent of the time is your child's speech understood by:

Mother _____ Father _____ Brothers & Sisters _____ Friends _____ Teachers _____ Other relatives _____

Was there ever a time when your child's language skills regressed or he/she stopped talking? ☐ Yes ☐ No

If so, when? _____ Please describe the circumstances: _____

_____

Describe your child's speech-language or hearing problem. _____

_____

_____

When was this problem first noticed? _____

Who first noticed the problem? _____

What do you think may have caused the problem? _____

_____

Is your child aware of the problem? _____

_____

What have you done to help your child with the problem? _____

_____

Describe other speech, language, or hearing problems in the family. _____

_____

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Feeding and Swallowing (only if applicable)

Is your child a picky eater? ☐ Yes ☐ No

Check all that apply:

Child currently eats/drinks:
☐ thin liquids ☐ thickened liquids
☐ pureed foods ☐ soft foods ☐ crunchy foods
☐ chewy/tough foods ☐ mixed consistencies
☐ from a bottle ☐ from a sippy cup ☐ from an open cup
☐ with a straw

Does your child:
☐ drool excessively ☐ suck their thumb ☐ use a pacifier
☐ thrust their tongue when swallowing

Describe any food preferences or avoidances: _____

_____

_____

Describe any feeding problems (e.g., problems with sucking, swallowing, gagging) your child has had: _____

_____

_____

Has your child ever undergone a Modified Barium Swallow evaluation? ☐ Yes ☐ No

If so, where and when? _____

What were the findings? _____

Child's position during feeding:

☐ Held by feeder ☐ Infant seat ☐ High Chair ☐ Regular chair ☐ Other_____

Child's posture during feeding:

☐ Upright ☐ Semi-upright ☐ Supine ☐ Other_____

Child's approximate weight: _____ ☐ average weight ☐ under weight ☐ over weight

Total feeding time: _____

Additional comments or concerns: _____

_____

DANBURY HOSPITAL MAIN STREET PHYSICAL REHAB CENTER

DANBURY OFFICE DIRECTIONS

203-730-5900

Traveling East on I-84

1. Get off highway @ Exit 5 (proceed down the ramp)
2. Make a right onto Main St (also has a route name)
3. Continue straight on Main St until you come to 5th traffic light
4. Make a left onto Liberty Street
5. Make another left onto Delay Street
6. Proceed straight until you see a white fenced-in parking lot on your left (the Danbury Ice Arena will be on your right)
7. Pull into the parking lot (free parking for all patients)
8. Enter the buildings and either take stairs or elevator down to LL (lower level)

Traveling West on I-84

1. Get off highway @ Exit 5 (get into right hand lane. Make a stop at the stop sign and continue to go straight)
2. Make a right at the first light
3. Go straight thru the next 5 lights & at the 6th light, make a left onto Liberty Street.
4. Make another left onto Delay Street
5. Proceed straight until you see a white fenced-in parking lot on your left (the Danbury Ice Arena will be on your right)
6. Pull into the parking lot (free parking for all patients)
7. Enter the buildings and either take stairs or elevator down to LL (lower level)

Reminder: If you're using your GPS device to locate our office, please use the address 8 Delay Street to locate our parking lot, otherwise you will be routed to the front of the building where you have to pay for parking or else be ticketed by the Danbury Parking Authority.