



## Patient Registration

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Residence Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Sex: F / M Marital Status:  Single  Married  Widowed  Divorced

Cell Phone #: \_\_\_\_\_ Home Phone #: \_\_\_\_\_ Work #: \_\_\_\_\_

Email: \_\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Driver's License #: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone #: \_\_\_\_\_

## Medical History

### 1. Have you ever had or been diagnosed with any of the following?

High Blood Pressure	Yes	No	Dizzy Spells	Yes	No
Heart Trouble	Yes	No	Diabetes	Yes	No
Circulation Issues	Yes	No	Other _____		
Seizures	Yes	No			

### 2. List all surgeries and dates below:

Procedure:	Date:	Procedure:	Date:
(1) _____	_____	(3) _____	_____
(2) _____	_____	(4) _____	_____

### 3. Do you have a cardiac (heart) pacemaker? Yes No

4. Please list any known allergies: \_\_\_\_\_

5. WOMEN: Are you pregnant? Yes No Date of last menstrual cycle: \_\_\_\_\_

*To the best of my knowledge, I certify that the above information is true and correct.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Patient Symptom Overview

**Patient Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

1. Are you currently working? Yes No (If not, please indicate last day worked \_\_\_\_\_)

2. Describe the physical demands of your occupation: \_\_\_\_\_  
\_\_\_\_\_

3. Describe your main complaints and symptoms: \_\_\_\_\_  
\_\_\_\_\_

4. Please rate your pain: 1 2 3 4 5 6 7 8 9 10

5. Circle how you would describe your pain. *(use all that apply)*

Sharp	Dull	Aching	Tingling
Numb	Constant	Variable	Radiating ( moves )

6. How did the symptoms start?  
\_\_\_\_\_  
\_\_\_\_\_

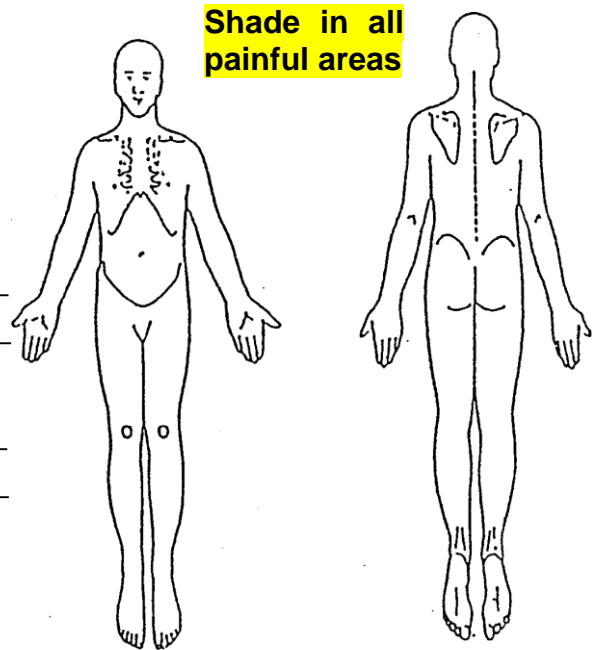
7. What positions or activities make your pain worse?  
\_\_\_\_\_  
\_\_\_\_\_

8. What positions or activities make your pain better?  
\_\_\_\_\_  
\_\_\_\_\_

9. Have you received any treatment or undergone any tests for your current problem?  
\_\_\_\_\_

10. Have you ever had physical therapy treatments? Yes No *If yes, please specify:*  
\_\_\_\_\_

11. Do you have metal implants? Yes No *(If yes, explain)*  
\_\_\_\_\_





## CONSENT TO TREAT

I, \_\_\_\_\_, hereby consent to routine physical therapy services as provided by From the Heart Physical Therapy under the supervision of a licensed Physical Therapist. I acknowledge that treatment may include any number of manual procedures, Myofascial Release techniques, exercises and/or modalities that will be rendered as part of the physical therapy treatment program provided by this office.

### ACCEPTANCE OF OFFICE POLICIES & FINANCIAL AGREEMENTS

- A valid credit card is required to secure appointment reservations and will be held on-file for future visits. Visa and MasterCard are accepted. **Patient Initials:** \_\_\_\_\_
- Patients must provide a 48-hour advance notification to cancel or reschedule appointments. If less than 48-hours' notice is given; the patient will be held accountable for the full amount of the service charged to the credit card on file. **Patient Initials:** \_\_\_\_\_
- Your appointment time is set-aside solely for you; therefore, we appreciate you being on-time. Late arrivals will result in abbreviated treatment time.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- For **private patients**, payment is required at the time services are rendered. We accept checks, cash, debit, and credit cards. We do not bill insurances other than Medicare as per eligible benefits and will provide a Superbill upon your request. If we receive a payment from your insurance company, we will issue a refund check to your address on-file.
- For **Medicare insured patients**, Patients will accept full financial responsibility if for any reason Medicare does not pay From the Heart Physical Therapy for their treatments. Patients need to communicate any changes made to their Medicare, Secondary policy or coverage immediately. Our office will submit claims to Medicare only up to the first cap of \$2040. If a patient pays for uncovered services and if we receive payment from Medicare, we will issue a refund check to the patient's address on file.
- **Patient Statements:** All balances are due in full within 14 days of the statement date. We reserve the right to charge all accounts with a balance over 30 days from billing date a service charge of 1.5% per month. We reserve the right to submit your account in a collection program, report delinquent accounts to credit bureaus, assess a collection fee of up to 40% of the outstanding balance, take other collection action, and/or terminate you as a patient of this practice. In addition, if legal action is taken you will be responsible for the cost, which may be up to \$250.00 per hour.

***I have read the Office Policies and Financial Agreements and agree to abide by all terms in this document:***

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



## Release of Medical Information

**Patient Name:** \_\_\_\_\_

Medical Facility: \_\_\_\_\_

You are hereby authorized and requested to furnish any and all medical information, history, records, diagnosis, reports and/or radiographs in your possession regarding the above named patient to From The Heart Physical Therapy.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## HIPAA Privacy Authorization

**\*\*Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) \*\***

1. Authorization: I authorize From The Heart Physical Therapy to use and disclose the protected health information described below to \_\_\_\_\_ (individual or entity seeking the information).
2. **(Initial: \_\_\_\_\_)** Effective Period: This authorization for release of information covers the period of healthcare for all past, present, and future periods while under the care at From the Heart Physical Therapy.
3. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_



Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### THERAPIST NOTICE / BENEFIT AGREEMENT

I am being advised by this document that my insurance will only pay for service(s) that it determines to be “medically necessary” and that are covered benefits. If my insurance company determines that a particular service(s), although it would be otherwise covered, is not medically necessary, nor a covered benefit, they will deny payment for that service(s). If any type of service at From the Heart Physical Therapy is not covered for any reason, I understand that From the Heart Physical Therapy will bill me for all services rendered and not paid by my insurance company and that I will be held personally and fully responsible for payment of all services rendered at From the Heart Physical Therapy.

**Initial:** \_\_\_\_\_

### HOME HEALTH NOTIFICATION POLICY

Our company policy requires that you notify us of any changes concerning Home Health Services received while under our care. **According to Medicare regulations, out-patient therapy services will not be covered if you are enrolled in any Home Health agency.** If you are or become enrolled in any home health services without notifying us, you will be personally responsible for all incurred therapy expenses to From The Heart Physical Therapy, Inc.

**Initial:** \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

*(Office Use)*

Witness Name: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_



A. Notifier:

B. Patient Name:

C. Identification Number:

### Advance Beneficiary Notice of Noncoverage (ABN)

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

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Outpatient Physical Therapy Services @ From The Heart Physical Therapy, INC.	<b>A.</b> If you have exhausted your \$2040.00 Physical Therapy Cap OR <b>B.</b> If you have exhausted \$3700 Physical Therapy Cap using KX modifier	\$200.00-\$260.00 per visit

**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. \_\_\_\_\_ 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. \_\_\_\_\_ 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. \_\_\_\_\_ 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. \_\_\_\_\_ 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.

<b>I. Signature:</b>	<b>J. Date:</b>
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



## Pain Disability Index

Name: \_\_\_\_\_

Date: \_\_\_\_\_

**Family/Home Responsibilities:** It includes chores or duties performed around the house and errands or favors for family members (ex. driving the children to school).

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability

**Recreation:** Hobbies, sports, and similar leisure time activities.

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability

**Social Activity:** Activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concert, dining out, and other social functions.

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability

**Occupation:** Activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability

**Sexual Behavior:** Refers to the frequency and quality of one's sex life.

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability

**Self-Care:** Refers to bathing and dressing

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability

**Life-Support Activity:** Eating, sleeping, and breathing.

No Disability   0  1  2  3  4  5  6  7  8  9  10   Worst disability