PERFORMANCE
PHYSICAL THERAPY
OF NAPLES, INC.

Complete Orthopedic, Sports, and Spine Rehabilitation

PATIENT REGISTRATION

PLEASE PRINT FULL NAME _____ DATE: _____

SOCIAL SECURITY NUMBER: _____ - _____ - _____ DATE OF BIRTH: _____ AGE: _____

SEX: M ____ F ____ SINGLE ____ MARRIED ____ WIDOWED ____ DIVORCED ____ SEPARATED _____

LOCAL ADDRESS: _____
P.O. BOX OR STREET ADDRESS CITY STATE ZIP

NORTH ADDRESS: _____
P.O. BOX OR STREET ADDRESS CITY STATE ZIP

CELL PHONE NUMBER: (_____) _____- _____ HOME PHONE NUMBER: (_____) _____- _____

WORK NUMBER: (_____) _____- _____ OUT OF STATE NUMBER: (_____) _____- _____

EMAIL**:** _____ EMERGENCY CONTACT: _____

PHONE NUMBER: (_____) _____- _____

PRIMARY INSURANCE: _____

ARE YOU THE PRIMARY POLICY HOLDER? YES - NO

If you are *not* the primary policy holder, please complete the fields below:

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SS#: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

SECONDARY/SUPPLEMENT INSURANCE: _____

SUBSCRIBER NAME: _____ RELATIONSHIP TO PATIENT: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER SS#: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

IF THIS WAS AN ACCIDENT COMPLETE THE FOLLOWING INFORMATION:

INSURANCE COMPANY: _____ CLAIM NUMBER: _____

CASE ADJUSTER: _____ PHONE NUMBER: (_____) _____- _____

DATE OF INJURY: _____ (CIRCLE ONE): **AUTO - FALL - WORK ACCIDENT - OTHER**

I understand that if I do not cancel an appointment 24 hours in advance I will be charged a $50.00 cancellation fee.

_____ _____
Patient Signature Date

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Consent for Treatment

New Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, _____, understand that as part of my health care, Performance Physical Therapy of Naples, Inc. originates and maintains paper and /or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professional who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Privacy Practices that provides a more completed description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or health care operations

I understand that Performance Physical Therapy of Naples, Inc. is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Performance Physical Therapy of Naples Inc. reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should Performance Physical Therapy of Naples, Inc. change their notice, they will send copy of any revised notice to the address I've provided, (whether U.S mail or if I agree email).

I wish to have the following restrictions to use or disclosure of my health information:

☐ *No Restrictions* ☐ *I Have Restrictions Listed Below*

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosure via fax.

I fully understand and accept the terms of this consent.

_____ _____

Patient Signature Date

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Insurance Assignment/Authorization to Release Confidential Information/ Consent for Treatment

1. _____ (initials) **I understand that should I not provide 24 hours notice to Performance Physical Therapy of Naples, Inc. to cancel my appointment, I will be charged a No Show/Cancellation fee of $50.00, which cannot be waived.**

2. _____ (initials) I give my consent for a physical therapy evaluation and treatment to be administered by Performance Physical Therapy of Naples, Inc.

3. _____ (initials) If this is a Workman's Compensation claim or a motor vehicle claim, I authorize the release of information to claim adjusters, case managers and employers.

4. _____ (initials) I authorize medical information to be released from my chart to my physician. I also authorize medical information to be released to my insurance carrier as needed for billing purposes.

5. _____ (initials) I understand that I am responsible for payment of services rendered. Billing will be done from this office to my insurance carrier and I will be responsible for my deductible. I am aware that I am responsible for co-pay amounts dictated by my insurance carrier. I will be charged "usual and customary amounts" based on the fee schedule for rehabilitation that my insurance carrier has developed or allowed.

6. _____(initials) I understand that Performance Physical Therapy of Naples, Inc., will verify my insurance benefits as a courtesy and collect copayments, coinsurance and deductibles based on an estimates only provided by your insurance carrier. Should my insurance carrier deny or make partial payment, I understand that I am responsible for any remaining balances.

7. _____ (initials) I authorize my insurance carrier to directly pay Performance Physical Therapy of Naples, Inc. for service appropriately rendered and billed for.

8. _____ (initials) I recognize that it is my responsibility to remit checks issued directly to me from my insurance carrier to Performance Physical Therapy of Naples, Inc. if my insurance carrier issues payment to me for services rendered and I have a remaining balance with Performance Physical Therapy of Naples, Inc.

Signature: _____ Date: _____

A. Notifier: Performance Physical Therapy of Naples, Inc.

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

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D. Occupational Therapy Services** below, you may have to pay. Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D. Occupational Therapy Services** below.

D. Occupational Therapy Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
CPT Codes: 97165, 97166, 97167: Evaluation 97760, 97763: Orthotic(s) management and training 97530: Therapeutic Activities 97110: Therapeutic Exercises 97140: Manual Therapy 97035: Ultrasound	Annual $2,150.00 Occupational Therapy Capitation has been met or exceeded and you do not qualify for the capitation exception.	$105.35 each visit/date of service

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. Occupational Therapy Services** 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. Occupational Therapy Services** 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. Occupational Therapy Services** 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. Occupational Therapy Services** 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: Home Health services must be complete before outpatient occupational therapy will be covered by Medicare. The patient is solely responsible for confirming that they have been discharged from home health prior to starting outpatient services. If this is not done, the patient may be responsible for the full visit price.

_____ Initial Here

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.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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MEDICAL INFORMATION - Medicare

Patient Name: _____ Age: _____ Date: _____

Mental Health (Check Box)
Have you ever been diagnosed with Depression or Bipolar Disorder? ☐Yes ☐No

During the past two weeks, have you often been bothered by the following problems?

- Feeling down, depressed, irritable, or hopeless? ☐ Yes ☐ No
- Little interest, or pleasure in doing things? ☐ Yes ☐ No

0 = Not at all
1 = Several Days
2 = More than half the days
3 = Nearly every day

If you answered "Yes" to either question above, please answer all questions below.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1	Feeling down, depressed, irritable or hopeless	0	1	2	3
2	Little interest or pleasure in doing things	0	1	2	3
3	Trouble falling or staying asleep	0	1	2	3
4	Poor appetite or overeating	0	1	2	3
5	Feeling tired or having little energy	0	1	2	3
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7	Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9	Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you are experiencing any of the problems on this form, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐Somewhat difficult ☐ Very Difficult ☐Extremely Difficult

EASI (Check Box)
Within the past 12 months:

1	Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	☐ Yes	☐ No
2	Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?	☐ Yes	☐ No
3	Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	☐ Yes	☐ No
4	Has anyone tried to force you to sign papers or to use your money against your will?	☐ Yes	☐ No
5	Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	☐ Yes	☐ No

Height_____ Weight_____

Fall History (Check Box)
Have you had any falls within the last 12 months? ☐Yes ☐No
If yes, how many? _____
Have any resulted in injury? ☐Yes ☐No

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MEDICAL INFORMATION – Medicare Continued

Treatment related to condition	**Start Date**	**End Date**	**Improved?**
☐Primary Physician			☐ Y ☐ N
☐Orthopedic Surgeon			☐ Y ☐ N
☐Physical Therapy			☐ Y ☐ N
☐Pain Management Clinic			☐ Y ☐ N
☐Neurologist			☐ Y ☐ N

Surgical History (Check Box)		**Date of Surgery**		**Date of Surgery**
☐Knee Arthroscopy	☐ L ☐ R		☐Neck Surgery	
☐Knee Replacement	☐ L ☐ R		☐Back Surgery	
☐Hip Replacement	☐ L ☐ R		☐Cancer Removal	
☐Shoulder	☐ L ☐ R		☐Other	
☐Heart Procedure (Bypass or Stent)				

Medical Condition (Check Box)	**Date Began**		**Date Began**
☐High Blood Pressure		☐Cancer (Type)	
☐High Cholesterol		☐Osteoporosis	
☐Diabetes		☐Stroke	
☐Osteoarthritis		☐Pacemaker	
☐Cardiac Arrhythmia		☐Other	

Medications

****If you have a medication list, please allow us to copy it at the front desk****

Current Medications	**Dosage**	**Frequency**	**Reason**
		1 2 3 /Day, or As Needed	
		1 2 3 /Day, or As Needed	
		1 2 3 /Day, or As Needed	
		1 2 3 /Day, or As Needed	
		1 2 3 /Day, or As Needed	
		1 2 3 /Day, or As Needed	

Pain Scale (Please Circle Worst Pain Level within Last Few Days)

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.