ASTOUND
PHYSICAL THERAPY

PATIENT INFORMATION: TODAY'S DATE:_____

Patient Name: _____ Birth Date: _____

Sex:_____ Marital Status: _____ Social Security Number:_____

Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Employer: Drivers License #:

Responsible Party: Phone Number:

Contact Person NOT Living With You: Phone Number:

Referring Physician: Family Doctor:

Last Doctor Visit: Next Doctor Visit:

Was This Due To An Accident Or Injury? YES NO Injury Date:

Is This Injury Related To: WORK AUTO SPORTS OTHER: _____

Is This A Worker's Comp Claim? YES NO Is This An Auto Accident Claim? YES NO

Claim Number: Contact Name and Number:

**ARE YOU CURRENTLY RECEIVING HOME HEALTH OR HOSPICE? YES NO
IF SO, WHAT AGENCY? _____

INSURANCE INFORMATION:

Primary Insurance: Policy Number:

Name of Insured: Relationship to Patient:

Birth Date: Social Security Number:

Insured Employer:

Secondary Insurance: Policy Number

Name of Insured: Relationship to Patient:

Birth Date: Social Security Number:

PLEASE FLIP OVER AND SIGN THE BACK!

CONDITIONS OF ADMISSION:

I understand that in order to process healthcare coverage claims promptly, all forms and information necessary for billing purposes must be in our office within 24 hours from the registration time in order to be honored and that the office is not obligated to bill any carrier that is not reported at the time of registration. I further understand that the office accepts no liability for the failure to meet any pre/post admission certification procedures which may be required of me by my coverage, and I agree that any such procedures have and will be properly executed by me.

AGREEMENT TO GUARANTEE PAYMENT:

I agree to guarantee payment for all charges resulting from services rendered by this office as requested by me personally or my guarantor to pay the office its charges and any balance due in excess of any amount paid by other persons or agencies. I understand all charGes not covered by verified healthcare coverage are due and payable at the time of service. Provisional credit may be allowed to confirm coverage benefits when assigned to the office and all such credits are subject to collection by the office (Except as otherwise provided by applicable State and Federal laws). I understand and agree that I am responsible for any cost incurred for legal or collection fees (33%) necessary to satisfy financial obligation at this office, including reasonable attorney's fees, court costs, or collection expense. I further authorized this office to apply any overpayments on any accounts to any other open accounts that I or my guarantor have with this office. I waive now and forever my right of exemption under the laws of the Constitution of the State of Alabama and any other state.

AUTHORIZATION TO RELEASE INFORMATION:

I authorize this office to release to my insurance(s) or their agent(s) and and all medical information as may be necessary for payment of my medical claims except as otherwise provided by applicable State or Federal laws. This release also allows information to be released for utilization review and financial audits. This may include all reports and orders contained in the medical records chart pertaining to my treatment. I understand that this authorization may be revoked by me at any time upon written notice. I authorize Astound Physical Therapy, its employees and/or agents "express prior consent' to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message), for the purpose of treatment, insurance, reminders, or payment.

ASSIGNMENT OF BENEFITS:

I hereby authorized direct payment of the benefits provided under any healthcare plan or medical expense policy, including motor vehicle insurance, otherwise due or payable to me or on behalf, to this office, but not to exceed the regular charges of this office. I understand that I am personally responsible to this office for the charges not covered by this assignment.

I, the undersigned, certify that I have read the above, and am the patient (or the patient's duly authorized representative to execute the above), and accept its terms as noted.

PATIENT	GUARANTOR
WITNESS	DATE

PATIENT MEDICAL HISTORY AND PHYSICAL CONDITION INFORMATION

ANSWERS TO THE FOLLOWING QUESTIONS WILL ASSIST THE PHYSICAL THERAPIST IN PROVIDING A SAFE AND EFFECTIVE TREATMENT PROGRAM

NAME:_____ DATE: _____

DATE OF BIRTH:_____ HEIGHT: _____ WEIGHT: _____

REFERRING PHYSICIAN:_____ PRIMARY CARE PHYSICIAN: _____

PROBLEMS TO BE TREATED: _____

HAVE YOU HAD **TREATMENT** FOR THIS PROBLEM BEFORE: [Y] [N] *IF YES, STATE WHEN: _____

TREATMENT PROVIDER:_____ TREATMENT GIVEN: _____

HAVE YOU HAD SURGERY ASSOCIATED WITH THE PROBLEM? [Y] [N] IF **YES**, LIST THE DATE AND TYPE OF SURGERY: _____

****LIST ANY OTHER MAJOR ILLNESS OR SURGERY THAT HAS OCCURRED IN THE PAST YEAR**: _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? [Y] [N] * IF YES, PLEASE LIST ALL MEDICATIONS: _____

DO YOU NOW HAVE OR EVER HAD ANY ISSUES WITH THE FOLLOWING:

HIGH BLOOD PRESSURE:	[Y] [N]	SENSITIVE TO HEAT OR ICE:	[Y] [N]	KIDNEY PROBLEMS:	[Y] [N]
HEART DISEASE:	[Y] [N]	ALLERGIES:	[Y] [N]	NERVOUS DISORDERS:	[Y] [N]
HEART ATTACK:	[Y] [N]	HERNIA:	[Y] [N]	HEARING PROBLEMS:	[Y] [N]
PACEMAKER:	[Y] [N]	SEIZURES:	[Y] [N]	BALANCE PROBLEMS:	[Y] [N]
DIABETES:	[Y] [N]	METAL IMPLANTS:	[Y] [N]	VISION PROBLEMS:	[Y] [N]
HEADACHES:	[Y] [N]	DIZZY SPELLS:	[Y] [N]		

IF YES ON ANY OF THE ABOVE, PLEASE EXPLAIN AND GIVE APPROXIMATE DATES: _____

DO YOU NEED ASSISTANCE WITH ANY OF THE FOLLOWING:

TRANSPORTATION:	[Y] [N]	MEAL PREPARATIONS:	[Y] [N]
SHOPPING/ERRANDS:	[Y] [N]	PERSONAL CARE:	[Y] [N]
DOMESTIC CHORES:	[Y] [N]	OTHER:	_____

HAS YOUR ILLNESS/DISABILITY CAUSED ANY OF THE FOLLOWING:

FINANCIAL PROBLEMS:	[Y] [N]	FAMILY PROBLEMS:	[Y] [N]
EMOTIONAL PROBLEMS:	[Y] [N]	OTHER:	_____

HAVE YOU EVER HAD PHYSICAL/OCCUPATIONAL THERAPY BEFORE?: [Y] [N]

ARE YOU PREGNANT?: [Y] [N]

ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH OR HOSPICE CARE?: [Y] [N]

THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE.

SIGNATURE: _____ DATE: _____

PATIENT CONSENT FOR USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:

1. I UNDERSTAND THAT, AS PART OF MY HEALTH CARE TREATMENT, ASTOUND PHYSICAL THERAPY DEVELOPS AND MAINTAINS RECORDS CONTAINING MY HEALTH INFORMATION, WHICH INCLUDES INFORMATION ABOUT MY HEALTH HISTORY, SYMPTOMS, TEST RESULTS, DIAGNOSES, TREATMENT, AND CLAIMS/PAYMENT HISTORY, ETC. I UNDERSTAND THAT MY HEALTH INFORMATION WILL BE USED AND DISCLOSED BY ASTOUND PHYSICAL THERAPY FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS AND SERVES AS:

* A BASIS FOR PLANNING MY CARE AND TREATMENT
* A MEANS FOR COMMUNICATING AMONG HEALTH CARE PROFESSIONALS WHO MAY CONTRIBUTE TO MY CARE
* A SOURCE OF INFORMATION TO BILL FOR HEALTH CARE SERVICES RENDERED
* A MEANS BY WHICH AN INSURANCE COMPANY OR OTHER THIRD PARTY PAYOR CAN VERIFY THAT SERVICES BILLED WERE ACTUALLY PROVIDED
* A RESOURCE FOR "HEALTH CARE OPERATIONS", SUCH AS ASSESSING QUALITY OF CARE AND REVIEWING THE COMPETENCE OF HEALTH CARE PROFESSIONALS.

2. I HAVE BEEN PROVIDED WITH ASTOUND PHYSICAL THERAPY'S **PRIVACY NOTICE**, (THE "PRIVACY NOTICE") WHICH PROVIDES A MORE COMPLETE DESCRIPTION OF THE USE AND DISCLOSURE OF MY HEALTH INFORMATION. I UNDERSTAND ASTOUND PHYSICAL THERAPY CAN CHANGE THE TERMS OF THE PRIVACY NOTICE AND THAT ASTOUND PHYSICAL THERAPY RESERVES THE RIGHT TO MAKE THE NEW PRIVACY NOTICE PROVISIONS EFFECTIVE FOR MY HEALTH INFORMATION THAT IT ALREADY MAINTAINS AND USES, AS WELL AS FOR ANY HEALTH INFORMATION THAT IT MAY RECEIVE IN THE FUTURE.

3. I UNDERSTAND THAT IF I **REFUSE** TO SIGN THIS CONSENT FORM ALLOWING FOR THE USE AND DISCLOSURE OF MY HEALTH INFORMATION TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, ASTOUND PHYSICAL THERAPY MAY REFUSE TREATMENT.

4. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST THAT ASTOUND PHYSICAL THERAPY RESTRICT HOW MY HEALTH INFORMATION IS USED OR DISCLOSED TO CARRY OUT TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS, BUT SUCH REQUEST MAY NOT BE ACCEPTED. I REQUEST THE FOLLOWING RESTRICTIONS ***("N/A" IF NO RESTRICTIONS:)*** _____

_____

_____

5. I UNDERSTAND I MAY REVOKE THIS CONSENT AT ANY TIME BY NOTIFYING ASTOUND PHYSICAL THERAPY, BUT IF I DO, IT WILL NOT HAVE ANY EFFECT ON USES OR DISCLOSURES PRIOR TO THE RECEIPT OF THE REVOCATION.

ACKNOWLEDGMENT OF RECEIPT

I,_____, ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES ISSUED BY ASTOUND PHYSICAL THERAPY.

I,_____, AUTHORIZE ASTOUND PHYSICAL THERAPY TO DISCUSS MY HEALTH INFORMATION WITH THE FOLLOWING PERSONS:

SPOUSE: _____
CHILDREN: _____
PARENT: _____
_____
OTHER: _____

SIGNATURE OF PATIENT:_____ DATE: _____

ASTOUND PHYSICAL THERAPY

ATTENDANCE AND SCHEDULING POLICY

To better serve our clients, we would like to inform you on our attendance and scheduling policy:

Our goal is to find times and dates that work best for you. Generally, scheduling is made for 1 week and up to 2 weeks in advance. If you need a specific time or date/days, please let our front office staff know and we will do our best to accommodate.

We request a 24-hour notice on cancellations or to reschedule. Please arrive at the clinic within 15 minutes of your scheduled appointment time and notify us if you will be late. If you arrive more than 15 minutes past your appointment time, we may need to reschedule your appointment to a different time or date.

I acknowledge the information above and agree to the attendance and scheduling poilcy of ASTOUND PHYSICAL THERAPY.

Signature _____ Date _____

Print Name _____

MEDICARE SECONDARY PAYER QUESTIONAIRE

PATIENT NAME: PHONE NUMBER:

LOCATION: **ASTOUND PHYSICAL THERAPY** SOCIAL SECURITY NUMBER:

1. Was illness/injury due to a work related accident/condition covered by workers compensation plan or the federal black lung program (FBLP)?

_____ YES - Go to #3 _____ NO- Go to #2

2. Was illness/injury due to a non-work related accident?

_____ YES- Go to #3 _____ NO- Go to #5

3. Was illness/injury due to an auto accident?

_____ YES- Go to #16 _____ NO- Go to #4

4. Was another party responsible for the accident?

_____ YES- Go to #16 _____ NO- Go to #5

5. Is the patient age 65 or older?

_____ YES- Go to #6 _____ NO- Go to #10

6. Is this patient undergoing kidney dialysis for End Stage Renal Disesase (ESRD)?

_____ YES- STOP Medicare is Primary _____ NO- Go to #7

7. Is patient employed and covered by the Employers Group Health Plan?

_____ YES- Go to #16 _____ No- Go to #8

8. Is the patient's spouse employed?

_____ YES- Go to #9 _____ NO- STOP

9. Is the patient covered under the group health plan of the spouse's employer?

_____ YES- Go to #16 _____ NO- STOP

10. Is the patient entitled to benefits solely on the basis of End Stage Renal Disease?

_____ YES- Go to #11 _____ NO- Go to #14

11. Is the patient covered by an Employer's Group Health Plan?

_____ YES- Go to #12 _____ NO- STOP

12. Has the patient been undergoing kidney dialysis for more than 12 months or been entitled to Medicare for more than 12 months?

_____ YES- STOP Medicare is primary _____ NO- GO to #13

13. Is the patient within a 12 month period as defined in 264.4 [4143.85]?

_____ YES- Go to #16 _____ NO- STOP

14. Is the patient a disabled Medicare beneficiary under age 65?

_____ YES- Go to #15 _____ NO- STOP

15. Is the patient covered by a group health care plan based on the patients own employment of a spouse or parent?

_____ YES- Go to #16 _____ NO- STOP

16. Name/Address of: (Check the Appropriate Item Number)

_____ Workers Compensation or Federal Black Lung Program (FBLP) from #1
_____ Automobile Insurance from #3
_____ Liability Insurance from #4
_____ Employer's Group Health Benefit from #7
_____ Spouse's Employers Group Health Benefit Plan from #9
_____ Group Health Plan from #15

Name: _____

Address: _____

_____

_____

Phone: _____ Policy or Other ID#: _____

STOP MEDICARE IS SECONDARY TO THE ABOVE NAMED INSURER

ARE YOU CURRENTLY RECEIVING HOME HEALTH, HOSPICE, OR PHYSICAL THERAPY AT ANOTHER FACILITY?

_____ YES _____ NO

_____ _____

Patient Signature Date

ASTOUND
PHYSICAL THERAPY

2018 NOTICE OF MEDICARE YEARLY CAP ON REHABILITATION SERVICES

PATIENT'S NAME: _____ **MEDICARE #:** _____

Medicare does not pay for all of your health care costs.
Medicare only pays for covered benefits.

Current Medicare benefits in 2018 provide up to $2010 a year cap for Physical Therapy and Speech Therapy services combined and up to $2010 for Ocupational Therapy Services. Currently this a hard cap and Medicare will not pay for any services above this dollar amount. Congress must put another law in place in order to either remove the therapy cap or put another exception process in place for them to pay for services beyond this cap amount. Congress returns on January 19, 2018 so this cap will be in place until they pass a law to change it.

Patients Signature _____ Date _____

I have explained the Medicare cap to the above patient. He/She did not have any questions concerning their Medicare benefits with regard to the Medicare cap.

Astound Physical Therapy Employee _____ Date _____

(Updated 01/01/2018)