



LAFAYETTE PHYSICAL THERAPY, INC.

Patient Information

| | | | | |
|---|--|------------|------------|----------------|
| Last Name <small>(Legal Names Please)</small> | First Name | MI | Sex M F | Marital Status |
| Home Phone Cell/Alternate | SSN | DOB | | AGE |
| Address (No P.O. boxes please) | City | State | | Zip |
| Employer | Occupation | Work Phone | | |
| Employer Address | City | State | | Zip |
| Guarantor Name | Guarantor Employer | DOB | | Phone |
| Emergency Contact Person | Relation | Phone | | |
| Referring Doctor | How did you hear about us? <input type="checkbox"/> Doctor <input type="checkbox"/> I am returning <input type="checkbox"/> Website <input type="checkbox"/> Internet Search <input type="checkbox"/> Friend/Family <input type="checkbox"/> Other: _____ | | | |
| Automated Appt. Reminders: Please select one phone number &/or e-mail to receive appt. reminder notifications on <input type="checkbox"/> Home <input type="checkbox"/> Cell/Alternate <input type="checkbox"/> Work <input type="checkbox"/> Email: _____ <input type="checkbox"/> No reminder | | | | |
| Would you like to receive our e-mail newsletter – sent approximately 2 times per year? <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | |

FOR OFFICE USE ONLY: Our front desk will fill out this portion upon your arrival

Insurance: The following benefits were quoted to us by your insurance company. This is not a guarantee of payment by your insurance. You are responsible for knowing your benefits.

- _____ Patient is eligible for benefits: Effective Date: _____ to _____
- Prior authorization is required Month to month coverage
- Coverage is based on medical necessity Rx required

Benefits Information:

\$ _____ Max \$ Per year, \$ _____ remaining

_____ Max visits per year, _____ visits used, _____ remaining

_____ % Insurance pays, _____ % patient co-insurance, we will collect \$ _____ per visit* ↴

\$ _____ Total deductible, \$ _____ deductible met, collect \$ _____ per visit toward deductible* ↴

\$ _____ Out of pocket, \$ _____ out of pocket met

\$ _____ Copayment: _____

_____ Combined Coverage: _____

_____ Other/Secondary Info: _____

*The amount collected toward your deductible and/or co-insurance each visit may be LESS than what your total financial responsibility is. You will receive a bill for the remaining balance once your insurance processes your claims and info is received.

I certify that the information provided is true and accurate. I authorize Lafayette Physical Therapy, Inc (herein referred to as LPT) to bill my insurance carrier, and instruct my insurer to pay any benefits directly to LPT. I understand that any charges not covered by my insurance will be my responsibility. I agree to pay LPT any amount due after my insurance company has paid or made a decision on my claims. **Should my insurance pay me directly, I agree to forward the payment to LPT.** Co-payments and deductibles are due at time of each visit and co-insurances will be billed to you after we receive confirmation from your insurance. **Account balances are due upon receipt of a statement.** I authorize the release of any medical information necessary to process my claims. I authorized my insurance carrier to provide LPT with detailed benefits information. I authorize LPT to leave messages on the phone numbers I have provided. I may chose to not have messages left on the phone number provided by submitting a request in writing. I have read and understand the above information. A photocopy of this agreement shall be as valid as the original.

ATTENTION: Please sign after the insurance information is entered by the front desk.

Patient/Guarantor Signature _____
Date



Patient Policies and Agreements

Thank you for choosing Lafayette Physical Therapy for your physical therapy needs. We look forward to a rewarding relationship with you throughout your plan of care. The policies below are important to our relationship and assist us in providing you with the best quality care. Please let our staff know if you have any questions.

- Initial
1. **Copayments, Deductibles and Co-Insurances:** Copayments are due at the time of service. Lafayette Physical Therapy, Inc. (herein referred to as "LPT"), asks that you pay a reasonable amount towards your deductible and/or coinsurance each visit. This collected amount typically does not cover your total share of cost. The front desk will inform you of your balance and you will receive a monthly statement when deductible and co-insurance balances are updated.
- Initial
2. **Account Responsibilities:** It is your responsibility to know your insurance coverage including deductibles, co-payments, visit limits, etc. Please verify your coverage with your insurance company. As a courtesy to you we will verify and bill your insurance carrier, however, you are ultimately responsible for the payment of your bill. You are responsible for any account balances not covered under your insurance, including deductibles and co-insurance amounts based on your insurance contract. Please be advised that a quote of eligibility and benefits is not a guarantee of payment. All benefits are subject to the eligibility, medical necessity, and the terms, conditions, limitations and exclusions of your individual health benefit plan at the time that the services are rendered. In the event that your insurance refuses to pay or does not pay within 90 days, you will be responsible for your balance in full. Many insurance companies have additional conditions that may affect your coverage. If your insurance carrier denies any part of your claim, or if you elect to continue therapy past the approved period, you will be responsible for your account balance.
- Initial
3. **Late Policy:** Please be on time for your appointments. A professional staff member has been scheduled to treat you specifically. If you are late by 10 minutes or more you may be required to reschedule or wait for the next available appointment. If you are unable to be seen due to tardiness you will be charged the no show fee below. If you are running late please call our office as soon as possible so we can attempt to accommodate you at a later time.
- Initial
4. **No Show & Cancellation Policy:** Our professional staffing is planned to accommodate scheduled visits. There is a \$65.00 charge for no show or same day cancellations (cancellations with less than a 24 hour notice for Tue-Fri appointments and notice after 3pm Friday for Monday appointments). LPT may discharge patients who fail to attend their scheduled appointments. Workers Compensation patients cannot be charged for missed visits, however, we are required to report them to your case manager which may affect your claim, and you may be required to schedule same day appointments only.
- Initial
5. **Overdue Accounts & Fees:** Balances are due upon receipt of a statement or being notified by the front desk. Accounts 60 days or more overdue may be assessed a late fee of \$25 and assigned to a collections agency (Transworld Collection Agency). A \$25.00 fee will apply to any returned checks.
- Initial
6. **Financial Hardship:** If you are experiencing difficulties and are unable to afford the cost of your therapy services please inform the front desk and our office will go over your options with you. Please let our office know immediately.
- Initial
7. **Insurance Changes:** It is your responsibility to notify our office of any changes to your insurance. In the event that you do not inform us of an insurance change and your insurance does not pay you will be responsible for the unpaid balance.
- Initial
8. **Insurance Ownership:** I guarantee that the insurance and personal information I have provided is true and correct and this is NOT a third party (someone else's) insurance, and that I am a direct beneficiary (self, spouse, or child) of the policy holder.

Patient Policies and Agreements Continued

Initial
9. **Cell Phones and Distractions:** As a courtesy to other patients and our staff please silence your cell phone while you are in our office. Please do not allow your phone to detract from your treatment. If you are unable to attend your full treatment due to urgent phone conversations you may be asked to re-schedule. A missed appointment fee may apply.

Initial
10. **Children Requiring Supervision:** Please do not bring children to your appointments that require supervision. Your full attention is required for your full treatment. You may bring children who are capable of waiting for you in the waiting room unattended. We appreciate your understanding.

Initial
11. **Informed Consent:** I understand the expected benefit of physical therapy and I understand that I can refuse any procedure prior to its performance. I hereby consent to the procedures which may be performed while I am a patient of LPT under the direction of a Licensed Physical Therapist. This may include but not limited to: examination/evaluation, physical testing, application of modalities such as hot/cold pack, electrical stimulation, ultrasound, etc, application of therapeutic procedures intended to improve function including therapeutic exercises, neuromuscular rehabilitation, gait training, manual or mechanical traction, soft tissue mobilization, joint mobilization, and any other procedure under the scope of physical therapy practice.

Initial
12. **Important Notice from the Federal Government:** “It is unlawful to routinely avoid paying your copay, deductible or coinsurance payments...even if your medical office allows it. Unless you complete a “Financial Hardship” form and qualify for financial assistance under the Federal Standards, you may not routinely evade paying your responsibility portions for medical care as outlined in your insurance plan...” [Federal Register, December 19, 1994, the Office of Inspector General (OIG).] Contact the Office of the Inspector General, Department of Health and Human Services for more information: (202)619-1343, paffairs@oig.hhs.gov.

Initial
13. **Privacy Acknowledgement:** I understand that I have the right to review LPT’s notice of privacy practices prior to signing this document. The full notice is posted in the waiting room and I have read and understand the notice. The notice of privacy practices describes the types of uses and disclosures of my protected health information and is summarized below. I further acknowledge that I have the right to request a copy of the notice.

Consent to Use and Disclose Health Information: I also understand that when necessary, LPT or anyone affiliated with our organization may contact me at any phone number provided. Your verbal communication and clinical records are strictly confidential. The following are the ways that we use your information and communications: (1) Treatment: information shared with our staff to provide quality treatment and billing, (2) Payment: information on your diagnosis, dates, treatment, etc. shared with your insurance company to process your claims, (3) Internal Administrative Activities: including quality control audits, software updates, etc, (4) Appointment Reminders: may be provided to a phone number or e-mail of your choosing. You may discontinue reminder calls or emails at any time by contacting our office in writing. (5) When required by Law, (6) To inform you of treatment alternatives or update you on relevant products or services offered, (7) Emergencies, (8) When you sign a release to have information shared.

Initial
or N/A
14. **Permission to Treat a Minor:** I consent to _____ being treated as a patient by LPT. I understand that at times it may be necessary to schedule appointments during school hours and that it is my responsibility to ensure he/she is on time for his/her treatment.

Parent or Legal Guardian Name

Signature

Date

Thank you for your cooperation.

I have read and understand the above policies and agreements.

Patient Name (Or Parent/Guardian if under 18)

Signature

Date



LAFAYETTE PHYSICAL THERAPY, INC.

Medicare Coverage Requirements & Information

Prescription: A current referral from your treating Medical Doctor is required for Medicare to cover your physical therapy treatment. This “certification” for treatment is valid for 90 days. If treatment is needed beyond 90 days we will obtain a signed recertification from your physician prior to expiration.

Medical Necessity and Measurable Progress: Medicare only covers medically necessary treatment. Patients must show measurable progress during their treatment, **maintenance therapy is not covered.** Medical necessity is determined by your physician and your physical therapist.

Home Health Care: You may **not** receive home health care and outpatient physical therapy simultaneously. You must be discharged from home health care in order for Medicare to cover your outpatient physical therapy treatment.

Yes **No** Have you received any home health services this year?

Yes **No** Have you been discharged? **Date:** _____ **Agency Name:** _____

Medicare Therapy Cap: Medicare has placed a monetary cap of \$1880 for therapy services in 2012.

- The \$1880 cap combines **physical therapy and speech therapy.** (Approximately 15 visits).
- Some patients may be exempt from the cap based on Medical Necessity. You will be informed about the eligibility of your status prior to reaching the cap. Pending legislation for 2012.
- If the cap is reached and you are **not** exempt, you will have the option to continue your treatment at our clinic via private pay or wellness program.
- If you have received any outpatient physical therapy or speech therapy this year you need to inform our office so we can determine how much of the cap is remaining.

Yes **No** Have you received outpatient physical therapy or speech therapy this year?

Yes **No** If yes, was your diagnosis the same as the one we will be treating you for?

Where did you receive your treatment? _____

Other Coverage: Medicare needs to know if you have alternative coverage for your therapy expenses.

Yes **No** Do you have group health coverage through an employer?

Yes **No** Are you seeking treatment for an injury or illness caused by a work, auto or other accident?

Yes **No** Are you taking legal action in regards to the condition you will be treated for?

Medicare Billing: Medicare will be billed for your treatments in accordance with Medicare guidelines.

- After Medicare pays their portion they will forward the balance of the claim to you or your **registered** secondary insurance for payment “crossover” if you have a secondary insurance. **It is your responsibility to register your secondary insurance with Medicare.**
- If your account has a balance after Medicare and your secondary insurance (if applicable) has paid, you will be billed for the remaining balance. It is your responsibility to know what your secondary insurance will cover.
- **Medi-Cal:** Lafayette Physical Therapy, Inc. is **not** contracted with **Medi-Cal**. If you have Medi-cal you will be responsible for the remaining balance after Medicare pays their portion.

Medicare Deductibles and Coinsurance for 2012:

- You have a \$140 deductible per calendar year.
- You are responsible for a 20% coinsurance if your secondary insurance does not pay.

Name

Signature

Date



LAFAYETTE PHYSICAL THERAPY, INC.

Medical History and Pain Questionnaire

Name: _____ Date: _____ Age: _____

1) Have you ever had any of the following problems or conditions?

| Now | Past | Never | | Now | Past | Never | | Now | Past | Never | |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|--------------------------|-------------------------|--------------------------|--------------------------|--------------------------|---|
| <u>Heart Disease</u> | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Congestive Heart Failure (CHF) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure Meds |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angioplasty | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Vascular Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Coronary Artery Bypass Graft (CABG) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stents | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Atherosclerotic Disease (CAD) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arrhythmia | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <u>Lung Disease</u> | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic obstructive pulmonary disease (COPD) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Chronic Bronchitis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia | | | | |
| <u>Vascular Disease</u> | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acquired Respiratory Distress Syndrome | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Stroke/TIA | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Peripheral Artery Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hypertension | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | | | | |
| <u>General Medical Conditions</u> | | | | | | | | | | | |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis (rheumatoid/osteoarthritis) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Broken Bones | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Gastro Intestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Incontinence | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Kidney, bladder, prostate, urination problems |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Neurologic Disorders - MS, parkinsons, etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Dizziness/ Nausea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Metal pins/plates post fracture |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Visual Impairment - cataracts, glaucoma, macular degeneration | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, HIV, or AIDS | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | MERSA/Staph infections/other infections* Specify |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Back Pain (neck pain, low back pain, degenerative disk disease, spinal stenosis, etc.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prosthesis/ Implants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hearing Impairment: very hard of hearing, even w/hearing aids |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Sleep Dysfunction | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Depression | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Allergies (Specify) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Numbness or Tingling | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Headaches | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Pregnancy |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Anxiety/ Panic Disorders | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Seizures |

If YES to any of the above, please explain:

PLEASE FILL OUT BACK PAGE ↗

2) Have you ever had **Physical Therapy** treatment before? Yes No

If yes, when and what was it for? _____

3) Have you ever taken **steroids (ie: asthma inhalers)** for an extended period of time? Yes No

4) Have you ever taken **anti-coagulants (ie: Aspirin)** for an extended period of time? Yes No

5) Do you **smoke**? Yes No If yes, how much and how often? _____

6) Have you had an **unusual weight loss or gain** recently? Yes No

7) Please list **ALL surgical procedures** you have had in the past and give the dates if possible:

8) Please list **recent diagnostic studies (X-Ray, MRI, CAT, etc.)** and give dates if possible:

9) List any **medications** you are now taking. (Prescribed and over the counter: provide list if available)

10) Briefly describe the **history of your present injury, accident, or illness:** **Date of Injury:** _____

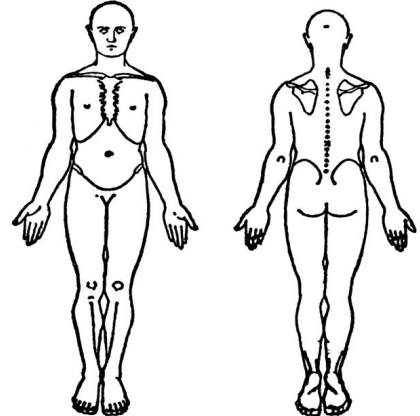
11) Do you have any pain with your condition? Yes No [If "Yes", please answer 11a-c]

a) What **aggravates** your pain?

- Bending Twisting Reaching
 Sitting Standing Walking
 Driving Other: _____

b) What **eases** your pain?

- Stretching Standing Changing Positions
 Lying Down Cold No Movement
 Walking Heat Massage
 Sitting Other: _____



c) For the **current** condition, on a scale of **0 to 10**

Visual Analog Scale: 0 Being no pain, and 10 being worst pain ever.

What is your: Pain level **today**: _____ Pain at its **best**: _____ Pain at its **worst**: _____

12) Please **indicate and describe** on the body chart the **area of your problem(s) and/or your discomfort**.

13) Have you **fallen** in the past year? Yes, ____ times. No

If Yes, Did you sustain any **injuries** from the fall(s)? Yes No

Please explain the circumstances surrounding the fall(s) that you are reporting above, including injuries.

Patient Signature

Date