E6 PHYSICAL THERAPY PAST MEDICAL HISTORY FORM

Patient name:_____ Today's date:_____

Doctor's name referring you to physical therapy:_____
Date of next doctor visit?_____
How long have you had these symptoms/injury?_____
Are you presently working? Y N
Have you had these symptoms before? Y N
Have you had recent surgery for these symptoms? Y N Surgeon's name:_____
Do you smoke? Y N
Do you participate in any sports, exercise programs or activities on a regular basis? Y N

Have you had any diagnostic testing for these symptoms?

☐ X-ray Date:_____ ☐ CT Scan Date:_____

☐ MRI Date:_____ ☐ Injections Date:_____

☐ EMG/NCV Date:_____

Check the item that best describes how your symptoms occurred:

____Work related injury ____Motor vehicle accident ____Lifting injury
____Athletic/recreational injury ____Unknown ____Other (explain)_____

Please check if you have, or ever had any of the following:

☐ Diabetes	☐ Chest Pain/Angina	☐ Stroke (CVA)/TIA
☐ Heart Attack	☐ Heart Palpitations	☐ Allergies to aspirin
☐ Seizures	☐ Heart Disease	☐ Allergies/poor tolerance to heat/cold
☐ Hernia	☐ Pacemaker	☐ Other Allergies
☐ Cancer	☐ High Blood pressure	☐ Metal Implants
☐ Headaches	☐ Asthma/Breathing difficulties	☐ Skin Abnormalities
☐ Recent Fractures	☐ Dizziness/Fainting	☐ Sexual Dysfunction
☐ Nausea/Vomiting	☐ Rheumatoid Arthritis	☐ Bladder/Bowel Abnormalities
☐ Surgeries	☐ Kidney problems	☐ Liver/Gallbladder problems
☐ Ringing in your ears	☐ Special Diet guidelines	Are you currently pregnant? Y N

Are you currently taking medication? Y N
If yes, give name & the condition it's for:

_____
_____
_____
_____
_____

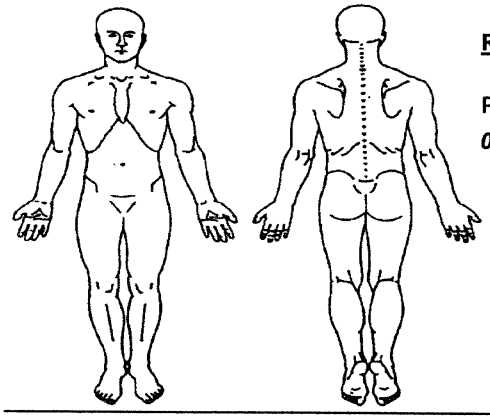
Is there any other information about your past medical history that we need to know?

_____
_____
_____
_____
_____

Pain / Symptoms:

On the Body Diagram, indicate your region of pain using the symbols below.

(X) : Sharp (+): Numb/Tingling (#): Dull/Aching (B): Burning



Rate your Pain:

Pain Level (0-10):_____

0=No Pain & 10= Emergency Room

_____
Patient or Guardian Signature & Relationship to the Patient

_____
Date of Signature

E6 Physical Therapy

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your claim with your insurance company; however, we cannot guarantee payment. We strongly suggest that you read your policy manual as it pertains to physical, occupational or speech therapy coverage. Many insurance companies have stipulations that limit the benefit in some way, such as sessions, supplies, deductibles, co-pays, etc. These stipulations should be noted in your policy manual. ***Please see E6 Physical Therapy's Financial Notice for further information regarding the benefits we were quoted.***

SUPPLIES POLICY

Payment for all supplies not covered by insurance is due at the time of service.
MEDICARE PATIENTS: Medicare does not cover supplies. You are responsible for payment for all supplies used in your treatment at the time of each visit.
ITEMS NOT COVERED BY YOUR INSURANCE ARE YOUR RESPONSIBILITY. We have an agreement with you, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly. WORKER'S COMPENSATION benefits will be verified; however, this does not guarantee payment. In the event of a denial, this account will become YOUR RESPONSIBILITY.

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to E6 Physical Therapy. A representative for E6 Physical Therapy will describe for me my individual treatment plan. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternatives to the treatment plan that was prescribed by my physician and/or recommended by my therapist. ***By signing this agreement, I consent to have E6 Physical Therapy provide treatment and care as prescribed by my physician and/or recommended by my therapist.***

The statements are true and complete to the best of my knowledge. I understand fully the payment policies and billing procedures of E6 Physical Therapy. I hereby authorize E6 Physical Therapy to furnish my insurance company(s), attorney, or legal representative all information that said parties might request concerning my present illness or injury. I hereby assign E6 Physical Therapy all money to which I am entitled for medical expenses related to the service reported herein, but not to exceed my indebtedness to E6 Physical Therapy. I also designate E6 Physical Therapy as an authorized representative to act on my behalf to appeal any denials of benefits and to pursue any remedies otherwise available under law, including under ERISA (Employee Retirement Income Security Act). It is understood that any money received from the above named parties over & above my indebtedness will be refunded to me when my bill is paid in full. ***I am financially responsible to E6 Physical Therapy for charges not covered by my insurance company. By signing this document, I, the undersigned, have read the above items, understand the above items and agree to the items as outlined above.***

Patient Name ***(please print)***: _____

Signature & Relationship to Patient ***(self, parent or legal guardian)***: **Date:**

BUSINESS DISCLOSURES TO INDIVIDUALS INVOLVED IN THE ABOVE NAMED PATIENT'S CARE

I, _____, authorize E6 Physical Therapy to disclose my health information that is directly related to my current treatment to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

EMERGENCY CONTACT INFORMATION

Name: **Relationship to Patient:** **Phone#** ***(incl Area Code)***: ( )

E6 Physical Therapy
FINANCIAL RESPONSIBILITY STATEMENT
IMPORTANT INFORMATION - PLEASE READ

Although we verify your health benefit coverage, we do not know your ***actual*** financial responsibility until your insurance company pays for all dates of service. The health benefit coverage outlined below is only an ***estimate*** and is based upon the information given to us by your insurance company. ***Please be aware that it is ultimately your responsibility to know your healthcare benefit coverage for physical, occupational and speech therapy. If you do not know your benefit coverage, we strongly recommend that you contact your insurance company directly for any questions and/or concerns you may have.*** Unless 100% coverage has been verified with no co-pay, deductible and/or co-insurance with your insurance company, you are responsible to pay per visit any co-pay, deductible and/or co-insurance as outlined below. ***Please note that any deductible/co-insurance payment you make per visit is only an estimated amount and it is probable that you will receive a bill from E6 Physical Therapy after your insurance company has paid all dates of service.*** In the event that you over-pay your deductible/co-insurance, a refund will be issued to you after your insurance company has paid all dates of service and all insurance payments have been posted to your account.

We accept cash, checks, Visa, MasterCard and Discover as forms of payments.

Your verified co-pay amount is $_____ per visit.

Your verified annual deductible amount is $_____ and has been MET/NOT MET.

Your verified co-insurance is _____% and your ***estimated*** payment is $_____ per visit.

CASH PATIENTS ONLY - your payment is $_____ per visit. ***Payment in full is expected at the beginning of each treatment visit and it is your responsibility to come to the front desk to make your payment.***

MEDICARE PATIENTS ONLY -
Your verified annual deductible amount is $147.00 and has been MET/NOT MET.

Your verified co-insurance is 20% and your ***estimated*** payment is $_____ per visit**.

Medicare has an annual monetary cap for physical/occupational therapy that changes each year. For 2014 the physical/occupational therapy cap is $1,920.00. E6 Physical Therapy estimates that this dollar amount equates to approximately 19 physical/occupational visits per calendar year. ***Secondary insurance may not pay for visits above the therapy cap and it is recommended that you contact your secondary insurance company to discuss their policies regarding Medicare's therapy cap.***

****If you have Secondary insurance, that insurance company should pay the Primary insurance deductible and co-insurance, but it is highly recommended that you check with your Secondary insurance regarding your policy and their payment processes for Primary deductibles and co-insurance.***

FEES

There is a $25 charge for all returned checks.

INTEREST - Any payment not received within 30 days from the first statement date, the outstanding account balance will accrue interest at the rate of 1.5% per month (18% per annum) beginning from the first date of treatment until the account is paid in full.

ATTORNEY FEES & COLLECTION COSTS – As permitted under applicable law, you agree to pay reasonable attorneys fees, expenses and court costs we incur in order to collect your account or protect our rights under this agreement.

SUPPLIES/DURABLE MEDICAL EQUIPMENT - Please be aware that most insurance companies ***do not*** pay for supplies and/or durable medical equipment. ***All supplies and/or durable medical equipment must be paid for at the time of service.***

By signing this document, the undersigned is agreeing to have read this policy, understands this policy and agrees to the policy as outlined above.

_____ _____

Patient or Guardian Signature Date

E6 Physical Therapy

WELCOME TO E6 PHYSICAL THERAPY

It is our mission to help you reduce pain, improve mobility and strength, and return to work and/or recreational activities as quickly as possible.

Listed below are a few items that we would like to make you aware of during your visit(s).

ATTENDANCE - Your medical care is very important to us and your physical therapy visits are based upon your physician's orders and the treatment plan that we create for you. Therefore, it is important that you attend your scheduled follow-up visits as recommended by your doctor and physical therapist. Attending your follow-up visits ensures that we are able to oversee your progress and modify your regimen in response to your improvement. ***Failing to attend your follow-up visits ensures that the rehabilitation process and your progress will be delayed.***

If you are unable to attend an appointment, you must notify our office 24 hours in advance and reschedule to make up for the missed appointment. ***Failure to give a 24 hour advance notice to cancel an appointment will result in a CANCELLATION FEE of $25.00 to be paid on your next scheduled appointment*** (cash, check or credit card are accepted forms of payment). Your insurance company will not pay for cancellation fees. ***2 consecutive missed appointments will result in discharge from our facility and your physician will be notified.***

Worker's Compensation Patients only – please be aware that your physician, employer, case manager/insurance adjustor will be notified of cancellations/no shows and this in turn could be detrimental to your worker's compensation claim.

HOME EXERCISE - You will receive a Home Exercise Program that has been individually tailored to you and your specific condition. It is very important that you perform your exercise program exactly as your therapist has outlined. It is our experience that patients who perform their exercise program improve at a faster rate and report a greater level of satisfaction with their overall recovery. Please feel free to ask your therapist if you have questions about your exercises as they are the most important part of your recovery. We look forward to partnering with you through the process of rehabilitation and are excited to provide you with the skills necessary to meet your goals.

CELL PHONE/PAGERS

In order to maintain an atmosphere with minimal distractions, we ask that all cell phones are turned to vibrate and ***if you need to make/take a call, please step outside of the office.***

MUSIC - We believe that upbeat music is an integral part of the rehabilitative process by creating a positive environment and to motivate and facilitate exercise.

GUESTS – Guests and children are to stay in the reception area during your treatment, however, if you have a concern, please speak to you therapist. ***An adult must remain with children at all times and quietly supervise them.*** Please understand that this policy is in place to promote safety for you, your guests, and children.

By signing this document, I, the undersigned, have read the above items, understand the above items and agree to the items as outlined above.

Patient Name *(please print)*: _____

Signature & Relationship to Patient *(self, parent or legal guardian)*: **Date:**

E6 Physical Therapy's Notice of Privacy Practices

Effective date: 6/16/14

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

We understand that medical information about you is personal and we are committed to protecting it. E6PT is required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this Notice of our legal duties and privacy practices with respect to your health information. We are required to follow the terms of the Notice that is currently in effect.

How E6PT May Use or Disclose Your Health Information

We may use or disclose your health information:

- For Treatment – To provide physical, occupational and/or speech services to you.
- For Payment – So that your PT, OT and/or SLP services may be billed to and payment may be collected from you, your insurance company, or a third party.
- For Health Care Operations – For activities necessary to run E6PT and make sure that you receive quality customer service.
- For Appointment Reminders and Health-Related Products and Services – including daily appointment cards, to tell you about health related services and products, or recommend possible treatment alternatives that may be of interest to you.
- To Individuals Involved in Your Care or Payment for Your Care – Including a family member or friend who is involved in your medical care or payment for your care, provided that you agree to the disclosure, or we give you an opportunity to object to the disclosure. If you are not available or are unable to agree or object, we will use our best judgment to decide whether this disclosure is in your best interests.
- We may also disclose your health information:
- As Required by Law – To comply with federal, state or local law.
- To Avert a Serious Threat to Health or Safety – In relation to you, another person, or the public. Any disclosure would be only to someone able to avert the threat.
- For Public Health Activities/Risk Prevention – Including activities to prevent or control disease or injury; report problems with products; or, report abuse or neglect.
- For Health Oversight Activities – When requested by a health oversight agency, where authorized by law, for activities necessary for the government to monitor the health care system, including audits, investigations, inspections and licensure.
- For Lawsuits and Disputes – In response to a court or administrative order, a subpoena, a discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request (which may include written notice to you) or to obtain an order protecting that information.
- For Specialized Government Functions – Such as, (1) if you are a member of the armed forces, as required by military command authorities; (2) if you are an inmate or in lawful custody, to a correctional facility or law enforcement official; (3) in response to a request from law enforcement, if certain conditions are satisfied; (4) for national security reasons authorized by law; and (5) to authorized federal officials to protect the President, other authorized persons or head of state.
- For Workers' Compensation or other similar programs.

Other Uses and Disclosures of Your Health Information

Except as described in this Notice, E6PT will not use or disclose your health information without your written authorization. If you do authorize E6PT to use or disclose your health information, you may revoke your authorization in writing at any time. If you revoke your authorization, this will stop any further use or disclosure of your health information for purposes covered by your written authorization, except if we have already acted on your permission.

You Have the Following Rights with Respect to your Health Information

- You have the right to request that we follow special restrictions when using or disclosing your health information for treatment, payment or health care operations, or to someone who is involved in your care or the payment for your care. E6PT is not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment and other exceptions pursuant to law.
- With certain exceptions, you have the right to inspect and copy your health information. Usually, such information includes prescription and billing records. We may deny your request to inspect and copy in certain limited circumstances, in which case, you may request that the denial be reviewed.
- You have the right to request that E6PT amend your health information if you feel that it is incorrect or incomplete. You must provide a reason in writing supporting your request. We may deny your request if the health information is accurate and complete or is not part of the health information kept by or for E6PT. Even if we deny your request for amendment, you have the right to submit a statement of disagreement regarding any item in your record you believe is incomplete or incorrect. If you request, this will become part of your medical record, and we will attach it to your records and include it whenever we make a disclosure of the item or statement you believe is incomplete or incorrect.
- You have a right to request an accounting of disclosures of your health information. This is a list of disclosures we made of your health information, other than for treatment, payment, health care operations, and other exceptions pursuant to law. You must specify the time period, which may not be longer that six years and may not include dates prior to December 1, 2006.
- You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we contact you only at work or at a different residence or post office box. We will accommodate all reasonable requests.

Changes to this Notice of Privacy Practices

E6PT reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for health information we already have about you as well as any information we receive in the future. If we change our Notice, you may be asked to sign a new Notice which will then be filed in your patient chart.

By signing below, I acknowledge that I have received the E6PT's Privacy Notice.

_____ _____

Signature of Patient or Authorized Representative Date

Medicare Secondary Payer Questionnaire

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

This form is a guide to help identify other payers that may be primary to Medicare

Patient Name:_____Date of Birth:_____Medicare number:_____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

Have you received Home Health Services in the last 6 months? Y N Have you been discharged? Y N

If yes to the above questions, please list the name of the Home Health Agency and their phone number:

_____

1. Are your current symptoms due to a recent automobile accident, 3rd party liability accident or Worker's Compensation injury? Y N
2. Are your current symptoms covered by the Black Lung Program or Veterans Administration Program? Y N
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement? Y N
4. If under 65, are your Medicare benefits due to disability? Y N
5. Are you or a spouse currently employed? Y N

5a. If yes, do you have insurance coverage with your employer? Y N

If you answered **NO** to questions 1 – 5a, **MEDICARE IS PRIMARY**
If you answered **YES** to any of questions 1 – 5a, **MEDICARE IS SECONDARY and you *MUST* provide the information below:**

Name of Insurance Company:_____

Address of Insurance Company:_____

Name of person that carries the coverage:_____

Policy/Member identification number:_____

Policy holder's Name of Employer:_____

Date of Accident (if Work Comp or Motor Vehicle Accident):_____

_____ _____

Patient or Guardian Signature & Relationship to the Patient Date of Signature