PHYSICAL THERAPY
PATIENT INFORMATION — PRIVATE INSURANCE — DATE:_____

(Please Print, Black Ink Only)

Patient Name:_____ Home Phone: _____

Address:_____Mutual # _____ Cell#:_____ Provider:_____

City & State: _____ Zip:_____ e-mail: _____

Date of Birth: _____ Sex: M F Marital Status: S M D W Soc. Sec#: _____

Driver's License/ID #: _____ State: _____ Exp: _____

Responsible Party:_____ **Relationship to patient**:_____

Employer: _____Bus. Phone: _____

Address: _____City & State: _____ Zip: _____

Occupation: _____ Student Status: Full Time or Part Time

Emergency Contact: _____ **Telephone**:_____

Physician's Name: _____UPIN#:_____NPI #:_____

Address: _____City & State: _____Zip: _____

Telephone: _____ Fax:_____

Dx:_____ Surgery? Yes/No Date of Sx: _____

Primary Ins.:_____Telephone: _____

Address: _____City & State: _____Zip:_____

Insured's Name: _____ Date of Birth: _____

ID# / SS: _____ **Group**/Policy#: _____

Deductible $_____ Met? Yes/No – How much has been met? $ _____ P.T. Paid at _____%

Co-Pay Per visit $_____ Policy Limits (#Visits/Max $ Per day/Exclusions): _____

Out of Pocket Max $_____ Met? Y/N – How much has been met? $ _____ _____

Effec. Date: _____ On Account to keep up with co-insurance balance_____

Requires Pre-Auth? Yes/No _____

Auth #: _____ Is SCPT a contract provider? YES/NO Benefits given by_____

Who referred patient / How did patient hear of our facility?_____

Therapist _____ Appt. Date & Time:_____Revised Dec 2012

Patient's Signature_____ SCPT Officer Signature_____

☐ Billing Face Sheet ☐ Ins Verification Script ☐ Ins Coverage Info ☐ Staffing Sheet ☐ Stamp Charts ☐ Doc's List

Consent to Treatment and Conditions of Treatment

Consent to Treatment: I, consent to the procedures which may be performed during my treatment and care at **Seniors' Choice Physical Therapy, Inc**., including emergency treatment services. These may include but are not limited to therapeutic tests, treatments or procedures, manipulation, stretching, or exercise treatment or procedures as directed under the general instruction of the Physical Therapist or aide. I am aware that the practice of Physical Therapy is not an exact science and that no guarantees have been made to me. I authorize my Physical Therapist to take photographs relating to my physical condition as are deemed necessary.

Release of Information: Seniors' Choice Physical Therapy, Inc. is authorized to release any information necessary, including copies of my Therapy and medical records to process payment claims for health care services, which have been provided. Such records may include information of a psychological or psychiatric nature, pertaining to my mental condition or treatment for conditions relating to the use of alcohol or drugs. In addition, I authorize my insurance carrier, employer or person otherwise responsible for payment to provide to **Seniors' Choice Physical Therapy, Inc.** information necessary to determine benefits or process a claim. This release will be valid for the period of time to process the claim or until consent is revoked by the patient.

Financial Agreement/Assignment of Benefits: I assign any and all insurance benefits payable to me to **Seniors' Choice Physical Therapy, Inc.** I understand that I am responsible for payment of services rendered by **Seniors' Choice Physical Therapy, Inc.** including excluded services from my insurance either because of the plans deemed such services not medically necessary, or for any other reason including pre-certification requirements, second opinions or pre-existing conditions. Should the account be referred to any attorney or collection agency for collection, I understand that I will be responsible for attorney and/or collection expenses.

I, the undersigned, state that the information that I have provided **Seniors' Choice Physical Therapy, Inc.** is correct to the best of my knowledge. I acknowledge by my signature that I have read and received a copy of this statement.

_____ _____

Signature of Patient or Representative **Date**

_____ _____

Seniors' Choice Physical Therapy Representative **Date**

SENIORS' CHOICE PHYSICAL THERAPY, INC.

NOTICE OF PRIVACY PRACTICES

As posted on the reception area wall, this notice describes how medical information about you may be used and disclosed and also how you can get access to this information. Please review it carefully.

Understanding your health record/information:
When receiving physical therapy services from **Seniors' Choice Physical Therapy, Inc.**, a record is made of your treatment. This record contains your symptoms, diagnoses, examinations, assessments, evaluation and your treatment plan. It also contains daily treatment notes and progress notes. This record is referred to as your medical record and serves as a:

- Basis for planning your care and treatment
- Means of communication among the health professionals who contribute to your care
- Legal document describing the care you receive
- Means by which services can be verified for billing purposes
- A tool for educating physical therapy professionals
- A source of data for facility planning
- A tool with which the quality and outcome of care and services given can be evaluated

Our pledge regarding medical information:
We understand the medical information about you is personal. We are committed to protecting this information. We create a record of care and services you receive. This record is needed to provide you with quality care and to comply with certain legal requirements. This notice applies to the records for your treatment.

How we may use and disclose your medical information:

1. **For treatment:** We may use medical information about you to provide you with treatment. We may disclose this information to your doctors, or other personnel who are involved in your treatment.
2. **For payment:** We may disclose medical information about you so that the treatment you receive may be billed to and payment may be collected from insurance or other benefits that you may be entitled to.
3. **Review for quality care:** We may disclose medical information about you for internal quality check to make sure all of our patients receive quality care.
4. **As required by law:** We will disclose medical information about you when required to do so by federal, state, or local law.
5. **Lawsuits and disputes:** If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a court or administrative order. We may also disclose medical information about you in response to a subpoena, 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 or to obtain an order protecting the information requested.

I have read and understand the information outlined above.

_____ _____
Signature of patient/guardian Date

_____
Witness

PATIENT COVERAGE INFORMATION SHEET

DATE: _____

Name: _____

Diagnosis: _____

Referring Doctor: _____

Therapist: _____

Have you received any previous physical therapy this year? □ Yes □ No If "yes," # of visits _____

Are you currently receiving or have you received **any** type of home health care within the past 60 days?
□ Yes □ No If "yes," Date of last visit _____

Is this injury a result of one of the following?:
□ MVA □Workers' Compensation □ Personal Injury

Insurance: _____

Visits Allowed: _____

Deductible: _____

Deductible Met: _____

Percentage of Coverage: _____

Amount responsible from patient per visit once deductible has been satisfied (Co-Pay or Co-Insurance):

_____

_____

*** Please Note That All Payments (Deductibles, Co-Pays) Should Be Paid On The Day Services Are Rendered.**

I understand that if my insurance company reimburses a percentage (i.e. an 80/20 plan), I may receive a bill for my co-insurance anywhere from a few weeks to a few months after services have completed.
_____ (Patient Initials)

*** Please Call 24 Hours In Advance To Cancel Or Change Your Appointments, Otherwise You May Be Charged A $25.00 No-Show Fee.**

_____	_____	_____	_____
Patient Signature	**Date**	**SCPT Officer Signature**	**Date**

Some insurance companies are now reimbursing patients directly for services rendered by out-of-network providers. If you receive a check from your insurance carrier for services performed here at SCPT, Incorporated, please provide us with a photocopy of both the insurance check and Explanation of Benefits, and accompany that with a personal check in the amount paid by the insurance company. If you have any questions regarding this matter, please feel free to contact our office staff for assistance.

A. Notifier: SCPT, Inc., 1661 Golden Rain Rd., Bldg. D401, Seal Beach, CA 90740 (562) 795-6217

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Non-Coverage (ABN)

NOTE: ***If Medicare doesn't pay for the physical therapy treatment below, you will have to pay. Medicare does not pay for everything, even some care that you or your physician have good reason to think you need. We expect Medicare will not pay for the physical therapy treatment below:***

D. Physical Therapy Treatment	E. Reason Medicare Will Not Pay:	F. Estimated Cost
Treatment procedures and modalities rendered by the physical therapist as prescribed by your treating physican.	**1. You cannot receive home healthcare at the same time as outpatient physical therapy.** **2. You have exceeded the Medicare PT cap of $1,980.00.** **3. If you exceed the Medicare PT cap threshold of $3,700 for an "exceptional" diagnosis and Medicare denies further treatment.** **4. Medicare does not pay for this service for your condition.**	

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 physical therapy treatment 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 physical therapy treatment 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 physical therapy treatment 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 physical therapy treatment 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 of this.

I. Signature:	J. Date: