Consent to Treat/Release of Information

CONSENT TO EVALUATE AND TREAT

I do hereby consent to the evaluation and treatment by TwinBoro Physical Therapy Associates. I understand that it is my right to accept or refuse any treatment offered me. I acknowledge and understand that no guarantee has been made to me as to the results that may be obtained from such treatment.

RELEASE OF INFORMATION

I authorize TwinBoro Physical Therapy to release information from my medical record, whether it be written, video, photographic, audio or verbal, to my physician and/or any third party payor (such as insurance company or governmental agency) for its use in processing claims for payment. I understand the nature of the authorization and have been informed that I have the right to revoke consent at any time by written communication with custodians of records. I consent to the release of medical information to ____________________________________ for communication and care coordination on by behalf.

PRIVACY PRACTICES

I acknowledge receipt of the TwinBoro Notice of Privacy Practice, which I have received at the time of this initial visit or previously.

ASSIGNMENT OF BENEFITS

I request that payment of Medicare and/or other insurance benefits be made on my behalf to TwinBoro Physical Therapy Associates for any services furnished to by TwinBoro Physical Therapy.

FINANCIAL AGREEMENT

The undersigned agrees, whether signing as agent or patient, that s/he individually obligates her/himself to pay for services rendered in accordance with the regular rates and terms of TwinBoro Physical Therapy Associates. TwinBoro will verify insurance benefits on behalf of the patient. Verification is no guarantee of payment. The agent/patient is responsible for any co-payment, deductible, coinsurance and all amounts identified by the insurer as the patient's responsibility.

iNSURANCE COVERAGE

I understand that if I fail to disclose any effective insurance coverage at the time of this signing or after the first service date when said insurance became effective, I can be held responsible for any balances not covered by said insurance. This includes balances due to lack of authorization.

- ❑ I do not have secondary coverage
- ❑ I choose not to use my secondary coverage

HOME HEALTHCARE

As a Medicare beneficiary, I am aware that I can not receive physical therapy through an independent clinic if I am currently enrolled with a Home Healthcare Agency. If services were provided and I was not formally discharged by the agency, I realize that I will be held responsible for services denied by Medicare.

_________ I have received some form of home healthcare   __________ I have not received some form of home healthcare
Patient Initials   Patient Initials

MEDICARE PRIMARY HORIZON BLUE CROSS BLUE SHIELD SECONDARY

Although Medicare will cover an evaluation and/or re-evaluation procedure, Horizon BCBS does not pay for these procedures. Should Horizon deny, the patient will be held responsible for the Medicare coinsurance on these and any other services Horizon deems patient responsibility.

The undersigned certifies that s/he has read, understood and accepts the terms of this form, received a copy, and is the patient or is duly authorized by the patient as the patient's general agent to execute this form.

___________________________________   ____________________________
Signature of Patient or Responsible Party   Date

___________________________________   ____________________________   ________________________
Witness   Date   Account Number

Dear Patient,

Welcome to our practice. Thank you for your confidence and trust in scheduling an appointment with our clinic. We are always dedicated to quality care for all our patients and we are always here to discuss your problems and find together the most appropriate solution. Our office patient policies are as follows. Please read carefully the following policies and sign below.

GENERAL OFFICE POLICIES

1) We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in ***to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible.***
2) There is a **$25.00** charge for a no show or cancellation without proper notice. This charge will probably not be covered by your insurance company, but will have to be paid by you personally.
3) You should understand that when you no-show, three people get hurt: 1) yourself because you don't get the treatment you need as prescribed by the doctor and our staff, 2) the therapist who now has a "vacancy" in their schedule since the time was reserved for you personally, and 3) another patient who could have been given treatment if you had given us proper notice.
4) **Regarding Lateness:** If you are late, you may not get in your full treatment because it would mean other patients are delayed.
5) **Regarding Being Early:** We will do our best to get you in as soon as possible. Most of the time you'll have to wait until your scheduled time to be seen because there are other patients who are still in treatment.
6) For your health's benefit we have developed both a formal evaluation process and a discharge process. In each of these, the Physical Therapist prepares a report for your doctor.
7) Please understand that your insurance policy is a contract between you and your insurance company. While we may accept your insurance as payment, your contract with us is a separate agreement. In other words, if your insurance refuses to cover a certain treatment or otherwise fails to pay us, your contract with us still exists, and you are responsible for payment personally.
8) ***Co-pays, deductibles, and payments*** if you are a self-pay patient, are due at the time of service. We accept payments by credit card, cash, check or money order **only.**
9) We will allow, on special occasions, a long term payment plan budgeted on the individual according to need. In any event, if you request such a plan, you will sign a written agreement which must be given final approval by the Clinical Director.
10) If at any point you have a problem regarding billing and payment, talk to our secretary and they will arrange for you to see our office manager.

After you have read carefully the above, please sign the following:

I ____, agree to be treated in this Physical Therapy clinic by the Physical Therapist and their staff and I also agree with the terms specified above.

____	__________________
Patients Signature	**Date**

MEDICAL HISTORY

NAME:_______________________________________AGE:__________DOB:_________________

Weight:________Weight: 5yrs. Ago____________Height:___Height: 5yrs. Ago__________

Doctors: Family:_____________________________Referring:__________________________________

Others:____

Please check if you have any of the following:

______________Allergies
______________Anemia
______________Arthritis
______________Bone Loss(Osteoporosis, Osteopenia)
______________Cardiac (MI, Arrhythmia, Angina)
______________Cancer
______________Cerebral Palsy
______________COPD
______________CVA (stroke)
______________Diabetes
______________Hearing Loss
______________High Blood Pressure
____________Hypoglycemia
____________Kidney Disease
____________Liver Disease
____________Lupus
____________Multiple Sclerosis
____________Parkinson's
____________Polio
____________Seizure Disorder
____________Thyroid(hyper,hypo)
____________Visual Loss
____________Other_______

Past Surgeries:

	TYPE	DATE
1.	________________________	________________________
2.	________________________	________________________
3.	________________________	________________________

Have you ever broken any bones?:____

Past motor vehicle accidents?:____

Are you taking any medications?:____

Please list:____

Do you have any metal implants?:____

Are you, or do you think you may be, pregnant?: Yes__________ No__________

Do you have children?: Yes_________ No ____________ Ages:____________________

Do you smoke?: Yes_________ No_______How long have you smoked?________________

What sports or recreational activities do you participate in?:_________________________

____

Briefly describe your present problem:_____________________________________

____

Are you working?: Please circle from the following: Full Time Part Time Retired
Student Not Employed

Occupation:_______________________________

WELCOME 2012 Medicare Beneficiary!

Dear Patient:

Welcome to Twin Boro Physical Therapy, where we have been committed to serving all our patients' with the highest quality of care, helping each patient achieve their goal of feeling a difference!

As of January 1, 2012, Congress has voted for the Medicare financial limit or cap for physical and occupational therapy to be extended until the end of 2012.

The limit has been set to $1880.00 per year.

What does this mean to you?

As a patient in an outpatient facility, you are entitled to $1880 of coverage for your outpatient physical therapy and speech therapy combined and $1880 of coverage for outpatient occupational therapy. This limit is for the year and not per diagnosis.
If you have received physical or occupational therapy within the calendar year, either with us or with another provider, please notify our front office staff.

We, as a provider, are responsible for accessing your progress throughout your treatment. As you approach the limit imposed by Medicare, your therapist will discuss with you whether or not continued treatment is considered medically necessary and will result in an improved outcome or maintain your current status. We will assist you in making an informed choice about continuing therapy after meeting the limit set by Medicare.

Medicare does give the beneficiary the option of continuing to treat with your current Outpatient Physical Therapy facility if treatment is considered medically necessary, or at your request, you may continue to obtain treatment at a Hospital Outpatient Therapy Facility, where Medicare will continue to cover your treatment after the Medicare limit has been met.

Should you choose to continue your services with Twin Boro Physical Therapy after the therapist determines that any additional progress will be limited and is not considered medically necessary, you will treat as a self pay patient, responsible for $65.00 per visit.

We appreciate that you have chosen Twin Boro Physical Therapy to provide you with your therapeutic care.

We will do our utmost to assist you with any questions you may have concerning this new cap put into effect for the 2012 calendar year.

Thank you.

Patient's Initials ______

Medicare Secondary Payor Questionnaire

Patient Name: ____________________ Clinic Name: ____________

Medicare ID #: ____________________ Patient Account #: ____________

Date: ____________________

1	Are you entitled to Medicare Based on	Age (65 and over)	YES	NO
		Disability	YES	NO
		End Stage Renal Disease	YES	NO
2	Do you receive Veteran's Benefits?		YES	NO
3	Are you receiving benefits under the Black Lung Program?		YES	NO
4	Was this injury due to a work-relate accident or condition?		YES	NO
	If YES, indicate accident date and complete # 10		____________	
5	Was this injury due to an automobile accident?		YES	NO
	If YES, indicate accident date and complete # 10		____________	
6	Was this injury related to an accident in which you intend to file a liability suit or litigation is pending?		YES	NO
	If YES, indicate accident date		____________	
	If YES, please provide attorney name:	____________		
	attorney address:	____________		
	attorney Phone:	____________		
7	Are you currently employed?		YES	NO
	If NO, indicate date of retirement		____________	
8	Are you currently receiving primary health coverage from current or previous employer?		YES	NO
	If YES, complete # 10			
9	Is your spouse currently employed?		YES	NO
	Do you have coverage under a group plan through spouse's employer?		YES	NO
	If YES, does the employer have more than 20 employees?		YES	NO
	If YES complete #10			

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Insurance Name: ____________________

Policy ID #: ____________________

Phone Number: ____________________

Subscriber's Name ____________________