PATIENT INFORMATION FORM

(PLEASE PRINT)

PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST FOR COPYING

1. Patient's Name (first, m.i., last) _____

2. Patient's Address _____

_____

3. Medicare # _____ if not applicable, check _____

4. Home phone # _____ Work phone # _____

5. Patient's Sex _____M _____F

6. Patient's Date of Birth _____

7. Patient's Employer _____

8. Patient's primary doctor _____ referring doctor _____

Primary doctor's phone number _____

9. If patient is same as insured, check here _____ and skip to #18

10. Insured's Name (first, m.i., last) _____

11. Insured's Address _____

12. Insured's telephone # _____

13. Insured's relationship to patient: _____spouse _____parent sex: _____M _____ F

14. Insured's Date of Birth _____

15. Insured's Employer _____

16. Is the Patient's condition related to or involving any of the following:

_____ Employment / Workman's comp.
_____ Auto Accident
_____ Lawyer / Attorney

17. Is there Secondary insurance? _____yes _____no If yes, please give insurance card to receptionist and complete the following if insured is not yourself.

Insured's name _____
Insured's date of birth _____

18. In case of emergency contact: _____ phone # _____

I authorize JVS Rehabilitation, Inc. to provide therapy services and to receive payment of medical benefits for the services. If the patient is under the age of 18, a parent or guardian must sign.

_____ _____

Patient's Signature Date

CONSENT FOR TREATMENT

The patient and/or patient's representative consent to have JVS Rehabilitation, Inc. provide any and all examinations and treatment as prescribed by his/her physician. Such treatments will be rendered according to JVS Rehabilitation's policies and procedures.

AUTHORIZATION FOR RELEASE OF INFORMATION AND PAYMENT

The patient and/or patient's representative consent to the release of JVS Rehabilitation's health care records to representatives of Medicare/Medicaid, Medicare Intermediary and/or private insurance companies for use in obtaining payment via the patient's benefits. Such records will also be available to all Health and Social Serviced agencies rendering medical or social services to the patient including, but not limited to medical review committees, accreditation boards or in response to legal process.

ASSIGNMENT OF BENEFITS

The patient and/or patient's representative certify that the information given in applying for payment is correct. Payment of authorized benefits is to be made directly to JVS Rehabilitation, Inc. in behalf of the patient.

PATIENT RESPONSIBILITY FOR PAYMENT OF SERVICES

The patient and/or the patient's representative are aware that they are responsible for any health insurance deductibles and co-insurance payments as indicated in his/her insurance policy or Medicare Part B claims.

In non-Medicare /Medicaid cases, the patient and/or patient's representative are aware that they are responsible for the entire bill, or balance of same, as determined by JVS Rehabilitation if the submitted claims or any part of them are denied for payment.

If patient is under the age of 18, a parent or guardian must sign.

Please list any people authorized by you to discuss your medical treatment with JVS:

Authorized to discuss treatment: _____

_____

DATE: _____ **SIGNATURE: _____**

CANCELLATIONS AND NO-SHOWS

The following are our policies regarding cancellations and no-shows. We take this subject very seriously at the clinic because it can make the difference between whether you succeed in your treatment or not.

- **We require 24 hours notice the event of a cancellation, if not there is a $25 cancellation fee. This fee is not covered by any insurance.**

- **For Worker's Compensation and Personal Injury patients, documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.**

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will review your chart, so you will be in good hands.

When you don't show as scheduled, three people are hurt: You because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

If the patient is under the age of 18, a parent or guardian must sign.

_____ _____

Patient's Signature Date

Medicare Cap

VERY IMPORTANT, WE MUST HAVE THIS INFORMATION
Have you had Physical Therapy or Speech Therapy at any time this year?

If 'YES' to the above, where did you have the therapy?

There is a $1900.00 cap on Physical Therapy and Speech Therapy combined at any other outpatient facility. If you answered 'YES' to the above question we can check to see how much of your benefit is left or if your condition is an exception to the cap.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient: _____

1) Is illness/injury due to an automobile accident, liability or workman's compensation?

   Yes _____ No _____

2) Is illness covered by the Black Lung or V.A. Program?

   Yes _____ No _____

3) Is your Medicare Coverage due to a disability? If yes, are there more than 100 employees in a group?

   Yes _____ No _____

4) Are you covered by an Employee Group Health Plan through your current employer, spouse's current employer or other family member's current employer? If yes, are there more than 20 employees in a group?

   Yes _____ No _____

5) Are you a renal dialysis patient in your first 18 months of dialysis?

   Yes _____ No _____

If the patient has responded "NO" to questions 1-5, Medicare is primary. If the patient has responded "YES" to any question, Medicare is secondary and the primary insurance information must be obtained.

NOTICE OF PRIVACY PRACTICES

Uses - Your Protected Health Information (PHI) will be used to obtain payment for treatment. The PHI will be provided to the patients referring physician and any other physician identified by the patient as requiring the information. PHI will be provided to attorneys/case managers identified by the patient when requested, in cases such as auto accidents or workman's compensation cases. Your PHI will not be used for any other purposes without your permission.

Patients' Rights – Patients may view, request a copy of, amend, or receive a list of individuals and organizations that have seen their medical information from the previous six years. A provider may deny access to a patient's records if the provider believes that release of that information will endanger the life or physical safety of the individual. In all other cases, providers have 60 days from the date of request to make the information available. Providers may provide a summary of the data instead of the actual data itself and may charge a fee for providing this information. A provider does not have to include material submitted by a patient if it was generated by another provider, is inaccurate, or is not part of the record set.

Complaints – If you are concerned that we have violated your privacy rights, you may ask to speak with our compliance officer, Janice Sallitt.

Legal Duty – We are required by law to protect the privacy of your information, provide this notice, and to attempt to get your acknowledgement of receipt of this notice. If you would like more detailed information about the HIPAA Privacy Rule you can speak with Janice Sallitt.

_____ _____

Patient's Signature Date

Physical Therapy
Speech Therapy

Phone (410) 740-0300

JVS Rehabilitation, Inc.

Century Plaza, Suite 129
10632 Little Patuxent Pkwy
Columbia, MD 21044

Fax (410) 740-0302

PLEASE READ CAREFULLY AND SIGN. YOU WILL GET A COPY TO KEEP FOR YOU RECORDS, along with a copy of your insurance therapy benefits, as they were stated to us.

As a service to our patients, we contact your insurance company to find out your therapy benefits before you start here.

Sometimes, your insurance company gives us incorrect information. We are not responsible for their error. You may want to contact your insurance company yourself to check your therapy benefits. We will do everything we can to help you with this process. Thank you.

Sincerely,

Janice Sallitt, PT,DPT,NCS
Clinical Director /JVS Rehab.

PATIENT SIGNATURE _____
DATE:_____

MEDICAL HISTORY FORM

Patient Name:_____

Check any of the following that apply to you:

_____ diabetes
_____ high / low blood pressure
_____ pacemaker / defibrillator
_____ deep brain stimulator
_____ other medical issues
_____ hearing / sight impairment
_____ past head injury
_____ mental illness
_____ Osteoporosis / Osteopenia
_____ Cancer

Surgeries (please provide dates):

For sterile precautions, please check if the following apply to you:

☐ HIV positive

☐ Hepatitis C positive

Current Medications and condition they treat (or provide a list):

What things can't you do now since this injury/problem?

PAIN LOCATION AND SEVERITY

Please rate the severity at this time of your pain / symptoms:

Circle Below

0	1	2	3	4	5	6	7	8	9	10
Pain Free										Severe

The pain is, ☐ **intermittent** ☐ **constant**

Please circle where your pain is located on the below diagram: