David Stevenson Physical Therapy, Inc Patient Intake Information

Name:_____
(Last) (First) (M.I.)

Local:_____
(Street) (City) (State) (Zip Code)

Out of State Address: _____

Home Phone ( ) _____ Cell ( ) _____ Work ( ) _____

Social Security # _____ Date of Birth: _____ Age: _____

Occupation: _____ Employer: _____

Marital Status: _____ Spouse's Name: _____

Emergency Contact: _____ Phone #: _____ Relationship: _____

Referring Physician: _____ Family Physician: _____

Date of Injury: _____ How did injury occur? _____ Date of Surgery: _____

Have you had physical therapy for this injury before? _____

Is your injury related to a Workman's Compensation Claim?	☐ Yes	☐ No
Is your injury motor vehicle related?	☐ Yes	☐ No
Have you had ***any*** home health services in the last 60 days?	☐ Yes	☐ No
Have you received ***any*** previous therapy this year?	☐ Yes	☐ No

PATIENT CONSENT TO RECEIVE EMAIL, MAIL AND /OR TELEPHONE MESSAGES

DO WE HAVE PERMISSION TO CALL OR EMAIL YOU? ☐ Yes ☐ No

Call you at home? ☐ Yes ☐ No Leave a message? ☐ Yes ☐ No
Call you at work? ☐ Yes ☐ No Leave a message? ☐ Yes ☐ No

Email Address _____

Share appointment information or billing information with another person in your home?

☐ Yes ☐ No ** If yes, Name _____ Relationship_____

Patient Name _____ DOB:_____ Date of Eval: _____

Height:_____ Weight:_____ Hand Dominance: _____Right _____Left

Briefly describe the current problem(s) that brought you here:

_____

When did your symptoms begin? _____

Are your symptoms: _____Improving _____Getting Worse _____Staying the Same

Have you had any testing? _____ X-rays _____MRI _____EMG/Nerve conduction test _____ CT Scan

Results:_____

Have you had these symptoms before? _____Yes _____No

Have you had treatment before for these symptoms? _____Yes _____No

If yes, what has helped in the past?_____

Date of next doctor appointment: _____

Are you currently receiving home health care? _____Yes _____No

If you have pain, what is your pain level?

*(0= No pain, 10=Extreme pain- **Please Circle**)*

At Worst: 0 1 2 3 4 5 6 7 8 9 10

At Best: 0 1 2 3 4 5 6 7 8 9 10

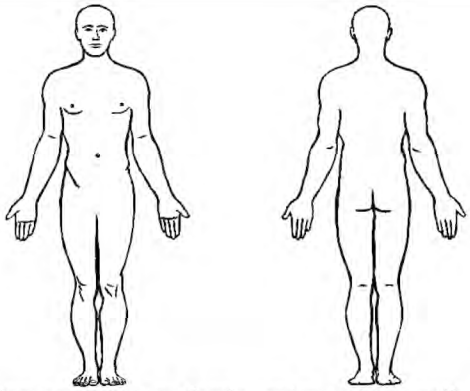
Are your symptoms: _____Constant _____Come and Go

_____Deep _____Sharp _____Shooting _____Numbness/Tingling

_____Burning _____Dull/Ache _____Other

What makes your pain better? _____

What makes your pain worse?_____



Mark on figure above your areas of pain and symptoms with an "X"

Previous/Current Medical History:

Please check ***ALL*** that apply

- ☐ Allergies
- ☐ Osteoarthritis
- ☐ Rheumatoid Arthritis
- ☐ Night Pain
- ☐ Heart Disease
- ☐ Pacemaker
- ☐ Cancer
- ☐ Osteoporosis/Osteopenia
- ☐ Bowel/Bladder Problems
- ☐ Fibromyalgia
- ☐ Smoking History
- ☐ High/Low Blood Pressure
- ☐ Diabetes I or II
- ☐ Neurological Problems
- ☐ Circulation Problems
- ☐ Unexplained weight loss/gain
- ☐ Other _____
- ☐ Surgery (please list/describe)

_____

_____

Have you had any falls in the last 12 months? _____Yes _____No

If yes, please describe the nature of the fall: _____

If yes, please describe if an injury(ies) occurred: _____

Are you currently using an assistive devices? _____Yes _____No If yes, what assistive device? _____

Do you have difficulty with any of the following activities?

_____Walking _____Bathing _____Feeding _____Dressing/Grooming _____Toileting _____Transferring

_____Bed Mobility _____Stairs/Curbs _____Standing _____Sitting _____Household Chores _____Sleeping

What are your goals for participating in Therapy? _____

_____

To the best of my knowledge, I have fully informed you of the history of my problems and current status.

Patient's Signature:_____ Date:_____

***We are required by your insurance company to have your list of medications on file.**

Medications, Over the Counter, Supplements and Herbals	Dosage	Frequency	Route of Administration (ex: Oral, IV, etc.)
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
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21			
22			
23			
24			
25			

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practice, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

_____

Please print your name here

_____

Signature

_____

Date

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss care with. Your PHI may be disclosed to the individuals(s) listed below until you notify us otherwise in writing.

_____ _____

_____ _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgment.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____

_____

_____

_____ _____

Employee signature Date

DAVID STEVENSON PHYSICAL THERAPY, INC.

FINANCIAL POLICY

Thank you for choosing us to be your therapy provider. It is important that you understand your financial responsibility before treatment begins, as you are responsible for the timely payment of charges. Please read the following form and do not hesitate to ask us any questions.

MEDICARE: As a participating Medicare provider, we will file your claims. Medicare has a yearly deductible. You are responsible for:

1. any of your yearly deductible met at our office.
2. the 20% co-insurance not covered by Medicare.
3. any supplies purchased.
4. any visits over the Medicare fee cap where you were not deemed medically necessary.

PRIVATE INSURANCE: As a courtesy to you, we will file with your primary insurance company. You are responsible at the time of service for any portion your insurance doesn't cover, including any unmet deductible. It is your responsibility to check if we are in network with your insurance plan. As participating providers, we have accepted your insurance company's fee schedule. If you have a co-pay, it is payable at each visit. Some policies also charge the patient a cost share amount, which is shown on the check remit to us. Please pay our statement promptly when received.

LIABILITY/AUTO: As a courtesy to you, we will file with your auto insurance carrier. You are responsible for giving us your adjuster name and phone number, claims address, and claim number. You are responsible for any unmet deductible, co-pays, and full payment if insurance has been exhausted. **WE DO NOT ACCEPT "LETTERS OF PROTECTION".**

WORKERS COMPENSATION: Excluded from patient payment.

*****For Patients With Insurance: Insurance is not accepted in place of payment unless we have confirmation from your insurance company that you do indeed have coverage for the procedures being performed. Patients are responsible for any balance on their account not covered or paid by their insurance.**

MEDICAL RECORDS REQUEST: Medical records release form will need to be completed/signed before released. There will be customary and reasonable charges for your records.

CANCELLATION POLICY: **A $50 charge will be made for broken appointments unless 24 hours notice is given.**

I have read and understand the Financial Policy and agree to abide by it.

_____ _____

Patient's Signature or Responsible Party Date

A. Notifier:
B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE; If Medicare doesn't pay for D._____below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D._____**below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Outpatient Physical Therapy	Home Health Services Medicare Part B monies used elsewhere or Open Medicare Secondary Payer (Auto, Liability Claim or Other Health Ins.)	Initial Evaluation: $150.00 Follow-ups: $100.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D._____**listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D._____**listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D._____**listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D._____**listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You may ask to receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.