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: _____

Circle one: Single Married Separated Widow Divorced

Emergency Contact: _____ (_____) _____-_____
Name Relationship Phone Number

(2) Patient

Sex: M F **Birthdate:** _____/_____/_____

S.S # _____/_____/_____ **Legal Photo ID #** _____
(Driver's License, Passport, Other State/Federal Photo ID)

(3) 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**

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

MEDICARE PATIENT & PAYOR INFORMATION FORM

(4) Condition to be treated in Physical Therapy: _____

Date Condition Began?			Date: _____/_____/_____
Did this Condition Result in Surgery?	No	Yes	If Yes Date of Surgery ____/____/____
Did this Condition Result from a Work Injury?	No	Yes	If Yes Date of Accident ____/____/____
Have You Had PT Anywhere this Year?	No	Yes	If Yes Where?_____
Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to or for you?)	No	Yes	If Yes From Who?_____
Do You Live in a Nursing Home?	No	Yes	If Yes What Is Its Name?_____
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	

(5) Patient's Doctor: Please list the Doctor who referred you to therapy below.

_____ **Office Phone:** (____) _____-_____

Referring Dr's Name: Last First Initial MD, DO, DDS, Other

_____

Address: Street City,State Zip Code

(6) Payor Information Primary:

Primary Insurance Company: Medicare

Insured's Name:_____ **Patient ID #** _____ **Group #** _____

Regular Medicare: **Yes** **No** **Rail Road Medicare:** **Yes** **No**

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

MEDICARE PATIENT & PAYOR INFORMATION FORM

(7) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph#_____

Insured is: _____Patient _____Spouse _____Parent

Patient ID #: _____Group. # _____ Policy/Plan #: _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ Employer Phone # ( ) _____- _____

Address: _____ _____
Street City State Zip Code

(8) 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 or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing 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.**

(9) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

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 Physical Therapy 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

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

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 (including Stephenville Sports Rehab & Physical Therapy, Inc. and Weatherford Physical Therapy, Inc.).

_____

Signature

_____

Print name/Date

Sports Rehab & Physical Therapy

To Our Medicare Patients

Dear patient we are in need of your help and speedy communication to avoid billing you for 100% of your therapy services.

Many of you either have had or will have home health services paid for by Medicare. We should not provide Physical Therapy to patients who are having home health services of any kind, not just physical therapy. All of the six services listed below must be provided and paid for by your Home Health Agency if your physician has determined that they are medically necessary. The services are:

- Skilled Nursing Services for the assessment and/or treatment of injuries or illnesses or for giving medications/injections, inspecting or inserting feeding tubes, catheters, wound care, etc.
- Occupational Therapy Services
- Physical Therapy Services
- Speech & Language Pathology Services
- Home Health Aide Services provide assistance with basic personal care, meal preparation, feeding, incidental household services such as preparation of meals, light cleaning, etc.
- Medical Social 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. If you are referred for home health services while you are being treated by us, we must be informed prior to you starting home health. We would like to avoid holding your responsible for payment if your Home Health Agency is not providing the services.

So, please tell us if you are receiving and/or will be receiving home health services of any kind.

Thank you for your help.

Mark Blackburn, PT, DPT
Owner/President

Patient's Signature: _____ Date: _____

Physical Therapy Medical Screening Questionnaire

Name: _____ **DOB:** _____ **Date:** _____

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

Occupation: _____

What is your personal goal for therapy? _____

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:

What are your current symptoms or pain? _____

What date (approximately) did your present symptoms start? _____

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

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? _____

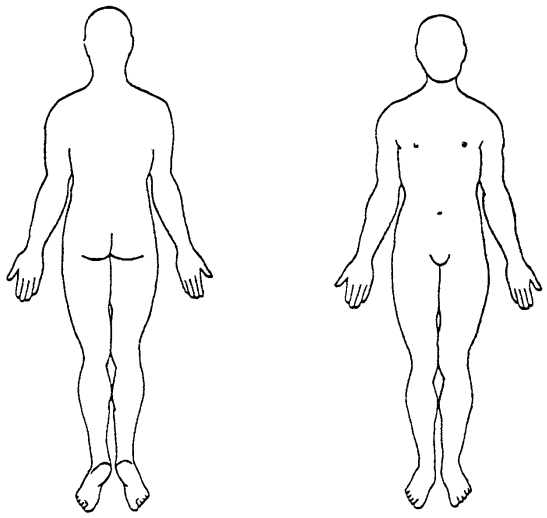
Treatment received so far for this problem (chiropractic, injections, etc) _____

Please list special tests performed for this problem (x-ray, MRI, labs, etc) _____

Have you ever had this problem before: ❑ **Yes** ❑ **No** When_____ Treatment rec'd_____

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/Bldder Chnge
+ / - Numb/Ting.

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

Current:	**No Pain** 0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**
Best for the past 48 hours:	**No Pain** 0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**
Worst for the past 48 hours:	**No Pain** 0	1	2	3	4	5	6	7	8	9	10	**Worst Pain Imaginable**