

PATIENT INFORMATION FORM

Patient Information

Appt. Date: _____

Patient Name: _____ Sex: M/F

Address: _____ City/State/Zip: _____

Home phone: _____ Work phone: _____ Cell Phone: _____

DOB: _____ SSN#: _____ Email: _____

Marital Status: **M S D W** Employer: _____ Occupation: _____

Emergency Contact: _____ Phone: _____

Referral Information

Prescription Date: _____ Frequency and Duration: _____ Area of Treatment: _____

Referring Doctor: _____ Phone: _____

Fax: _____ Upin/NPI: _____ Therapist: _____

Insured Information (insurance policy holder information)

Insured Name: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: _____ SSN#: _____ Relationship to Patient _____

Employer: _____
Name Address

Guarantor Information

Name: _____ Home Phone: _____

Address: _____ City/State/Zip: _____ Relationship to Patient: _____

Insurance Information

Primary Insurance: _____ Insured ID #: _____ Group#: _____

Worker's Comp: Date of Injury: _____ Date of Loss: _____ W/C Claim #: _____

Auto: Date of Injury: _____ State of Accident: _____

Insurance Adjuster: _____ Phone: _____ Fax: _____

Case Manager: _____ Phone: _____ Fax: _____

Employer Contact (if applicable): _____ Phone: _____ Fax: _____

**RICHARDSON SPINE AND SPORTS THERAPY
CONSENT FOR CARE & TREATMENT**

I, the undersigned, do hereby agree and give my consent for Richardson Spine and Sports Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian /Responsible Party _____ **Date** _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to Richardson Spine and Sports Therapy. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including medial records, to secure payment.

Patient/Guardian/Responsible Party _____ **Date** _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining. If any payments are made directly to you for services billed by us, you recognize an obligation to promptly remit same to Richardson Spine and Sports Therapy. I understand and agree that if my insurance company fails to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS: Per Medicare

Allowed Medicare rates of 80%. UP TO \$1840.00 maximum paid per calendar year on ALL physical therapy for 2009. If you have received ANY physical therapy in 2009, the maximum applies to all conditions. If you are under any home health care & are/was receiving physical therapy & not released by the home health agency, Medicare WILL NOT cover your physical therapy at Richardson Spine & Sports. It is your responsibility to make certain you are not classified as "home health". There have been situations where a Medicare patient was interviewed by a Home Health Agency and was denied benefits for Home Health however Medicare will consider a Medicare policyholder on Home Health until the agency files the necessary paperwork & discharges the patient. It is imperative that Medicare patients confirm with Medicare via 800-633-4227 that they are not shown to be on Home Health & are discharged, otherwise the patient will be responsible for 100% of charges that are denied.

Any Balance to be billed.

Note: Estimated coverage information is provided as a courtesy to our patients, but it is not intended to release them from total responsibility for their account balance.

Information Privacy: Richardson Spine and Sports Therapy will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facility and have copies available for distribution. The undersigned acknowledges receipt of this information.

I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Date

Center Representative/Witness

Date

Patient Health Information

Name: _____

Please put a check in the box next to any medical conditions you may have, or have had in the past.

Musculoskeletal

- Osteoarthritis
- Rheumatoid arthritis
- Polymyalgia
- Lupus/SLE
- Fibromyalgia
- Chronic Fatigue
- Osteoporosis
- Headaches/Migraines
- Bulging Disks
- Leg Cramps
- Jaw pain/TMJ
- History of Falls
- Use cane, walker or crutches
- Other: _____

Circulation/Respiration

- Heart Condition
- Heart Attack
- Heart Arrhythmias
- Pace Maker
- High Cholesterol
- Blood Clots/Phlebitis
- Anemia
- Other: _____

Digestion

- Diabetes
- Kidney Problem
- Irritable bowel
- Bladder problem
- Liver problem
- Hernia
- Other: _____

Nervous System

- Stroke/TIA
- Parkinson's
- Multiple Sclerosis
- Epilepsy/Seizures
- Concussion/Brain injury
- Numbness or tingling
- Other: _____

Infectious Diseases

- TB
- Hepatitis
- Polio
- Other: _____

Skin

- Skin allergies/rashes
- Eczema/psoriasis
- Infectious skin diseases
- Shingles
- Other: _____

Please list any prior accidents, broken bones, or surgeries with approximate dates: _____

1. Have you had surgery for this injury? Yes ___ No ___ Surgery Date(s): _____

2. When did pain begin? (Date of Injury) _____

3. Have you had any Medical or Rehabilitative services for this injury/episode? Yes ___ No ___

4. Have you had **ANY** physical therapy this calendar year? Yes ___ No ___ If so, please identify the area(s) of therapy you have been treated for **THIS** year. _____

5. Are you currently taking any prescription or non-prescription medications? If so please list them: _____

6. Do you Smoke? Yes ___ No ___ 7. Are you pregnant? Yes ___ No ___

8. List any other information that would assist us in your care: _____

9. Are you aware of what your diagnosis is? _____

10. Based upon your awareness, what are your expectations/goals while in Therapy? _____

Patient/Guardian Signature: _____ Date: _____

I have reviewed contraindications with _____ prior to initiating evaluation and treatment. The following contraindications were identified:

I have reviewed with _____ their rehabilitation potential prior to initiating treatment.

Therapist Signature: _____ Date: _____

Notifier(s):

Patient Name:

Identification Number:

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items checked or listed in the box 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 items listed or checked in the box below.

Listed or Checked Items Only:	<p>Service – Outpatient Physical Therapy when Patient is enrolled with a home health plan.</p> <p>Service – Medicare Therapy Cap for 2009 is \$1840.00. Patients' diagnosis must qualify for The exception rule in order for Medicare to pay beyond the 2009 Physical Therapy Cap.</p>		
Reason Medicare May Not Pay:	Home Health takes precedence over all patient physical therapy. Patient MUST be discharged from Home Health prior to beginning out patient physical therapy.		
Estimated Cost:	No cost estimate available – duration of treatment plan.		

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 checked items listed in the first box 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.

<p>Options: Check only one box. We cannot choose a box for you.</p>
<p><input type="checkbox"/> OPTION 1. I want the _____ 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.</p> <p><input type="checkbox"/> OPTION 2. I want the _____ 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.</p> <p><input type="checkbox"/> OPTION 3. I don't want the _____ listed above. I understand with this choice I am not responsible for payment, and I cannot appeal to see if Medicare would pay.</p>

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 also receive a copy.

Signature:	Date:
-------------------	--------------

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.