Medicare

New Patient

Registration Forms

Medical History Questionnaire

Patient Name		Date of Birth		Age	
Reason for Therapy		Date of Injury or Onset			

Is the Reason for Therapy Accident Related? ☐ No ☐ Yes

If yes, please check one: ☐ Accident ☐ Auto ☐ Work ☐ Other If other, please explain:

Are you **currently** receiving any other care for the condition mentioned above? ☐ No ☐ Yes If yes, please list:

Have you ever received therapy **in the past** for the condition mentioned above? ☐ No ☐ Yes If so, when?

Previous Treatment Received:		Previous Treatment: ☐ Successful ☐ Unsuccessful

Have you received therapy services for **other problems/conditions during this calendar year**? ☐ No ☐ Yes If yes, please list:

Could you be or are you pregnant? ☐ **No** ☐ **Yes**

Do you now have or have you ever had any of the following conditions?

Condition	Yes	No	Condition	Yes	No	Condition	Yes	No
Arthritis	☐	☐	**Diabetes**	☐	☐	**Numbness / Tingling**	☐	☐
Osteoporosis	☐	☐	**Anemia**	☐	☐	**Thyroid Problems**	☐	☐
High Blood Pressure	☐	☐	**Swelling in Ankles**	☐	☐	**Headaches**	☐	☐
Heart Disease / Heart Attack	☐	☐	**Deep Vein Thrombosis (DVT)**	☐	☐	**Head Injury / Concussion**	☐	☐
Pacemaker	☐	☐	**Seizures / Epilepsy**	☐	☐	**Hernia**	☐	☐
Stroke	☐	☐	**Fatigue / Weakness**	☐	☐	**Kidney / Bladder Problems**	☐	☐
Vascular Disease	☐	☐	**Cancer / Tumor**	☐	☐	**Previous Fractures**	☐	☐
Hypersensitivity to Heat/Cold	☐	☐	**Recent Weight Loss or Gain**	☐	☐	**Previous Surgeries**	☐	☐
Asthma	☐	☐	**HIV / AIDS**	☐	☐	**Metal in Body or Surgical Implants**	☐	☐
Shortness of Breath	☐	☐	**Hepatitis**	☐	☐	**Depression**	☐	☐
Chronic Cough	☐	☐	**Tuberculosis**	☐	☐	**Anxiety**	☐	☐
Dizziness / Light Headedness / Fainting Spells	☐	☐	**Recurrent Infection(s) or Infection in past 3 months**	☐	☐	**Smoking**	☐	☐
Nausea / Vomiting	☐	☐	**Fever / Chills**	☐	☐	**Other (please describe below)**	☐	☐

If you answered "yes" on any of the above or have other conditions not listed, please explain and give approximate date(s):

Do you have any allergies? ☐ No ☐ Yes, list allergies:

Are you presently taking any medications? ☐ No ☐ Yes, list medications and specify condition:

At the present time, would you say that your health is (circle one): Excellent Very Good Fair Poor

The information is correct to the best of my knowledge.

X	
Patient/Parent/Guardian Signature	Date

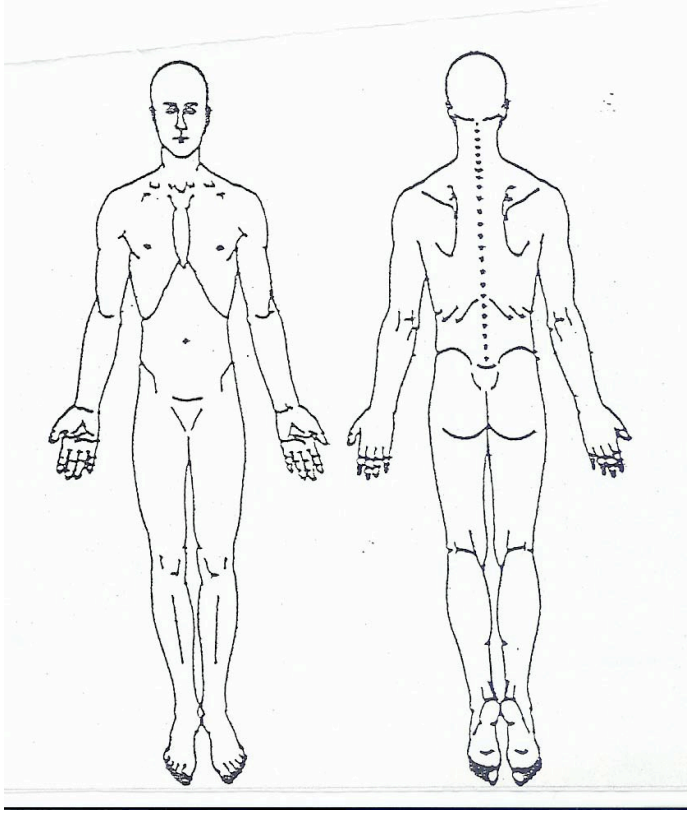
Pain Diagram and Pain Rating

Name: _____ Date: /____/____

INSTRUCTIONS: Please use the diagram below to indicate the symptoms you have experienced over the past 24 hours. Use the key to indicate the type of symptoms.

KEY:

Pins and Needles	= 000000	Stabbing	= / / / / / /
Burning	= xxxxxx	Deep Ache	= zzzzzz



Please rate your current level of pain on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your worst level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Please rate your best level of pain in the last 24 hours on the following scale (check one):

0 1 2 3 4 5 6 7 8 9 10
(no pain) (worst imaginable pain)

Patient Authorization

Patient Name:	Date of Birth:

Release of Information & Consent for Treatment

All information provided herein is true and correct.

I am aware of my diagnosis and wish to receive treatment at this Marketplace Physical Therapy subsidiary or affiliate company. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I consent to rehabilitation and related services at Facility. I understand, acknowledge and affirm that such rehabilitation and related services may involve bodily contact, touching and/or direct contact of a sensitive nature. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Marketplace Physical Therapy and its subsidiaries and affiliates to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it relates to my treatment and/or payment for services provided.

I authorize Marketplace Physical Therapy and/or its subsidiaries and affiliates to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information. **Initial:** _____

Assignment of Benefits

I authorize payment directly to Marketplace Physical Therapy, its subsidiaries and/or affiliates for services and to bill and release payment directly to Marketplace Physical Therapy, its subsidiaries and/or affiliates for any physical therapy, occupational therapy, speech-language pathology, rehabilitation, orthotic or prosthetic services provided.

This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Notice of Privacy Practices (HIPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of The Notice of Privacy Practices for Marketplace Physical Therapy, its subsidiaries, and/or affiliates.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment, and health care operations.

Initial _____

Payment Guarantee

I agree to pay Marketplace Physical Therapy, its subsidiaries and/or affiliates for the services provided to me or the party named above. If any law, such as workers' compensation, or insurance contract prohibits payment for these services I will cooperate and assist in the provision of information, authorizations, releases, or any other type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The Intake & Verification of Benefits Form is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment for services. , I will be responsible for payment for services. I understand that my good-faith payment may not be inclusive of all payments for which I am responsible and I may be billed for any remaining balance.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Physiotherapy Corporation and/or its affiliates or subsidiaries.

Initial _____

Patient Information & Data Sheet

I hereby acknowledge that the information I provided on the Intake Form and the Patient Data Sheet is correct.

Initial: _____

Patient or Guardian Signature:	Date:

Medicare Patient – Therapy Questionnaire

Name: _____ **Date of Birth:** _____ **Age:** _____

Please answer each of the following questions by circling YES or NO and completing the requested information:

Yes No 1. Are you currently receiving **both** Physical Therapy and Speech Language Pathology Services? If yes, Name of the other therapy provider:

_____

Yes No 2. Are you currently receiving any Home Health Services (including nursing, bathing or dressing assistance, injections or respiratory services)?
If yes, what type of Home Health Services are you receiving?

_____

Name of the Agency:

Date of Last Service:

Yes No 3. Do you need to use any special medical equipment as a result of your current problem?

Yes No 4. Since the onset of this current problem, has the need for assistance from family or friends increased?

Yes No 5.Has this current problem resulted in the need to change your living situation?

Yes No 5.a. If yes, is this therapy necessary in order to return to your previous living situation?

6. What type of home environment do you live in **now** (private home, assisted living, etc.)?

_____

7. What type of home environment do you **plan to** live in when you complete this therapy (private home, assisted living, etc.)?

_____

8. Who do you live with (or intend to live with) when you complete this therapy?

_____

Yes No 9. Have you had 2 or more falls in the past year or any fall with injury in the past year?

Yes No 10. Are you in need of therapy services as a result of a fall?

Yes No 11. Are you currently having difficulty with walking, balance or fear of falling?

Thank you for completing this questionnaire. The information above will assist your therapist in providing you the therapy treatment that you need.

_____ _____

Patient Signature **Date** **Therapist Signature** **Date**

MEDICARE SECONDARY PAYER QUESTIONNAIRE

There may be situations where Medicare is not your primary payer or Medicare coverage policies vary. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.
We appreciate your help by completing this questionnaire.

Patient Name: _____ Account #: _____

Responses Section I

☐ Yes ☐ No 1. Are you currently receiving any Home Health Services (including nursing, bathing or dressing assistance, injections or respiratory services)?

☐ Yes ☐ No 2. Are you covered under a Medicare Part C (Medicare Advantage/Medicare+Choice) program?
If YES, enter the name of the health plan: _____

☐ Yes ☐ No 3. Was your illness or injury due to a work-related accident or condition?
If YES, enter the date of illness or injury: _____
Provide the name of your employer on the Patient Registration Form.

☐ Yes ☐ No 4. Was your illness or injury due to a non-work-related accident?
If YES, enter the date of illness or injury: _____
If no-fault, auto, or liability insurance is available, enter information in Section II.

☐ Yes ☐ No 5. If you are entitled to Medicare based upon Age or Disability, are you currently employed?
If YES, provide your employer's information on the Patient Registration form.
If NO, enter your retirement date: _____ ☐ Never Employed

☐ Yes ☐ No 6. Do you have a spouse who is currently employed?
If YES, provide your spouse's employer's information on the Patient Registration form.
If NO, enter your spouse's retirement date: _____ ☐ Never Employed

☐ Yes ☐ No 7. Do you have group health plan coverage based upon your own or your spouse's employment?
If YES, enter your and/or your spouse's group health plan information in Section II.

☐ Yes ☐ No 8. Are you entitled to Medicare due to End Stage Renal Disease (ESRD)?
If YES, enter the date of the kidney transplant: _____ ☐ No Transplant
If YES, enter date that dialysis began: _____ ☐ No Dialysis

☐ Yes ☐ No 9. Are you receiving Black Lung (BL) Benefits?
If YES, enter date benefits began: _____

Section II (Please provide us with your insurance card.)

Type of Insurance Coverage ☐ Workers Compensation ☐ No-fault, Auto, or Liability ☐ Group Health Plan

Insurance Name _____

Street Address _____

City, State Zip _____

Phone Number _____

Policy Number _____

Group Number _____

Name of Policy Holder _____

If Group Health Plan, approximate number of employees: ☐ 1 – 19 ☐ 20 – 99 ☐ 100 or more

I certify that all of the information provided herein is true and correct.

_____ _____
Signature of Patient/Representative Date

Effective 1/1/08

Medicare Financial Responsibility Disclosure

Thank you for choosing our clinic for your therapy needs. As a Medicare provider, we are required to inform you about your responsibilities as a Medicare beneficiary. Please read this notice carefully. If you have any questions, please contact one of our staff.

Patient Financial Responsibilities

Effective, January 1, 2011, you are responsible for an annual $162.00 deductible. (Medicare will only pay for services after expenses exceed $162.00).

Medicare will pay 80% of the allowable charges. You are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy for you. If you do not have secondary coverage or your secondary coverage fails to pay for your services, you are responsible for the payment of the 20%.

If Medicare denies charges because you have other insurance that is considered your primary insurance, you will be responsible for all incurred charges. It is your responsibility to inform us of any other insurance coverage that you may have.

Medicare as the Secondary Payer

There may be situations where Medicare is not your primary payer. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer.

If any of the following items below apply to you, Medicare may not be the primary payer.

- Black Lung Benefits
- Veterans Administration (VA)
- Workers' Compensation
- Automobile Accident, No Fault or Other Liability Insurance
- Employer Group Health Plan (EGHP)
- End Stage Renal Disease Benefits (ESRD)
- Disabled and covered by a Large Group Health Plan (LGHP)

Medicare Part C (Medicare Advantage or Medicare+Choice)

Please notify one of our office staff if your Medicare coverage is Medicare Part C Coverage. Medicare Part C Coverage is also known as Medicare Advantage Program or Medicare+Choice. Medicare Part C coverage is purchased and administered through a private insurance company and includes HMO, PPO, PFFS, PSO and MSA products. Medicare Part C beneficiaries pay premiums that typically provide them with more coverage than the "traditional Medicare programs" (Medicare Part A and B) at a lower cost. Failure to provide us with this information may result in non-payment of your health claims.

Medicare Home Health Services

Medicare has required that patients receiving certain Home Health Services must have outpatient therapy services consolidated with the Home Health Agency. Failure to provide us with this information may result in non-payment of your health claims by Medicare.

You will be asked to complete a Medicare Secondary Payer Questionnaire to ensure that we properly determine whether Medicare is the Primary or Secondary Payer in your case or if Medicare will not allow payment for our services.

Thank you for reviewing this important information regarding your Medicare coverage. If you have any questions, please contact one of our staff.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

Uses and Disclosures of Your Health Information

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of evaluations will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health care operations. Your health information may be used as necessary to support the day-to-day activities and management of the Company. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to improve quality.

Law enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law-enforcement investigations, and to comply with government mandated reporting.

Public health reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. Your health information will be used by our staff to send you appointment reminders.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition or new technology that you may find to be of interest. We may also send you information describing other health-related goods and service that we believe may interest you.

YOUR HEALTH INFORMATION RIGHTS

You have certain rights under the federal privacy standards. These include:

- the right to request restrictions on the use and disclosure of your health information
- the right to receive confidential communications concerning your medical condition and treatment
- the right to inspect and copy your health information
- the right to amend and/or submit corrections to your health information
- the right to receive an accounting of how and to whom your health information has been disclosed
- the right to receive a printed copy of this notice

OUR HEALTH INFORMATION DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

OUR RIGHT TO REVISE PRIVACY PRACTICES

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. The revised policies and practices will be applied to all protected health information that we maintain and will be available at our facility for you upon your request.

REQUESTS TO INSPECT PROTECTED HEALTH INFORMATION

As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Company's Privacy Officer.

COMPLAINTS

If you would like to submit a comment or complaint about our privacy practices, or if you believe your privacy rights have been violated, you can contact the Company by sending a letter outlining your concerns to:

Privacy Officer
Marketplace Physical Therapy
3191 B. Mission Inn Ave.
Riverside, CA 92507

You may also file a written complaint with the Office of Civil Rights.

Effective Date: April 1, 2003

Revised February 1, 2008