Medicare Patient & Payor Information Form

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) ______-_________ Home (_____) ______-_________ Mobile (_____) ______-_________ Work

Email: ____

Appointment Reminders No Yes Please send me ☐ **text** ☐ **email** ☐ **call** notifications to remind me of my appointments at Sports Rehab & Physical Therapy (SRPT) We provide this at no additional cost, however, **YOUR STANDARD MESSAGING RATES MAY APPLY**

Sex: M F **Birthdate:** _____/_____/______ **S.S #** ______/______/_______

Circle one: Single Married Separated Widow Divorced

Emergency Contact: ____ (_____) ______-___________
Name Relationship Phone Number

(2)

Are You Covered:

a. **Under Black Lung Disease?** **No Yes**
b. **End Stage Renal Disease?** **No Yes**
c. **Large Group Insurance?** **No Yes** **If Yes Name/Group#**________________
d. **Veterans Affairs** **No Yes**

All Patients or Patients' Legal Representative Please Sign Section 4 on Page 2

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(3) Payment Authorization (Initials required for all 3 Statements)

_______ **Assignment of Insurance Benefits**
Initials
I authorize that the payment of my insurance benefits be made directly to SRPT for any services that are reimbursable by Medicare or my any other insurance company, if I have one.

_______ **Guarantee of Payment**
Initials
I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service <u>or</u> statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date

________ **Certification of Information**
Initials
I certify that the information I have provided SRPT for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(4) Signature/ Date:

____ ____________________
Patient or Legal Representative's Signature Today's Date

Notice of Home Health Services

If you have had home health services within six months of being referred to us, we must know so we can verify your discharge from that service. When referred for home health services it will included: Skilled Nursing Services, Occupational Therapy, Physical Therapy, Speech, and Language Pathology Services, and Home Health Aide Services (<u>Example</u>: Assistance with basic personal care, meal preparation, feeding, incidental household services, light cleaning, treatment of injuries or illnesses or giving medications/injections, inspecting or inserting feeding tubes, catheters, wound care. etc.) We should know if you are receiving and/or will be receiving home health services of any kind.

Please check mark the following:

☐ I am not receiving home health services of any kind.

☐ I was discharged of all home health services on this date ___/____/____

☐ I am currently receiving home health services.

All Patients or Patients' Legal Representative Please Sign Section 4 on Page 2

Informed Consent for Therapy Services

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information and I consent to the evaluation(s) and treatment provided by Sports Rehab & Physical Therapy

____

Patient's or Authorized Representative's Printed Name & Date

____

Patient's or Authorized Representative's Signature

Acknowledgement of Receipt of Notice of Privacy Practices

My signature below indicates that I have been given the Notice of Privacy Practices for Sports Rehab & Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Sports Rehab & Physical Therapy to release any of my protected healthcare information.

____

Patient's or Authorized Representative's Printed Name & Date

____

Patient's or Authorized Representative's Signature

Copyrights Protected By BCMS, Inc COM 202-Informed
Written Authorization For Use Required

AUTHORIZATION FOR RELEASE OF INFORMATION

Authorization is not required for the Use or Disclosure of Information Related to *Treatment, Payment, Healthcare Operations or if Required by Law or Rules*

(1) Patient's Printed Name:

____

Last   First   Initial   or Other

Date of Birth: ____/_____/_____ Insurance # exactly as on card (including letters)____________________

(2) Sports Rehab & Physical Therapy will only disclose the protected health information you want disclosed.

Check only one box to tell Sports Rehab & Physical Therapy the specific information you want disclosed/released:

☐ Do NOT release any information other than for treatment or payment (skip #'s 3, 4, and 5)

☐ Limited information (complete ALL Sections)

☐ ALL records regarding my care at Sports Rehab & Physical Therapy to any requesting party (skip 3 and 4)

(3) Complete only if you selected "limited information". Please initial all that apply:

_____ Evaluation/Examination   ______ Attendance   _____ Correspondence re: your Services

_____ Past Medical History   ______ Treatments   _____ Other ____________________

(4) Complete only if you selected "limited information". I only authorize the release of information to the individuals/entities identified below by name:

Spouse: ______________________________   Attorney: ______________________________

Parent: ______________________________   Employer: ______________________________

Friend: ______________________________   School: ______________________________

Other: ______________________________   Other: ______________________________

(5) Check only one box indicating how long Sports Rehab & Physical Therapy can use this authorization:

☐ Disclose my information indefinitely (as long as Sports Rehab & Physical Therapy has custody of my files)

☐ Disclose my PHI for the following period beginning ___/___/_______ and ending ___/___/________

(6) Please initial all items below indicating that you have read and understand the rights or information below:

________ I understand that this authorization does not expire unless I have indicated an expiration date above

________ I understand that I can refuse to give authorization without fear of retaliation or treatment limitations

_______ I understand that if I give authorization I may revoke it at any time by notifying this Sports Rehab & Physical Therapy in writing

_______ I understand that the information used/disclosed as a result of my authorization may be subject to re-disclosure by the recipient and may not be protected by Federal privacy regulations once in the recipient's possession

_______ I understand that if Sports Rehab & Physical Therapy requests my authorization it is required to tell me the purpose and to whom my PHI (protected health information) is being released to

________ I understand that I will receive a copy of this authorization after I sign it and before I sign, if I request it

________ Sports Rehab & Physical Therapy will not be compensated for using or disclosing my PHI unless related to treatment or payment procedures unless specific permission is obtained by the patient after full disclose of purpose & intent

______________________________ or ______________________________

Signature of Patient   Date   **Signature of Parent or Authorized Representative Date (Indicate the Relationship)**

You may refuse to Sign this Authorization

Physical Therapy Medical Screening Questionnaire

Name: ______________________ **DOB:** __________ **Date:** __________

Age: ______ Ht: ______ Wt: ______ Gender: **M F** Pregnant: **Y N** Smoker: **Y N**

Occupation: ______________________________

PAST MEDICAL HISTORY: Please check each condition that you have been told you have or had.

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ fibromyalgia
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ eye problem/infection
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia
- ❑ pacemaker
- ❑ latex allergy

SURGERY HISTORY (Please list all & date): ______________________________

____

MEDICATIONS: Please list all current medications (including pills, injections, skin patches).

____

____

Do you currently take: NSAIDS or anti-inflammatory medications? **Y N** Blood thinners? **Y N**

CURRENT SYMPTOMS: Have you recently noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance
- ❑ falls
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness
- ❑ heartburn/indigestion
- ❑ difficulty swallowing
- ❑ changes in bowel or bladder function
- ❑ constipation
- ❑ diarrhea
- ❑ shortness of breath
- ❑ fainting
- ❑ cough
- ❑ headaches
- ❑ changes in appetite

Please list any illnesses you have had in the past 3 months: ______________________________

During the past month have you been feeling down, depressed or hopeless? **Y N**
During the past month have you been bothered by having little interest or pleasure in doing things? **Y N**
Is this something with which you would like help? **YES** **Yes, but not today** **NO**

CURRENT SYMPTOMS:

Condition to be treated in Physical Therapy or Occupational Therapy: ______________________

What are your current symptoms or pain? ______________________

What **date** (approximately) did your present symptoms start? ______________________

How did your symptoms start (gradual, suddenly, surgery)? ______________________

Is it Related to an Auto Accident? **No Yes** Date of Accident ____/____/____

Is it Non-Work Related Accident? **No Yes** Date of Accident ____/____/____

Did this Condition Result in Surgery? **No Yes** If Yes, Date of Surgery ____/____/____

Have You Had PT/OT for this Condition? **No Yes** If Yes, Where? ______________________

Are You Currently Receiving any Home Health services? **No Yes** If Yes, Agency's name?______________________

(SRPT should not provide any therapy services to patients who are having home health services of any kind, not just physical or occupational therapy.)

Do You Live in a Nursing Home? No Yes If Yes What Is Its Name?______________________

My symptoms are currently: ❑ **Getting better** ❑ **About the same** ❑ **Getting worse**

How are you able to sleep a night? ❑ **Fine** ❑ **Moderate difficulty** ❑ **Only with medication**

My symptoms currently: ❑ **Come and go** ❑ **Are constant** ❑ **Are constant, but change with activity**

When are your symptoms worst? ❑ **Morning** ❑ **Afternoon** ❑ **Evening** ❑ **Night**
When are your symptoms the best? ❑ **Morning** ❑ **Afternoon** ❑ **Evening** ❑ **Night**

Please circle the activities which make you symptoms worse:
lying down **standing** **walking** **stress** **sitting**

Any other activities that make your pain worse?: ______________________

What makes your symptoms better? ______________________

Treatment received so far for this problem (chiropractic, injections, etc) ______________________

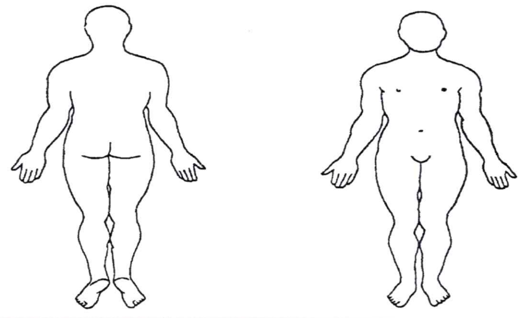
Please list special tests performed for this problem (x-ray, MRI, labs, etc)______________________**Date:**__________

Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**______________ **Treatment rec'd**______________

What is your personal goal for therapy? ______________________

BODY CHART:
Please mark the areas where you feel symptoms or pain on the chart to the right.

For the therapist
+ / - Cough/Sneeze
+ / - Saddle Anesth.
+ / - Bwl/Blddr Chnge
+ / - Numb/Ting.



Using the scales below, please circle the number that best represents the severity of your pain.

At Worst:	**No Pain**	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**
Current:	**No Pain**	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**
At Best:	**No Pain**	0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**

How did you hear about us?

Patient Name: ______________________________ **Date:**____________

Did a physician refer or recommend you to Sports Rehab & Physical Therapy?

☐ **yes** ☐ **no**

What made you choose Sports Rehab & Physical Therapy?

☐ I am a returning patient

☐ It was recommended by a friend or family member

Please tell us who recommended SRPT to you: __________________

☐ Another healthcare provider recommended SRPT to me

Please tell us who recommended SRPT: ______________________

☐ I found Sports Rehab & Physical Therapy through one of the following:

Check all that apply:

☐ SRPT Website ☐ Yelp
☐ Facebook ☐ Other Social Media
☐ Google ☐ Other: ___________

Thank you, we appreciate your feedback!

"The results you want. The care you deserve."

Date revised: 07/08/2020