FRUITVILLE PHYSICAL THERAPY

NEW PATIENT INFORMATION

Name:_____
Last First Middle

Address:_____
Street City State Zip

Out of Town Address:_____
Street City State Zip

Home Phone:_____ **Work Phone:**_____

Email:_____ **Age:**_____ **Sex: M / F**

Social Security Number:_____ **DOB:**_____

Emergency Contact Name/Relationship:_____

Emergency Contact Phone:_____

Have you had <u>HOME HEALTH</u> services within the last 90 days? Y / N

If yes, please provide the agency name, phone number, and date of discharge:_____

Is this injury <u>WORK</u> related? Y / N If yes, date of injury:_____
Employer's Address:_____

Is the injury <u>AUTO</u> related? Y / N If yes, date of accident:_____
Claim number:_____

Spouses Name/DOB(if covered under their insurance):_____

Primary Care Physician/Phone#:_____

Referring Physician/Phone#:_____

FRUITVILLE PHYSICAL THERAPY

Patient Name:_____

Please read each section below and initial at the end of each statement as this will signify your agreement or understanding of each statement.

RELEASE OF INFORMATION
I hereby authorize Fruitville Physical Therapy to release and/or obtain any information acquired in connection with my therapy services, including but not limited to, diagnosis and clinical records, to my insurance company, attorney, physician and/or other appropriate parties. **INITIAL HERE:**

MEDICAL CONDITIONS
I understand that I must inform Fruitville Physical Therapy of any conditions or disorders that may interfere with my treatment, e.g., heart condition, diabetes, high blood pressure, etc. I will inform my therapist{s} of any medical condition{s) that I now have or have had in the past. If discomfort arises, I will request assistance immediately. I also understand that if, at any time, during the course of my therapy, I am unsure as to the proper use of any equipment, I will stop immediately and consult a staff member for further instructions. **INITIAL HERE:**

ASSIGNMENT OF INSURANCE BENEFITS / INSTRUCTION FOR DIRECT PAYMENT
I, _____, hereby assign to Fruitville Physical Therapy any and all claim{s} proceeds relating to charges for therapy services under my insurance policy, otherwise payable to me. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. I authorize and direct that payment for covered services be made by my insurer directly to FRUITVILLE PHYSICAL THERAPY. A photocopy of this Assignment shall be considered as effective and valid as the original. _____ **INITIAL HERE:**

MEDICARE CO-PAYMENT
On an ongoing basis, our charges and expenses are reviewed by Medicare to ensure that they are fair and competitive. We will file your Medicare claim for you and, if you request, your supplement insurance. However, it is very important that you understand your plan of insurance is a business matter between you and your insurance company, and as the recipient of treatment, you are obligated to pay any charges which your insurance company does not pay. **INITIAL HERE:**

THERAPY SUPPLIES
Please be advised that therapy supplies are not covered by Medicare. If your therapist recommends a therapy supply item in connection with your treatment, payment will be your responsibility. If you have any questions, please ask your therapist.
INITIAL HERE:

PAYMENT
Payment is expected on the date services are rendered. When necessary, special arrangements can be made for a payment plan to accommodate your circumstances. If your charges are not paid in full, you will be responsible for a service charge as well as costs of collection, including up to 40% of your account balance for collection agency costs, and/or the full amount of legal fees and costs.
INITIAL HERE:

APPOINTMENTS
Please understand that your appointment represents a commitment on our part. We reserve facilities, equipment and most importantly, the time of professional personnel especially for you. If you are unable to keep your appointment, you must notify us 24 hours in advance. Failure to provide notice may result in a charge to your account, a charge for which you personally will be responsible.
INITIAL HERE:

CONSENT TO TREAMENT/CONSENT OF MINOR
I,_____, authorize, in advance, FPT to perform necessary evaluation, diagnosis, treatment and care required for my diagnosis within the scope of practice of the treating professional ie PT, PTA, SLP, OT, COTA. I, _____, parent/guardian of _____, a minor, authorize treatment by FPT as aforementioned in this paragraph. **INITIAL HERE:**

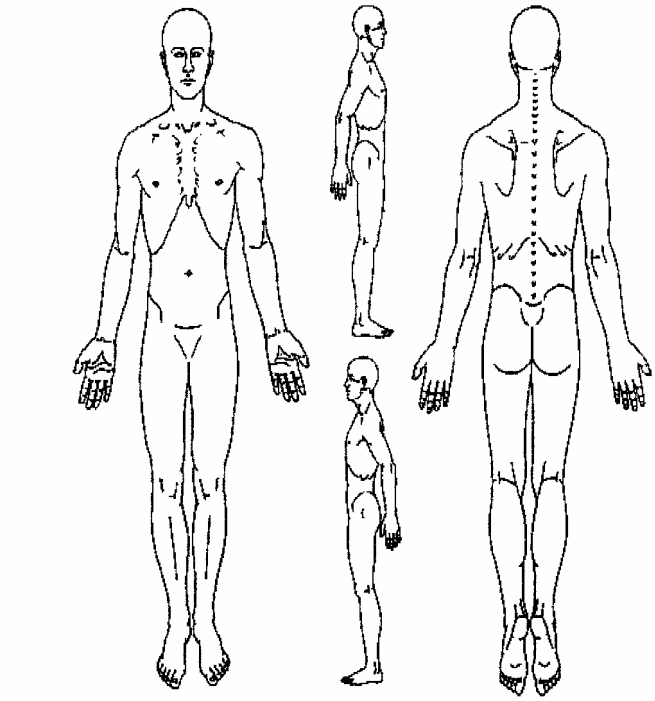
If, at any time, you have questions or concerns regarding our policies or the handling of your account, please feel free to discuss them with a member of our office staff. We look forward to working with you to make your rehabilitation both successful and pleasant. Your signature is necessary for us to process any insurance claims and to ensure payment for services rendered.

Insured/Patient or Guardian Signature:_____ **Date:**_____

FRUITVILLE PHYSICAL THERAPY

MEDICAL INFORMATION

On the diagram below, please indicate where you are experiencing pain or other symptoms, right now.



A = ACHE **B** = BURNING **N** = NUMBNESS
P = PINS & NEEDLES **S** = STABBING **O** = OTHER

RATE YOUR PAIN TODAY

0 = No Pain
10 = Worst Pain Imaginable

Pain level today:_____

Worst pain in last 30 days:____

Least pain in last 30 days:_____

What makes your pain:
Better_____
Worse_____

Please list medications you are currently taking:_____
_____
_____
_____

Please circle any of the following medical conditions you may have been diagnosed with/or have experienced:

Cancer	Heart Disease	Allergies	Arthritis	Dizziness
Emphysema	Diabetes	Chest Pain	Asthma	Liver Disease
Pneumonia	Polio	Hypoglycemia	Kidney Disease	Hepatitis/Jaundice
Ringing Ears	Stroke	Reiter's	Hypertension	Urinary Tract Infection
Ulcers	Gout	Pacemaker	Pregnancy	Rheumatic Fever
Shortness of Breath		Irritable Bowel Syndrome		Chronic Bronchitis

Please note any other past medical problems, illnesses, surgeries, or hospitalizations:

I certify that the above information is true and complete to the best of my knowledge:

Signature:_____ Date:_____

FRUITVILLE PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES
PATIENT CONSENT FORM

I have read and fully understand the **Notice of Patient Information Privacy Practices**. I understand that my protected health information may be used or disclosed for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and administrative healthcare operations. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations if I notify the practice. I also understand that my request for restriction will be considered on a case-by-case basis, but my request for restrictions may not be honored based on the reasonableness of the request.

I hereby consent to the use and disclosure of my protected health information for purposes as noted in the **Notice of Patient Information Privacy Practices**. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time. I understand that the practice has the right to change its **Notice of Patient Information Privacy Practices** and that I may contact this organization at any time to obtain a current copy of this notice.

_____
Patient's Printed Name

_____ _____
Signature of Patient or Guardian Date

AUTHORIZED DESIGNEES

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

_____ _____
Signature of Patient or Guardian Date

FOR OFFICE USE ONLY:
The above noted patient was provided with this consent form and the **Notice of Patient Information Privacy Practices**, but refused to sign this consent form for the following reason:

_____

_____

_____ _____
Staff Signature Date

FILENAME: HIPAAFORM04 Consent to Privacy Practices

FRUITVILLE PHYSICAL THERAPY

MEDICARE SECONDARY PAYOR INFORMATION

This information is required for Medicare beneficiaries. The purpose of this questionnaire is to identify Medicare as the primary or only insurance coverage for your condition.

1. Are you entitled to Medicare based on: □ Age □ Disability

2. Are you receiving **Black Lung** medical benefits? □ Yes □ No
   If yes, date benefits began:_____

3. Are the services to be paid by a government program such as a research grant?
   □ Yes □ No

4. Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for these services? □ Yes □ No

5. Is this treatment for a work related injury? □ Yes □ No
   If yes, please list the name and address of Workers Compensation company:
   _____
   _____
   Date of injury:_____

6. Is this service for the treatment of an injury which resulted from an automobile accident? □ Yes □ No
   If yes, please list the name and address of the insurer and policy number:
   _____
   _____
   Date of accident:_____

7. Are you currently working full or part time? □ Yes □ No
   If yes, please list the name and address of your employer:
   _____
   _____

8. If retired, Date of Retirement:_____

9. If working, are you covered under your employer's health plan? □ Yes □ No
   If not, are you covered under your spouse's insurance? □ Yes □ No
   If yes to either, please list the name and address of the insurance company:
   _____
   _____
   Please list the Policy number:_____

_____
Patient Name

_____ _____
Patient Signature Date

ANNUAL MEDICARE PAYMENT CAP SURVEY

In January, 2006, Medicare implemented an annual payment cap for physical and occupational therapy services.

Please indicate if you have received physical or occupational therapy services this year (January to present,).

Patient Printed Name: _____

I, the above named patient, □ Have □ Have Not received therapy services this year.

If "□ Have" is checked above, please indicate which service(s) you have received:

□ Physical Therapy and/or Speech Therapy

□ Occupational Therapy

□ Physical or Speech Therapy AND Occupational Therapy

Please list the name of the company from which you received these services: _____

Patient Signature: _____

Date: _____

Thank you for your cooperation.

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or service.

We expect that Medicare will not pay for the items or services that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for:**
Items or Services:

Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost $_____**), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**
I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pat the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 1. NO. I have decided not to receive these items or services.**
I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____

Date Signature of Patient/Guardian/Power of Attorney