

**Coral Desert Rehabilitation  
Patient Medical History Continued**

Patient Name: \_\_\_\_\_

Yes	No	Have you ever had:	Yes	No	
		Diabetes Controlled by <input type="checkbox"/> Diet <input type="checkbox"/> Pills <input type="checkbox"/> Insulin			Do you currently or have a history of smoking
		Hypoglycemia (low blood sugar)			Do you Drink Alcoholic Beverages? How often _____ how much _____
		Thyroid Problems			Do you have any of the following
		Heart Problems			False Teeth
		Blood Clots, Transfusion Problems, Or Bleeding Tendency			Loose Teeth
		High Blood Pressure			Chipped Teeth
		Stroke			Bridges
		Seizures			Braces
		Neurological Problems			Body Piercing
		Glaucoma			Contact Lenses
		Severe Headaches			Hearing Aids
		Lung Problems			Do you use any of the following
		Tuberculosis/TB			Oxygen
		Sleep Apnea (Breathing interruption during sleep)			CPAP
		Liver Problems (Jaundice, Hepatitis)			BiPAP
		Recent Exposure to Any Communicable Diseases?			Other:
		Influenza Vaccine (In the last 12 months)			Do You have any problems sleeping?
		Pneumonia Vaccine			Snoring
		Chronic Infection (MRSA, VRE, etc)			Breathing Difficulties
		Skin Problems			Up at night to use bathroom
		Stomach Problems			Insomnia
		Bowel Problems			Pain
		Back Trouble	<b>CORAL DESERT REHABILITATION WILL NOT BE RESPONSIBLE FOR PERSONAL BELONGINGS AND VALUABLES. AS MANY BELONGINGS AND VALUABLES AS POSSIBLE SHOULD BE TAKEN HOME BY FAMILY MEMBERS</b>		
		Previous broken bones of head, neck or spine			
		Arthritis			
		Muscle Disorders			
		Mental Health/Phobias			
		Mental Disability			
		Pain in the past several weeks or that limits Daily Activity			
		Other Medical Problems			
<b>If yes to any of the above please explain:</b> _____ _____ _____ _____					

**Insurance Information:**

Insurance Company: \_\_\_\_\_  
 Policy Number: \_\_\_\_\_  
 Group Number: \_\_\_\_\_

For cosmetic elective procedures Coral Desert Rehabilitation *does not* bill your insurance for you. The patient will be expected to pay for their stay at the time of discharge. A bill will be provided for you at that time. Any pharmacy supplies will be billed separately by Superior Care Pharmacy.

\_\_\_\_\_  
Patient or responsible party's signature

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Date

## Coral Desert Rehabilitation Patient Medical History

Patient Name: _____		Phone #: _____		Date of Birth: _____	
Address: _____ _____		<b>EMERGENCY MEDICAL CARE</b> As evidenced by my signature below, I hereby grant Coral Desert Rehabilitation permission to seek medical treatment for the above named patient as they deem necessary for care.		<input type="checkbox"/> Yes <input type="checkbox"/> No Do you currently or immediately prior to procedure, have any type of infection, cough cold or fever? List: _____	
Name of Procedure		Procedure Date	Surgeon/Doctor		Primary Care Physician
Current Medications/Routine Medications		Strength/Dose		Frequency:	
<b>ALLERGIES/REACTIONS</b> <input type="checkbox"/> None Known <input type="checkbox"/> Medications <input type="checkbox"/> Foods <input type="checkbox"/> Other List Item & type of Reaction: _____		HT: _____		WT: _____	
Have you had a bad reaction to anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes please explain: _____					
<b>LEGAL STATUS:</b> There is <input type="checkbox"/> Is Not <input type="checkbox"/> a representative designated for the patient who has the legal authority to make decisions of behalf of the patient? If Yes:					
Name: _____		Phone: _____			
Address: _____					
<input type="checkbox"/> Yes <input type="checkbox"/> No   Do You Have a living will? <input type="checkbox"/> Yes <input type="checkbox"/> No   Do You Have a Medical Treatment Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No   Do You Have A Physician Order for Life Sustaining Treatment? (POLST)					
<i>Emergency Contacts:</i>					
Name: _____		Phone: _____			
Relationship to Patient: _____					
Name: _____		Phone: _____			
Relationship to Patient: _____					
<b>FINANCIAL AGREEMENT</b> Financial Liability for this period at Coral Desert Rehabilitation will be assumed by: _____ (Name) At the following billing address: _____ _____ _____			I, the undersigned, agree, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she individually obligates himself/herself to pay the account of the facility in accordance with the regular rates and terms. Should the account be referred to an attorney for collection, the undersigned shall pay all reasonable attorney's fees and collection expenses.		
			(Patient Signature)		
			(Responsible Party Signature)		
			(Relationship to Patient)		
			(Date)		

# CORAL DESERT REHABILITATION

"Changing The Horizon Of Healthcare"

## FINANCIAL AGREEMENT

### Credit Card Information

(Circle One)

**VISA      MASTERCARD      DISCOVER      AMERICAN EXPRESS**

\_\_\_\_\_  
Name on Card (Exactly as it appears, Please Print)

\_\_\_\_\_  
Card Number

\_\_\_\_\_  
Exp Date

\_\_\_\_\_  
CIV Code (3 or 4 Digit Number on Back of Card)

\_\_\_\_\_  
Billing Zip Code

1. I authorize Coral Desert Rehabilitation to use the credit card information above to fulfill my financial obligations for their services.
2. Each patient, not the insurance company, is responsible for payment on all charges to his/her account at the time services are rendered unless other arrangements are made in advance.
3. Delinquent accounts will be charged interest at 1½ % per month, I/We agree to pay collection costs and/or reasonable attorney's fee if any delinquent balance is placed with an agency or attorney for collection or suit.
4. I/We agree to pay all attorney fees, court costs, and filing fees including charges of commissions that may be assessed to us by any collection agency retained to pursue this matter, which may be as much as 50% of the principle owing. I/We further agree to pay interest at the rate of 1 ½ % per month (18% per year).
5. I/We authorize the facility to release any information acquired in the course of my treatment to the insurance company, physician and/or anesthesia offices, laboratory, and x-ray services.
6. I/We authorize the release of any hospital medical records associated with this admission and request the records be submitted to Coral Desert Rehabilitation.

\_\_\_\_\_  
Responsible Party

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date



Omicare

Patient Admission Record and Agreement

Pharmacy Name: SUPERIOR CARE

Facility Name: CORAL DESERT REHAB Admission Date:

PATIENT INFORMATION

Room # \_\_\_\_\_ Bed \_\_\_\_\_

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ MI \_\_\_\_\_

SSN# \_\_\_\_\_ DOB \_\_\_\_\_ Sex [ ] M [ ] F Medicare (HICN)# \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone Number (\_\_\_\_) \_\_\_\_\_

Patient is solely responsible for the financial and legal authorizations: YES [ ] NO [ ] If NO, please list the Legal Representative below:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

A Legal Representative is a person who has been granted the authority in writing by either the Patient or a court of law to make medical and/or financial decisions on behalf of the patient.

PRIMARY CONTACT and FINANCIALLY RESPONSIBLE PARTY INFORMATION

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_

Primary Contact is also Financially Responsible Party YES [ ] NO [ ] If NO, please list Financially Responsible Party below:

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone \_\_\_\_\_

A Financially Responsible Party is a person, other than the Patient, who agrees to be responsible for payment of all charges for products and services provided to the Patient.

PAYMENT SOURCE FOR PHARMACY PRODUCTS AND SERVICES

To assist in billing for medications and services provided to the patient while at this facility, please check all that apply:

Admitting Pay Source: MEDICARE-A [ ] MEDICARE-D [ ] SELF [X] MEDICAID [ ] INSURANCE [ ] MEDICARE ADVANTAGE [ ] HOSPICE [ ] VETERAN [ ] OR OTHER PRIVATE PAY Please describe "other" and provide pharmacy with copies (FRONT and BACK) of ALL Drug Coverage cards.

Authorization for Invoice Payments by the following methods:

Credit Card [ ] Visa/MC/Discover/AmEx Card# \_\_\_\_\_ Exp \_\_\_\_\_ Security Code \_\_\_\_\_

Bank Account Transfer [ ] Acct# \_\_\_\_\_ Routing# \_\_\_\_\_ Bank \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_



Omnicare

Patient Name X

Facility CORAL DESERT REHAB

Patient Admission Record and Agreement

By signing below, the Patient or their Legal Representative and the Financially Responsible Party acknowledge and agree to each of the following terms:

- 1. Authorizations: Omnicare, Inc. and its subsidiaries ("Omnicare") are authorized to provide the Patient all products and services prescribed or ordered by the Patient's Physician or by the facility. The Patient requests the products provided by Omnicare be dispensed in containers that are not child resistant. The Patient requests that the facility and/or Omnicare dispose of, or otherwise process, all unused and/or discontinued medications dispensed to the patient, according to facility and pharmacy policy as allowed by professional standards and regulations.
2. Legal Representative: Legal Representatives will provide Omnicare with documentation establishing their legal authority.
3. Assignment of Benefits: The Patient or Legal Representative hereby requests and authorizes any third-party payer to make payment directly to Omnicare for products and services provided to the Patient.
4. Payment: The Patient and Financially Responsible Party are responsible for paying all charges for products and services provided to the Patient by Omnicare. As a courtesy, Omnicare will submit claims to any insurance companies or other third-party payers listed above or of which Omnicare is subsequently notified in writing; however, the Patient and Financially Responsible Party are ultimately responsible for paying any charges not covered by insurance or another third party payer. Payment in full is due within 30 days of the invoice date, and a finance charge equal to the lesser of 1.5% per month or the maximum rate permitted by law will accrue on all delinquent accounts beginning on the day after the payment is due. The Patient or their Legal Representative and/or the Financially Responsible Party hereby authorize Omnicare to charge any credit card or bank account number identified above for any amounts owed.
5. Fees and Expenses: The Patient and Financially Responsible Party are responsible for paying all costs and expenses incurred by Omnicare in the collection of amounts owed and the enforcement of its rights under this agreement, including without limitation, attorney's fees, court costs and expenses.
6. Assurance of Payment; Termination of Services: The Patient or Legal Representative and Financially Responsible Party acknowledge that if the Patient and Financially Responsible Party are delinquent on payment of any amount owed to Omnicare, Omnicare may, in its sole discretion, do either or both of the following: (a) condition its continued provision of products and services to the Patient upon Omnicare's receipt of assurance of payment acceptable to Omnicare, which may include, without limitation, a requirement that Omnicare receive authorization to charge all amounts owed, past and future, to a valid credit card number; and/or (b) suspend or terminate its provision of products and services to the Patient. Such suspension or termination will in no way affect the Patient's or Financially Responsible Party's obligations to pay all amounts owed under this agreement, including costs of collection.
7. Reliance and Consideration. Omnicare is relying upon the Financially Responsible Party's agreements herein in determining to provide products and services to the Patient, and Omnicare's provision of products and services to the Patient constitutes good and adequate consideration for Financially Responsible Party's agreements contained in this agreement.
8. Disclosure or Use of Patient Information for Treatment, Payment, and Healthcare Operations. The Patient or Legal Representative hereby authorizes Omnicare, its employees, agents and sub-contractors to disclose to the Medicare or Medicaid program or to any other third party payer any medical or other information needed for payment for all products and services provided by Omnicare to the Patient until payment has been made in full. The Patient or Legal Representative further authorizes Omnicare, its employees, agents and sub-contractors to use and disclose the Patient's medical and other information for the provision of products and services, for the business operations of Omnicare and for the review of Omnicare's services, including review by accrediting bodies or governmental agencies.
9. Modification: No modification or amendment of this agreement shall be effective unless agreed to in writing by Omnicare.

Signature lines for Patient/Legal Representative, Financially Responsible Party, and Authorized Representative's Relationship to Patient. Includes fields for City, State and Zip Code, and Medical Reason for Patient's Inability to Sign.

NOTE: If patient has personally signed, it is not necessary to complete the information below. If the patient is unable to sign, an authorized Representative may sign on his/her behalf, but must complete all information, including the patient's medical reason for an inability to sign.



# Omnicare, Inc. and Affiliated Entities

# Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.  
Provided in compliance with 45C.F.R. § 164.520

Omnicare, Inc. and its affiliated entities (collectively "Omnicare") use health information about you for treatment, to obtain payment for treatment, to evaluate the quality of care you receive, and for other administrative and operational purposes. Your health information is contained in a medical record that is the physical property and responsibility of Omnicare.

### Your Health Information Rights:

You have the following rights with respect to health information about you.

**Right to Copy of Notice of Privacy Practices.** You have the right to a paper copy of our Notice of Privacy Practices at any time. To obtain a copy of our current Notice of Privacy Practices, please contact your local Omnicare location or Omnicare's Chief Privacy Officer at the address or phone listed below.

**Right to Inspect and Copy.** You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. Your request must be in writing. If you request a copy of your health information, we will charge you a fee to cover the costs of copying and mailing the information. In certain very limited circumstances, we may deny your request to inspect and copy your health information. If you are denied access to your health information, we will explain our reasons in writing. You have the right to request that another person at Omnicare review the decision. We will comply with the outcome of the review. For information about this right, see 45C.F.R. § 164.524.

**Right to Amend.** If you feel that health information about you that we maintain in certain groups of records is inaccurate or incomplete, you have the right to request that we amend the information. You have the right to request an amendment as long as we maintain the information. Depending on the nature of your request, we may ask that you submit it in writing and include a reason supporting the request. In certain circumstances, we may deny your request to amend your health information. If your request for an amendment is denied, we will explain our reasons in writing. You have the right to submit a statement explaining why you disagree with our decision to deny your amendment request. We will share your statement when we disclose health information about you that we maintain in certain groups of records. For more information about this right, see 45 C.F.R. § 164.526.

**Right to an Accounting of Disclosures.** You have the right to request an accounting or detailed listing of certain disclosures of your health information. The time period covered by the accounting is limited. Your request must be in writing. If you request an accounting more often than once every twelve (12) months, we may charge you a fee to cover the costs of preparing the accounting. For more information about this right, see 45 C.F.R. § 164.528.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information about you that we use or disclose. Your request must be in writing. Please be aware that we are not required to agree to your request for restrictions. If we agree to your request for a restriction, we will comply with it unless the information is needed for emergency treatment. For more information about this right, see 45 C.F.R. § 164.522.

**Right to Revoke Authorization.** You have the right to revoke your authorization to use or disclose health information, except to the extent that action has been taken in reliance upon your authorization. Your request must be in writing.

**Right to Request Alternative Method of Contact.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. Your request must be in writing. We will agree to the request to the extent that it is reasonable for us to do so. For example, you may request that we use an alternative address for billing purposes. For more information about this right, see 45 C.F.R. § 164.522(b).

### Complaints

If you believe your privacy rights have been violated, you may complain to Omnicare and to the Department of Health and Human Services. You may make a complaint to us by contacting Omnicare's Chief Privacy Officer at the address or phone listed below. You will not be retaliated against for filing a complaint.

### Omnicare's Obligations

Omnicare is required to:

- > maintain the privacy of protected health information;
- > provide you with this Notice of our legal duties and privacy practices with respect to your health information;
- > abide by the terms of the Notice of Privacy Practices currently in effect;
- > notify you if we are unable to agree to a requested restriction on how your health information is used or disclosed;
- > accommodate reasonable requests you may make to communicate health information by alternative means or at alternative locations;
- > obtain your written authorization to use or disclose your health information for reasons other than those identified in this Notice and permitted by law; and
- > comply with your state's laws if they provide you with greater rights over your health information or provide for more restrictions on the use or disclosure of your health information.

Omnicare reserves the right to change the terms of this Notice, our privacy practices, and to make the new provisions effective for all protected health information we maintain. You may contact your local Omnicare location or Omnicare's Chief Privacy Officer at the address or phone listed below to obtain a revised Notice of Privacy Practices.

### Uses or Disclosures of Your Health Information

**Treatment.** We may use and disclose health information about you to provide you with pharmaceutical care or other medical treatment or services. To this end, we may communicate with other health care providers regarding your treatment and coordinate and manage your health care with others. For example, information related to your treatment may be obtained by a health care provider, such as a pharmacist, nurse, respiratory therapist, or other person providing health services to you, and will be recorded in your medical record. This information is necessary for health care providers to determine what treatment you should receive. Health care providers also may record actions taken by them in the course of your treatment and note how you responded to the actions.



Under the Federal HIPAA Privacy Rule, we are required to give you our Notice of Privacy Practices and make a good faith effort, before providing services, to get your:  
**Acknowledgement of Receipt of Notice of Privacy Practices**

Name of Patient (*print*)

Facility or Organization

By signing this form, I acknowledge that I have been provided with a copy of the Notice of Privacy Practices for Omnicare, Inc. and its affiliated entities.

Signature (*patient, parent, or legal representative*)

Date:

Name and Relationship to Patient (*if signed by someone other than patient*)

**PLEASE FAX This document to your Omnicare products or service provider Immediately**

For Omnicare Use Only

Entered into computer.

Processed for filing.