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

PRIMARY NUMBER: (_____) ________- _____________ SECONDARY NUMBER: (_____) ________- ___________

☐Cell ☐Home ☐Other: _______ ☐Cell ☐Home ☐Other: _______

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

Performance Physical Therapy of Naples, Inc.
4949 Tamiami Trail N Ste 104, Naples, FL 34103 ● 3841 Tamiami Trail East, Naples, FL 34112 ● 1201 Piper Blvd Ste 18, Naples, FL 34110
239-643-2040 239-732-9094 239-593-3010

PERFORMANCE PHYSICAL THERAPY
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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 $2,410.00 Occupational Therapy Capitation has been met or exceeded and you do not qualify for the capitation exception.	$118.30 each visit/date of service. This amount is estimated and can vary depending on treatment received.

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 may also receive a copy.

I. Signature:	J. Date:

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about- us/accessibility-nondiscrimination-notice.

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.

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MEDICAL HISTORY

Patient Name: ______________________ Age: ________ Date: ______________

Height: ______________ Weight: ______________

Treatment related to condition

Have you seen any other healthcare professional in regards to your current ailment? ☐ Yes ☐ No

If yes, please list them below and when you last saw them.

______________________ ______________________

______________________ ______________________

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	________

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

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

0	2	4	6	8	10
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

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*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 not be calculated if there is greater than 1 missing item.