New Physical Therapy Patient Information Sheet

Name: _____

Date of Birth:_____ **Age:**_____ **SS#:**_____

Mailing Address: _____**City/State/Zip:** _____

Home#:_____ **Cell#:**_____ **Work #:**_____

How may we contact you? (circle one) Home Cell Work **Email:** _____
May we leave a detailed message on your machine? Y N
If not, who may we leave the message with?_____

Occupation:_____**Employer:**_____

Marital Status: S M D W **Spouse Name:**_____

Emergency Contact:_____ **Phone #:**_____

******Please provide us with your Physician's referral, copy of ALL insurance cards, and copy of driver's license******

Referring Physician:_____ **Referral Date:**_____

******I am aware that I may be responsible for fulfilling a deductable before my insurance begins payment******

Primary Insurance Company:_____ **ID#:**_____ **GRP#**_____

Policy Holder:_____ **Policy Holder Date of Birth:**_____

Secondary Insurance Company:_____ **ID#:**_____

ATTENTION MEDICARE PATIENTS:
Are you currently enrolled in Home Health Care? Yes or no

WORKMAN'S COMPENSATION/INJURY RELATED INSURANCE:

Company:_____ **Date of Injury:**_____
Name of Insured:_____ **Claim #:**_____
Adjustor's Name:_____ **Phone #:**_____
Mailing Address:_____

I authorize MedX of Estes to release medical records required by my insurance company(s). I authorize my insurance company(s) to pay benefits directly to MedX of Estes. I agree that a reproduced copy of the authorization will be as valid as the original. I understand that I am responsible for any amount not covered by my insurance.
I understand that it is possible for physical therapy to initially increase my symptoms. The physical therapist may perform tests during the initial visit, which may increase my symptoms. This is a normal physiological response.
I consent to and authorize of MedX of Estes to administer all treatments and services that may be considered advisable in the judgment of my physician and/or therapist in accordance with MedX's policies.
Signature of responsible party:_____**Date**:_____

Patient Health Questionnaire

Patient Name_____ **Date**_____

1. Describe your symptoms _____

_____

a. When did your symptoms start?_____

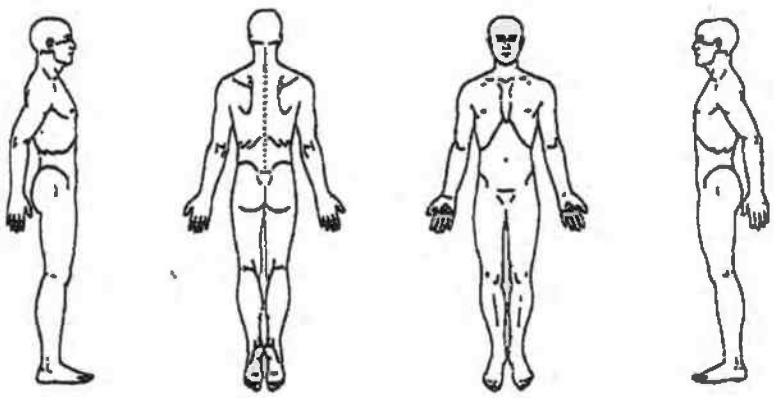
b. How did your symptoms begin?_____

c. What activities produce your symptoms/make them worse_____

_____

2. How often do you experience your symptoms? Indicate where you have pain on diagram below.

- o Constantly (100% of the day)
- o Frequently (25-75% of the day)
- o Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- o Sharp o Shooting
- o Dull Ache o Burning
- o Numb o Tingling

4. How are your symptoms changing?

- o Getting Better
- o Not Changing
- o Getting Worse

5. During the past 4 weeks:

	None									Worst Imaginable
a. Indicate the average intensity of your symptoms	0	1	2	3	4	5	6	7	8	9	10

6. In general would you say your overall health right now is...

o Excellent o Very Good o Good o Fair o Poor

7. Who have you seen for your symptoms? o No One o Medical Doctor o Chiropractor o Physical Therapist o Other

a. What treatment did you receive? _____

b. What tests have you had for your symptoms and when were they performed? o Xrays date:_____ o CT Scan date:_____ o MRI date:_____ o Other date:_____

8. Have you had similar symptoms in the past? o Yes o No

9. What is your occupation? _____

Patient Signature _____ Date _____

MEDICAL HISTORY CONTINUED...

Please check YES if you have ever (in your life) had, or do you presently have any of the following

		YES
1	Anemia / Blood Disease	
2	Bone / Joint Problem	
3	Arthritis / Rheumatism	
4	Allergies	
5	Back Trouble	
6	Breathing Problems (any kind)	
7	Broken Bones / Dislocation /	
8	Cancer or Tumor	

		YES
9	Diabetes	
10	Dizziness / Fainting	
11	Epilepsy / Seizure Disorder	
12	Fibromyalgia Syndrome	
13	Headaches	
14	Head / Spinal Injury	
15	Heart Disease / Chest	
16	Hernia / Rupture	

		YES
17	High Blood Pressure or High Cholesterol	
18	Lung Disease	
19	Paralysis	
20	Pregnancy (Current)	
21	Skin Disease or Sores That Won't Heal	
22	Stroke	
23	Swelling of Feet or Joints	
24	Other	

If you have had any prior surgeries please give details below

Surgery / Procedure	Date

MEDICATIONS

Are you allergic to any medications? YES / NO If YES, what? _____

_____

_____

If you are currently taking any medications please list below

Medication	
1	
2	
3	
4	

Medication	
5	
6	
7	
8	

Have you had physical therapy in the past 12 months for these symptoms or any other reason? *Yes*_____ *No*_____

I certify that I have reviewed and understand the above information supplied by me, and that it is true and correct to the best of my knowledge. I hereby consent to such treatment, procedures, patient care, and therapy supplies which, in the judgment of my therapist and/or physician, may be considered necessary or advisable.

Patient Signature _____ **Date** _____

Guardian Signature (if Minor) _____ **Date** _____

MedX of Estes Physical Therapy
PATIENT PRIVACY AND PROCEDURE STATEMENT

MedX of Estes maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

Our clinical and front office staff uses patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with the state law.

We protect all patient information within the guidelines provided by federal, state and local government.

If you have grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Office Manager, at (970) 577-0174.

MedX of Estes Physical Therapy reserves the right to amend, change and/or revise our privacy policy at any time in accordance with federal, state and local rules, regulation and guidelines.

_____ _____

Signature Date

A. Notifier: MedX of Estes

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Physical Therapy 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.** Physical Therapy below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy	Met Hard Cap Limit	$75.00

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.** Physical Therapy 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.** Physical Therapy 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.** Physical Therapy 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.** Physical Therapy 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 also receive a copy.

I. Signature:	J. Date:

Financial Policy for MedX of Estes

Thank you for choosing MedX for your Physical Therapy needs. We are dedicated to providing you with the best possible care and service. We want you to understand of our financial policy before beginning your care and treatment at MedX. We require you to read and understand the following information prior to your treatment.

You must complete our patient registration forms and present a copy of your driver's license and insurance card to the front desk. You are responsible for notifying us of ANY and ALL changes to your insurance coverage, address, phone numbers, and employment status.

INSURED PATIENTS: We have written provider contracts with many insurance plans. We will file claims with those insurance plans with which we are contracted. Please advise if you have received physical therapy or chiropractic treatment at another facility this fiscal year that may affect your insurance benefits.
You are responsible for knowing the terms and conditions of your insurance policy including those regarding referrals and prior authorizations. Obtaining referrals and authorizations from your insurance company often takes 48 hours or longer.
Insurance contracts state that you may be responsible for:
- Co-pays (paid at each visit)
- Deductibles
- Co-Insurance Expenses
- Supplies (not covered by your insurance)

In the event that your health plan determines a service is not covered, or applies the service to your deductible or coinsurance, full payment for these services is due upon receipt of a statement from MedX of Estes. Once insurance has made payment for services we will then bill you for the remaining collections.

The billing process and prices are set by the Health Care Financing Administration (HCFA) and follow the Colorado Standard for pricing and billing. MedX of Estes will accept all reimbursements that your personal insurance policy allows and you will not be responsible for what is not allowed by your policy. We will bill you accordingly.

Non-Insured Patients: *Full payment is due at time of service.* For your convenience we accept cash, check, Master Card and Visa.
Minor Patients: The adult and/or parent accompanying the patient or requesting the treatment is responsible for full payment of services as described above. Non-accompanied minors coming in for treatment must have prior approval from their parents or guardian in order to be treated. Payment must accompany the patient.
Minors of Divorced Parents: The parent accompanying the patient or requesting the treatment is responsible for full payment of services as described above for insured or non-insured patients, regardless of the divorce decree or settlement. **It is the requesting parent's responsibility to know the terms and limits of their insurance policy.**
Missed Appointments: In order to provide the best possible service and availability to all of our patients, we request that you call during business hours at least 24 hours in advance to cancel your appointment. ***Our policy is to bill you $25.00 for appointments that are canceled with less then 24 hours and more than 4 hours notice. Appointments cancelled within 4 hours or "no show" appointments, will be billed at $45.00.*** You will be responsible for the payments as most insurance companies do not pay for missed appointments.

Thank you for choosing MedX of Estes for your treatment. If you have any questions regarding our financial policy and/or your financial responsibilities, please contact our billing department.

I have read and understand the above policy and I agree to the terms of the policy.

Signature of Responsible Party _____ Date _____