



1401 Mercantile Lane, Suite 107
 Upper Marlboro, MD 20774
 (301)658-6881-Office (301)322-2563-Fax
 www.physicalandsportsrehab.com

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 Address _____
 Social Security Number _____
 Sex (M) (F) (Circle One)
 Age _____ Date of Birth _____

Referring Physician(s) _____
 Date of last Doctor Visit _____
 Date of next Doctor Visit _____
 Date of Onset _____
 Related to Accident? Y Work Auto Other N
 (Circle One)
 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 Name _____
 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
 Policy Number _____
 Group Number _____
 Claims Mailing Address _____

Emergency Contact Information

Relative/Friend _____
 Telephone _____

Relative/Friend _____
 Telephone _____

Patient Health History

Patient Information

Condition to be treated in Physical Therapy _____

Patient Age _____

Patient Occupation _____

When did the pain start? _____
 (Approximate Date)

Patient History

How did the pain start?

- | | |
|---|--|
| <input type="checkbox"/> Suddenly | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Gradually | <input type="checkbox"/> Injured at work |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Bending |
| <input type="checkbox"/> No apparent reason | <input type="checkbox"/> Other |

What activities make the pain worse?

- | | |
|--|--|
| <input type="checkbox"/> Exercise (during) | <input type="checkbox"/> Bending forward |
| <input type="checkbox"/> Exercise (after) | <input type="checkbox"/> Bending backwards |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Coughing |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Sneezing |

What reduces the pain?

- | | |
|--|---|
| <input type="checkbox"/> Lying down | <input type="checkbox"/> Pain pills |
| <input type="checkbox"/> Sitting | <input type="checkbox"/> Injection for pain |
| <input type="checkbox"/> Standing | <input type="checkbox"/> Muscle relaxants |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Nothing |
| <input type="checkbox"/> Anti-inflammatories | <input type="checkbox"/> 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 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| CT scan | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| EMG/NCV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| MRI | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| Arthrogram | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |
| Injections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Date _____ |

Have you been hospitalized for your problem?

Yes / No _____ Date _____
 (Circle One)

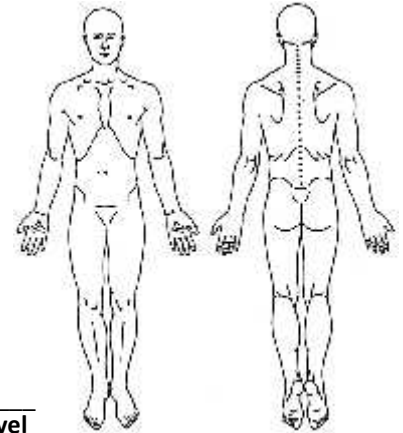
Have you had surgery for your problem?

Yes / No _____ Date _____
 (Circle One)

Pain/Symptoms

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

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



Pain Level
 (0-10)

What medications are you currently taking?

Yes/No

- | | | |
|--------------------------|--------------------------|------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | High blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke (CVA) |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer or tumors |
| <input type="checkbox"/> | <input type="checkbox"/> | Lung problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Arthritis-joint difficulties |
| <input type="checkbox"/> | <input type="checkbox"/> | (Ir)regular headaches |
| <input type="checkbox"/> | <input type="checkbox"/> | Dizziness-blackouts |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures-nerve disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Visual problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Menstrual problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunity disorders |
| <input type="checkbox"/> | <input type="checkbox"/> | Gout |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant? |
| <input type="checkbox"/> | <input type="checkbox"/> | Joint replacement |

Yes/No

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Night sleep disturbance |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in bowel or bladder habits |
| <input type="checkbox"/> | <input type="checkbox"/> | Change in stool color or rectal bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Increased thirst or hunger |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent urination |
| <input type="checkbox"/> | <input type="checkbox"/> | Indigestion or heartburn |
| <input type="checkbox"/> | <input type="checkbox"/> | Nausea or vomiting |
| <input type="checkbox"/> | <input type="checkbox"/> | Changes in memory |
| <input type="checkbox"/> | <input type="checkbox"/> | Unusual fatigue-weakness |
| <input type="checkbox"/> | <input type="checkbox"/> | Fever or chills |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent or easy bruising or bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Frequent cramping |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have pain 24 hrs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you awaken from pain? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke? _____#/Day |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you drink? _____#/Day |

What other types of doctor/healthcare providers have you seen for this condition? _____



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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 recommendation 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: _____

Payments 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.
- 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 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.
- 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.

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 \$1,900.00 in 2013.

**** 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:

- | | |
|--|---|
| <ul style="list-style-type: none"> □ 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 □ 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 | <ul style="list-style-type: none"> □ Routine physicals and most tests for screening <ul style="list-style-type: none"> □ Routine eye care, eyeglasses and examinations □ Cosmetic surgery <ul style="list-style-type: none"> □ Dental care and dentures (in most cases) □ Routine foot care and flat foot care □ Services by immediate relatives <ul style="list-style-type: none"> □ Services under physician's private contract |
|--|---|

Patient Signature

- This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations and rulings.

I HAVE READ AND UNDERSTAND THAT MEDICARE IMPOSED A THERAPY CAP IN 2013 AND BENEFITS FOR PHYSICAL AND SPEECH THERAPY COMBINED MAY NOT EXCEED \$1,900.00.

Patient Signature _____

Date _____

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**

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.



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Privacy Practices

Please read this document in its entirety

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- 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