PHYSICAL & SPORTS REHAB

1401 Mercantile Lane, Suite 107
Upper Marlboro, MD 20774
Office: 301-658-6881
Fax: 301-322-2563
Ptsrehab.org

Patient Intake Form

MEDICARE

Please fill this form out completely. Thank you!

Patient Information

Date _____

Patient Name _____
(Last Name, First Name, Middle Initial)

Address _____

City/State/Zip _____

Home Phone _____

Work Phone _____

Cell Phone _____

Email _____

Social Security Number _____

Sex (M) (F) *(Circle One)*

Age _____ Date of Birth _____

Referral Required

Referring Physician(s) _____

Date of last Doctor Visit _____

Date of next Doctor Visit _____

Date of Onset _____

Related to Accident? Y N Work Auto Other

Employed: Full-Time Part-Time Retired Not working
(Circle One)

Employer _____

Employer Address _____

Marital Status: Single Married Other *(Circle One)*

Student: Full-time Part-Time Not a Student *(Circle One)*

How did you hear about PTSRehab? _____

Responsible Party

Name _____
(Last Name, First Name, Middle Initial)

Address _____

City/State/Zip_____

Home Phone _____

Work Phone _____

Employer _____

Employer Address _____

City/State/Zip _____

Insurance Information

Name of Insurance Company MEDICARE

Member ID No. _____

Group No. _____

Secondary Insurance _____

Name of Insured _____

Insured is _____Patient _____Spouse

Secondary Insurance _____

Group Number _____

Claims Mailing Address _____

_____

Emergency Contact Information

Name _____

Telephone _____

Relationship _____

Name _____

Telephone _____

Relationship _____

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Patient Health History

Patient Information

Condition to be treated in Physical Therapy:

_____

Patient Age _____

Patient Occupation _____

When did the pain Start? _____

How did the pain start?
- □ Suddenly
- □ Gradually
- □ Lifting
- □ No apparent reason
- □ Pulling
- □ Injured at work
- □ Bending
- □ Other: _____

What activities make the pain worse?
- □ Exercise (during)
- □ Exercise (after)
- □ Sitting
- □ Walking
- □ Bending forward
- □ Bending backward
- □ Coughing
- □ Sneezing

What reduces the pain?
- □ Lying down
- □ Sitting
- □ Standing
- □ Walking
- □ Anti-inflammatories
- □ Pain pills
- □ Injection for pain
- □ Muscle relaxants
- □ Nothing
- □ Other

How long have you had this pain?

_____ Years

_____ Months

_____ Weeks

How long have you had similar pain?

_____ Years

_____ Months

_____ Weeks

Have you had any of these diagnostic tests?

X-rays □ Yes □ No Date_____

CT scan □ Yes □ No Date_____

MRI □ Yes □ No Date_____

Arthrogram □ Yes □ No Date_____

Injections □ Yes □ No Date_____

Have you been hospitalized for your problem?

□ Yes □ No Date_____

Current Medications (or provide front office with Medications List)

_____mg_____

_____mg_____

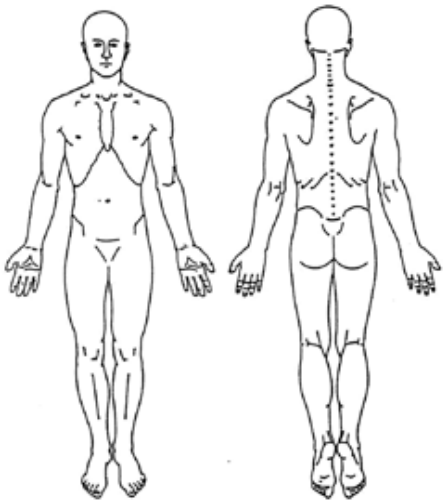
_____mg_____

_____mg_____

Pain/ Symptoms

On the Body Diagram below, indicate your region of pain using the symbols below:

(**X**) Sharp
(**+**) Numb/ Tingling
(**#**) Dull/ Aching
(**B**) Burning



_____
Pain Level
(0-10)

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Existing or Relevant Previous Conditions *(Please Circle Yes or No)*

Allergies	Yes or No	Dizzy Spells	Yes or No	MRSA	Yes or No
Anemia	Yes or No	Emphysema/Bronchitis	Yes or No	Multiple Sclerosis	Yes or No
Anxiety	Yes or No	Fibromyalgia	Yes or No	Muscular Disease	Yes or No
Arthritis	Yes or No	Fractures	Yes or No	Osteoporosis	Yes or No
Asthma	Yes or No	Gallbladder Problems	Yes or No	Parkinsons	Yes or No
Autoimmune Disorder	Yes or No	Headaches	Yes or No	Rheumatoid Arthritis	Yes or No
Cancer	Yes or No	Hearing Impairment	Yes or No	Seizures	Yes or No
Cardiac Conditions	Yes or No	Hepatitis	Yes or No	Smoking	Yes or No
Cardiac Pacemaker	Yes or No	High Cholesterol	Yes or No	Speech Problems	Yes or No
Chemical Dependency	Yes or No	High/Low Blood Pressure	Yes or No	Strokes	Yes or No
Circulation Problems	Yes or No	HIV/AIDS	Yes or No	Thyroid Disease	Yes or No
Currently Pregnant	Yes or No	Incontinence	Yes or No	Tuberculosis	Yes or No
Depression	Yes or No	Kidney Problems	Yes or No	Vision Problems	Yes or No
Diabetes	Yes or No	Metal Implants	Yes or No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates and describe any other Conditions.

_____

Medical Precautions

_____

Fall History *(Please Circle Yes or No)*

Injury as a result of a fall in the past year? Yes or No

Two or more falls in the last year? Yes or No

Patient is at risk for falls? Yes or No

Surgical History

Body Region _____ Surgery Type _____ When _____

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Medical Assignment of Benefits and Financial Policy

Please read this document in its entirety.

Financial Policy, Release of Information, Assignment of Benefits

We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment. If you have any questions, please discuss them with us prior to beginning therapy.

- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to us. In other words, you agree to have your insurance company pay us directly. If your insurance company does not pay us within a reasonable time period, we will have to look to you for payment of the outstanding balance.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for services is due at the time of service.
- You must inform our office of all insurance changes and authorization referral requirements. In the event the office is not informed, you will be responsible for any charges that are denied.
- All amount due for services billed by PTS Rehab to a Medicare payor which was subsequently declared by my employer to be a non-eligible claim.

- We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the copayment at the time of service. If you have a copay, you may either pay each time you come for your appointment or you may pay in advance to cover all visits for the week. Once the insurance company has begun to process our bills, if there is a balance due, we will send you a statement each month for the amount you owe – i.e. deductible, coinsurance, copay, until all claims have been processed. Payment is due upon receipt of our bill.
- All health plans are not the same and do not cover the same services. We will do our best to determine what services are covered by your insurance and let you know if there is a recommended treatment that is not a benefit of your insurance so that you may decide to proceed with the treatment or elect not to have the treatment performed. In the event your health plan determines a service to be “not covered” and we are unaware or you do not have authorization, you will be responsible for the complete charge

Patient/ Responsible Party Signature: _____

Date: _____

Payment and Patient Signature

- Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees, and court fees shall become your responsibility in addition to the balance due this office.have to look to you for payment of the outstanding balance.
- There is a **$40.00** service fee for all returned checks. Your insurance company does not cover this fee.
- A **$50.00** fee will be charged for all “No Shows” & Cancellations without a 24-hour notice. This fee is not reimbursable by insurance

- I have read and understand the financial policy of PTSRehab and I agree to be bound by its terms. I also understand that such terms may be amended from time to time by this office.
- I authorize the release of information necessary for treatment, payment & health care operations.
- I also authorize assignment of benefits for services rendered by PTSRehab.
- I certify that the information provided to PTS Rehab for payment under the Social Security Act (Medicare) is correct, including but not limited to any related accidents/illnesses other insurers/payors available.

Patient/ Responsible Party Signature: _____

Date: _____

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Exclusions from Medicare Benefits

Please read this document in its entirety.

Notice of Exclusions from Medicare Benefits (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does not pay for all of your health care costs. Medicare only pays for covered benefits.

Some items and services are not Medicare benefits and Medicare will not pay for them.

- When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.
  The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare won't pay.
- Ask us how much these items or services will cost you (Estimated Cost: N/A).

Medicare will not pay for:
Physical Therapy and Speech Language Pathology services over $1,940.00 in 2015.
**** You may receive covered services through a hospital outpatient therapy department.**

X 1. Because it does not meet the definition of any Medicare benefit.
□ 2. Because of the following exclusion * from Medicare benefits:

□ Personal comfort items
□ Most shots (vaccinations)
□ Hearing aids and hearing examinations
□ Most outpatient prescription drugs
□ Orthopedic shoes and foot supports (orthotics)
□ Health care received outside of the USA
□ Services required as a result of war
□ Routine physicals and most tests for screening
□ Routine eye care, eyeglasses and examinations
□ Cosmetic surgery
□ Dental care and dentures (in most cases)
□ Routine foot care and flat foot care
□ Services by immediate relatives
□ Services under physician's private contract
□ Services paid for by a governmental entity that is not Medicare
□ Services for which the patient has no legal obligation to pay
□ Home health services furnished under a plan of care, if the agency does not submit the claim
□ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997
□ Items or series furnished in a competitive acquisition area by any entity that does not have a contract with the Department of
□ Health and Human Services (except in a case of urgent need)
□ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital
□ Items and series furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF
□ Services of an assistant at surgery without prior approval from the peer review organization
□ Outpatient occupational and physical therapy services furnished incident to a physician's services

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This is only a general summary of exclusions from Medicare benefits. It is not a legal document.
I HAVE READ AND UNDERSTAND THAT MEDICARE IMPOSED A THERAPY CAP IN 2015 AND BENEFITS FOR PHYSICAL AND SPEECH THERAPY COMBINED MAY NOT EXCEED $1,940.00.

Patient Signature _____ Date _____

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Privacy Practices

Notice to 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.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- TREATMENT means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would be sending medical information to the referring physician.

- PAYMENT means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill and/or chart notes for your visit to your insurance company for payment.

- HEALTH CARE OPERATIONS include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be sending charts to the physical therapy network for quality assurance review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, reschedule appointments, or provide information about treatment alternatives or other health-related benefits and services that may be of interest to you.
Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

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- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive and accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a copy of the revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Physical and Sports Rehab
1401 Mercantile Lane, Suite 107
Upper Marlboro, MD 20774
301-658-6881

For more information about HIPAA or to file a complaint:
The US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
Toll Free: 1-877-696-6775

Patient Information and Signature

I have read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the ***Notice of Privacy Practices.***

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Date_____ Initials _____ Reason_____