PATIENT INFORMATION & BRIEF HISTORY

Patient's Name_____ Date_____

Address_____ City_____ State_____ Zip_____

Phone number_____ Age_____ Birth Date_____

SS#_____ E-Mail Address_____

Emergency contact_____ Phone number_____

Marital Status_____ Spouse's Name_____

Employer_____

Address_____ City_____ State_____ Zip_____

Work Phone_____ Occupation_____

Referred to this office by Doctor_____

Date of Injury_____ Date of Surgery_____

How did this injury occur?_____

Have you had previous physical therapy for your present condition for which you to receive treatment here? Yes_____ No_____

If yes, state where_____ When?_____

The above information is correct to the best of my knowledge.

I hereby authorize Rancho Santa Margarita Physical Therapy and Sports Medicine (RSMPT)/San Clemente Orthopaedic Rehabilitation (SCOR) to provide my insurance company with full information regarding treatment rendered, when so requested.

I hereby authorize my insurance company to pay directly to RSMPT/SCOR medical benefits otherwise payable to me, and I will be responsible to RSMPT/SCOR for all expenses incidental to treatment rendered not paid under this plan.

I hereby render my consent for evaluation and treatment of my injury/illness to RSMPT/SCOR.

Patient Signature_____(or if minor, Parent/Guardian signature)

Parent/Guardian Name_____

Name: _____ **SSN:** _____ **Date:** _____

Leisure activities, including exercise routines: _____

Occupation, including activities that comprise your workday: _____

Age: **Height:** **Weight:**
Are you on a work restriction from your doctor? Yes No **Are you latex sensitive? Yes No**
Do you smoke? Yes No **Do you have a pacemaker? Yes No**
FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No
ALLERGIES: List any medication(s) you are allergic to: _____

Have you RECENTLY noted any of the following (check all that apply)?

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty maintaining balance while walking
- ❑ 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

Have you EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ bone or joint infection
- ❑ chemical dependency (i.e., alcoholism)
- ❑ depression
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ bladder/urinary tract infection
- ❑ kidney problem/infection
- ❑ sexually transmitted disease/HIV
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ osteoporosis
- ❑ multiple sclerosis
- ❑ epilepsy
- ❑ eye problem/infection
- ❑ ulcers
- ❑ liver problems
- ❑ hepatitis
- ❑ pneumonia

Has anyone in your immediate family (parents, brothers, sisters) EVER been diagnosed with any of the following conditions (check all that apply)?

- ❑ cancer
- ❑ heart problems
- ❑ high blood pressure
- ❑ diabetes
- ❑ stroke
- ❑ depression
- ❑ tuberculosis
- ❑ thyroid problems
- ❑ blood clots

During the past month have you been feeling down, depressed or hopeless? **YES NO**
During the past month have you been bothered by having little interest or pleasure in doing things? **YES NO**
Is this something with which you would like help? **YES YES, BUT NOT TODAY NO**

Do you ever feel unsafe at home or has anyone hit you or tried to injure you in any way? **YES NO**

Please list any medications you are currently taking (INCLUDING pills, injections, and/or skin patches):

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____ 2. _____ 3. _____

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

What do you think caused your symptoms? _____

My symptoms are currently: ❑ **Getting Better** ❑ **Getting Worse** ❑ **Staying about the same**

I should not do physical activities that might make my pain worse: ❑ **Disagree** ❑ **Unsure** ❑ **Agree**

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

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

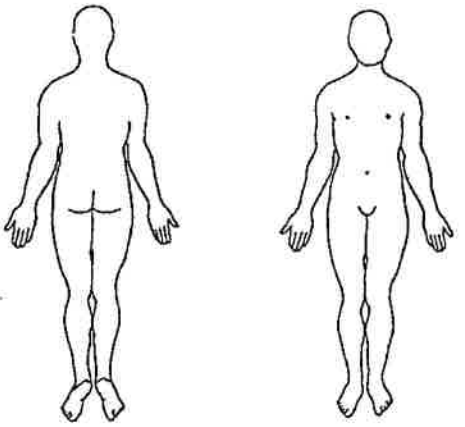
Have you ever had this problem before: ❑ **Yes** ❑ **No** **When**_____ **Treatment rec'd**_____

How long did it take for you to feel better? _____

Body Chart:

Please mark the areas where you
feel symptoms on the chart to the right with
the following symbols to describe your symptoms:

↓ **Shooting/sharp pain**
O **Dull/aching pain**
||| **Numbness**
= **Tingling**



My symptoms currently: ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

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Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?
❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

When are your symptoms worst? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
When are your symptoms the best? ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

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Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:

Your current level of pain while completing this survey:_____

The best your pain has been during the past 24 hours: _____

The worst your pain has been during the past 24 hours: _____

Payment Schedule

We believe that a clear definition of our financial policy will allow us to concentrate on the more important issue of **helping you regain and maintain your health**.

AS A COURTESY, INSURANCE BENEFITS WILL BE VERIFIED FOR OUR PATIENT'S PHYSICAL THERAPY, BUT THIS IS NOT A GUARANTEE OF PAYMENT. IT IS THE RESPONSIBILITY OF THE PATIENT TO KNOW WHAT HIS/HER INSURANCE WILL COVER FOR PHYSICAL THERAPY

Insurance - The patient is responsible for payment in full until the deductible is met. Once the deductible is met, the patient will be responsible for copayments/coinsurance.

- Co-payments are due at each appointment.
- Coinsurance will be accumulated based on the number of visits and billed to the patient.

Aetna- Aetna only allows one Initial Evaluation every 180 days and one Re-Evaluation every 90 days.

Worker's Compensation - Once we have received authorization, the designated insurance will be billed directly.

Auto Accident - No third party billing will be accepted! The proper insurance will be billed directly.

Medicare - All charges not covered by secondary or supplement insurance are the responsibility of the patient.

Cash Patient - Payment will be collected at each appointment.

- $130.00 for the Initial Evaluation
- $90.00 for each additional treatment

**Any supplies including pillows, tubing, braces, supports, etc. are to be paid for when items are received.

Patients who cancel their appointment within 24 hours of the scheduled time will be charged a $40.00 "no show" fee. However**, please do not come in if you are sick** out of respect for our other patients and staff. Cancellations due to illness will not result in a "no show" fee if you notify us before your scheduled appointment time.

_____ *(initial)* ** I have read and acknowledge the cancellation policy. **

I understand and agree that I am ultimately responsible for all charges regardless of my existing medical coverage. I also understand and agree that if it becomes necessary to commence legal action for the collection of any outstanding charges on my account, I will be responsible for any and all legal fees/court costs in addition to the outstanding balance.

I UNDERSTAND AND AGREE TO THE ABOVE TERMS AND RESPONSIBILITIES OF PAYMENT.

SIGNATURE _____ DATE_____

SCOR/RSMPT
PATIENT INFORMATION CONSENT FORM

I have read and fully understand SCOR/RSMPT's Notice of Information Practices. I understand that SCOR/RSMPT may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluation of the quality of services provide and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice. I also understand that SCOR/RSMPT will consider requests for restriction on a case-by-case basis, but does not have to agree to requests for restrictions.

I hereby consent to the use and disclosure of my personal health information for purposes as noted in SCOR/RSMPT's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____
Patient Name

_____
Signature

_____
Date

RSMPT & SCOR use a team approach to patient care. You will be seen by a licensed Physical Therapist on each visit, and under his or her supervision, part of the treatment may be delivered by a PTA (licensed Physical Therapist Assistant), ATC (Athletic Trainer Certified) or PT Aide.

Initials_____

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY

RSMPT/SCORPT/SCOR'S LEGAL DUTY

RSMPT/SCORPT/SCORPT is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

RSMPT/SCORPT uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities and evaluating the quality of care that we provide. For example, RSMPT/SCORPT may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives, or other health related benefits that could be of interest to you. RSMPT/SCORPT may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes and for emergencies. We also provide information when required by law.

In any other situation, RSMPT/SCORPT's policy is to obtain your written authorization before disclosing your persona health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

RSMPT/SCORPT may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request payment or other related administrative purposes.

You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. RSMPT/SCORPT will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that RSMPT/SCORPT may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed at the top of this page. You may also send a written complaint to the US Department of Health and Human Services. For further information on RSMPT/SCORPT's health information practices or if you have a complaint, please contact us at the address listed below.

RSM Physical Therapy
(949) 459-9010
SCOR Physical Therapy
(949) 496-0122
Craig A. Legacy, DPT Daniel A. Souza, DPT

2018 Medicare Cap on Therapy Services

Home Health Services & Outpatient Therapy:	
Beneficiaries receiving ANY type of home health services are ineligible for outpatient physical therapy.	
❑ Yes ❑ No	Are you currently receiving ANY home health services?
❑ Yes ❑ No	Have you received ANY home health services (nursing, therapy, etc…) in the last six months? If Yes, indicate date services ended:

2018 Therapy Cap Summary:	
Medicare has placed a financial limitation of $2,010 on the combined amount of physical therapy and speech-language pathology services for dates of service from January 1, 2018 through December 31, 2018. The cap excludes services provided at hospitals. The cap is based on the Medicare allowed fees. Based on our typical visit patterns, you may reach the cap after approximately 17 visits. If you are close to reaching the cap we will review the available options with you. Medicare has defined automatic and manual exceptions. We will inform you if you appear to be eligible for an exception and will institute the appropriate steps with Medicare. We believe that continuity of care is critical to reaching maximum function and returning you to an active lifestyle. Therefore, we have developed special programs to assist our patients that have reached the cap in continuing care here at SCOR/RSMPT. We will keep you informed about your options.	
❑ Yes ❑ No	Have you received ANY outpatient physical therapy since January 1, 2018? If Yes, indicate: Where: When:
❑ Yes ❑ No	Have you received ANY speech-language pathology services since January 1, 2018? If Yes, indicate: Where: When:

My signature below indicates that I have read and understand the above information regarding the Medicare Therapy Cap and have had all my questions answered.	
Signature:	Date:

Daniel A. Souza PT, DPT
Craig A. Legacy PT, DPT

Patient Options When Therapy Cap Has Been Reached

The maximum benefit in allowed fees that Medicare provides for combined physical therapy and speech-language pathology services for 2018 is $2,010. This form serves as the **Notice of Exclusions from Medicare Benefits (NEMB)** required by Medicare regulations.

There are items and services for which Medicare <u>will not pay</u>.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed decision about whether or not you want to receive these items or services, knowing that you will be responsible for paying. **Before you make a decision, you should read this entire notice carefully.** Ask us to explain if you do not understand why Medicare won't pay and/or how much these items or services will cost you (see the options below with estimated costs).

- Medicare will not pay for the following reason: Physical Therapy and Speech-Language Pathology services combined over $2,010 in 2018
- Medicare will not pay for the following reason: Occupational Therapy services combined over $2,010 in 2018

(Please note that our hand therapist is a Certified Hand Therapist (CHT), not an Occupational Therapist (OT). Any hand therapy you have here will fall under the physical therapy category)

Your therapist may believe that continued physical therapy care is in your best interest due to functional limitations that remain. Our goal is to help you reach the maximum functional level. We recognize that continued care will have a financial impact on you and want to work with you to minimize that impact. Therefore, we have developed a number of options including reduced fees for cash payments, reduced frequency or length of visits, combined post-rehab fitness program with intermittent therapy or other options.

When we are familiar with you and your therapy needs, your therapist may believe that the following options would provide you the appropriate level of care to maximize your functional gains.

Continue with therapy at our special cash discount rate: $75.00 (plus occasional other fees)

Continue care at a hospital outpatient department that is not limited by the cap. Patient remains responsible for any co-payment amounts.

My signature below indicates that I have read and understand the above information regarding the Medicare Therapy Cap and have had all my questions answered.	
Signature:	Date:

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

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

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Electrode Pads By signing below, you will be getting your own set of electrode pads for hygenic purposes.	Electrode pads are considered a supply This is a one time fee, you will NOT be paying $20 at every visit. If you are absent for two months or longer, we must discard your electrodes. We suggest you take your electrode pads home when you have been discharged. If you need to return for physical therapy at a later date just bring your electrodes back to avoid the fee.	$20.00

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.** Electrodes 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.** Electrodes 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.** Electrodes 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.** Electrodes 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: