NEW PATIENT FORM

Thank you for choosing our facility and Welcome to JVS/Theradynamics

If you have ever been a patient at our JVS Clinic, please see secretary.

PATIENT INFORMATION

Last:_____ **First:**_____

DATE OF BIRTH: _____/_____/_____ **SS#:** _____-_____-_____ **Sex: M / F**

ADDRESS:_____ **APT# :** _____

CITY:_____**STATE:**_____**ZIP#:** _____

PHONE: CELL:_____**HOME:**_____**WORK:**_____

MARITAL STATUS: _____ **EMAIL ADDRESS:**_____

EMPLOYMENT STATUS: ▫ **full time** ▫ **part time** ▫ **retired** ▫ **unemployed** ▫ **student p/t** ▫ **student f/t**

IN CASE OF EMERGENCY:

Please Contact:_____ **Tel: (_____)**_____ **Relationship:**_____

MAJOR COMPLAINT:_____

IS YOUR COMPLAINT A RESULT OF A WORK-RELATED INJURY: **YES** ( ) **NO** ( ) IS YOUR COMPLAINT A RESULT OF A MOTOR-VEHICLE RELATED INJURY: **YES** ( ) **NO** ( ) IS YOUR COMPLAINT A RESULT OF A PERSONAL INJURY: **YES** ( ) **NO** ( )

WHEN DID YOUR CURRENT CONDITION START _____

INSURANCE INFORMATION

INSURANCE PROVIDER: _____

TEL: (_____)_____

INSURED NAME:_____

INSURED DOB: _____/_____/_____**SS#:**_____

RELATIONS TO THE INSURED:_____

POLICY ID#:_____**GROUP #:**_____

ADDRESS ***(IF DIFFERENT FROM ABOVE)*:**

_____

EMPLOYER:_____

ADDRESS :_____

SECONDARY INSURANCE

INSURANCE PROVIDER: _____

TEL: (_____)_____

INSURED NAME:_____

INSURED DOB: _____/_____/_____**SS#:**_____

RELATIONS TO THE INSURED:_____

POLICY ID#:_____**GROUP #:**_____

ADDRESS ***(IF DIFFERENT FROM ABOVE)*:**

_____

EMPLOYER:_____

ADDRESS :_____

REFERRAL INFORMATION:

How did you hear about JVS? Who referred you to us?

☐ Hospital ☐ Facebook ☐ Twitter ☐ Insurance ☐ Other: _____

☐ Newspapers ☐ Google ☐ Instagram ☐ TV Commercial

Who is your referring MD? _____

Primary Care Physician Name: _____

Primary Care Physician Contact Information

Telephone Number: _____ **Fax Number:** _____

APPOINTMENT REMINDER CONSENT

Last:_____ **First:**_____

Phone #: **Mobile:** _____ **Home:** _____ **Work:** _____

EMAIL ADDRESS:_____

This form gives your permission to provide automatic appointment reminder service by email or by cell phone text message.

- ☐ **May send email messages to confirm my upcoming appointments to THERADYNAMICS**
- ☐ **May send cell phone text messages to confirm my upcoming appointments to THERADYNAMICS**

I recognize that normal text messaging rates may apply.

Please indicate your Cell Phone Carrier.
We cannot set your account up to send email text message reminders without knowing your cell phone carrier.
Please indicate your carrier below, if you would like text message reminders:

- ☐ **ALL Tel**
- ☐ **AT&T**
- ☐ **Boost Mobile**
- ☐ **Cingular**
- ☐ **Cricket Wireless**
- ☐ **Metrocall**
- ☐ **MetroPCS**
- ☐ **Nextel**
- ☐ **Qwest**
- ☐ **Sprint PCS**
- ☐ **T Mobile**
- ☐ **US Cellular**
- ☐ **Verizon**
- ☐ **Virgin Mobile**

_____ _____

Patient Acknowledgment Signature **Date**

OFFICE POLICY INFORMATION

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE MEDICAL INSURANCE, WE ARE ANXIOUS TO HELP YOU RECEIVE YOUR MAXIMUM ALLOWABLE BENEFITS. IN ORDER TO ACHIEVE THESE GOALS, WE NEED YOUR ASSISTANCE, AND YOUR UNDERSTANDING OF OUR PAYMENT POLICY.

PAYMENTS FOR SERVICE IS DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN APPROVED IN ADVANCE BY OUR STAFF. YOU CAN CHECK WITH US FOR DIFFERENT FORMS OF PAYMENT WHICH ARE ACCEPTABLE.WE DO AS A COURTESY TO OUR PATIENTS, VERIFY YOUR INSURANCE COVERAGE FOR YOU. ALTHOUGH WE WOULD LIKE TO ACCEPT ASSIGNMENT FROM ALL INSURANCE CARRIERS, YOU CAN CHECK WITH US TO SEE IF WE ACCEPT ASSIGNMENT UNDER YOUR SITUATION.

IF OUR OFFICE ACCEPTS ASSIGNMENT, WE WILL FILE YOUR INSURANCE CLAIMS FOR YOU. YOUR INSURANCE CARRIER WILL MAKE PAYMENT DIRECTLY TO THIS OFFICE. YOU ARE RESPONSIBLE FOR PAYING THE DEDUCTIBLE AND CO-PAYMENT, IF ANY, BY MEANS OF PAYMENT WE ACCEPT. THESE PAYMENTS ARE DUE THE FIRST VISIT OF EACH WEEK OF CARE AND WILL INCLUDE THE CO-PAYMENT DUE FOR ALL THE VISITS FOR THAT WEEK. WE WILL GLADLY DISCUSS YOUR PROPOSED TREATMENT AND ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE

.

YOU MUST REALIZE HOWEVER, THAT: YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE CARRIER. WE ARE NOT A PARTY TO THAT CONTRACT.

1. OUR FEES ARE GENERALLY CONSIDERED TO FALL WITHIN THE ACCEPTABLE RANGE BY MOST CARRIERS, AND THEREFORE ARE COVERED UP TO THE MAXIMUM ALLOWANCE DETERMINED BY EACH CARRIER.THIS APPLIES ONLY TO CARRIERS WHO PAY A PERCENTAGE OF %50 TO % 80 OF U.C.R (USUAL, CUSTOMARY AND REASONABLE) FOR THIS REGION. THUS, OUR FEES ARE CONSIDERED U.C.R. BY MOST CARRIERS. THIS DOES NOT APPLY TO CARRIERS WHO REIMBURSE BASED ON AN ARBITRARY SCHEDULE OF FEES, WHICH BEARS NO RELATIONSHIP BASED ONAN ARBITRARY SCHEDULE OF FEES, WHICH BEARS NO RELATIONSHIP TO THE CURRENT STANDARD AND COST OF CARE IN THIS AREA.

2. NOT ALL SERVICES ARE A COVERED BENEFIT IN ALL CONTRACTS. SOME INSURANCE CARRIERS ARBITRARILY SELECT CERTAIN SERVICES THEY WILL NOT COVER. SINCE OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE CARRIER, WE STRONGLY RECOMMEND YOU CONTACT YOUR INSURANCE CARRIER TO VERIFY THE COVERAGE YOU HAVE. INACCURATE INFORMATION GIVEN TO US BY AN INSURANCE REPRESENTATIVE CONCERNING YOUR COVERAGE IS YOUR RESPONSIBILITY. WHILE FILING FOR INSURANCE CLAIMS IS A COURTESY WE EXTEND OUR PATIENT, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE THE SERVICES ARE RENDERED. WE REALIZE THAT TEMPORARY FINANCIAL PROBLEMS MAY AFFECT TIMELY PAYMENT OF YOUR ACCOUNT. IF SUCH PROBLEMS ARISE, WE ENCOURAGE YOU TO CONTACT US PROMPTLY FOR ASSISTANCE IN THE MANAGEMENT OF YOUR ACCOUNT. RETURNED CHECKS AND BALANCE OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES OF 1/5% PER MONTH (18% APR) CHARGES MAY ALSO BE MADE FOR BROKEN APPOINTMENTS AND APPOINTMENTS CANCELLED WITHOUT 24 HOURS ADVANCED NOTICE.

IF YOU HAVE ANY QUESTIONS ABOUT THIS INFORMATION OR UNCERTAINTY REGARDING INSURANCE COVERAGE, PLEASE DO NOT HESITATE TO ASK US. WE ARE HERE TO HELP

_____ _____

Patient Acknowledgement Signature **Date**

NOTICE OF PRIVACY PRACTICES / ACKNOWLEDGEMENT & CONSENT

I understand under the health insurance portability & accountability. Act of 1996, i have certain rights to privacy regarding my protected health information, I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among the mutilple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from third-party payers.**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have read, received and understand your notice of privacy practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization may change its notice of privacy practices from time to time and I can call obtain a copy of the current copy. I understand that I may request in writing that you restrict how my private information is utilized or disclosed to carry out my treatment, payment or healthcare operation. I also understand that you are not required to carry out my request. I have been given the right to review above notice of privacy practices prior to signing this consent. I understand that i may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name: _____

Signature: x_____ Date: _____

I attempted to obtain the patient's signature in acknowledgement of this notice, but was unable to do so as documented below.

Reason: _____ _____ _____
Initials Date

HIPAA PRIVACY AUTHORIZATION FORM

****Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)****

I authorize JVS to use and disclose the protected health information described below to

Information described below to _____
(individual seeking the information).

_____ _____
Patient Acknowledgement Signature Date

ASSIGNMENT AND INSTRUCTION FOR DIRECT PAYMENT TO DOCTOR PRIVATE AND GROUP ACCIDENT AND HEALTH INSURANCE

I hereby instruct and direct the _____ insurance company to pay by check made out and mailed directly to:

JVS
10632 Little Patuxent Pkwy., Ste. 129
Columbia, MD 20144
Tax Id #: 52-1901247

If my current policy prohibits direct payment to doctor, then I hear by also instruct and direct you to make out the check to me and mail it as follows: see above address

The professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services rendered. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed my indebtedness to the above mentioned assignee, and i have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment. I understand the above doctor has a financial interest, in any diagnostic testing. A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Date _____ **Day of _____** **20_____**

_____
Signature of the Policy Holder

_____
Signature of Claimant, If Other Than Policy Holder

INFORMED CONSENT

Physical / Occupational / Speech Therapy involves the use of many different types of physical evaluation and treatment. At this office, we use a variety of procedures and modalities to help us try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with therapy services.

Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality of procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your therapist what type of treatment he or she is planning based upon your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of treatment might be. You have the right to decline any portion of your treatment at any time before or during a treatment session. Therapeutic exercises are an integral part of your treatment plan. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by my therapist, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical/Occupational/Speech Therapy as outlined to me, and I wish to proceed.

_____
Patient Acknowledgement Signature

_____
Date

ALLERGIES TO MEDICATIONS

PLEASE LIST ALL MEDICATIONS, BOTH PRESCRIPTION AND NONPRESCRIPTION, YOU ARE ALLERGIC TO:

PRESCRIPTION MEDICATION

Use the chart below to list all the brand-name and generic prescription medications you currently take. Be sure to fill in all the information for each medication. The amount of medication in each pill appears on the prescription label in milligrams (mg). This is called the dose, or strength. The label on liquids and shots lists the dose too.

Medication Name	Prescribing doctor's name	Reason for taking the medication	Dose(example is 10mg, 50mg)	How Often (2x/ day, once per day)

NON-PRESCRIPTION MEDICATIONS, VITAMINS AND/OR SUPPLEMENTS

List all those you take occasionally, such as aspirin for headache, as well as those you take every day, such as a multivitamin or nutritional supplement. Include any herbs or alternative medicines that you take.

Medication Name	Prescribing doctor's name	Reason for taking the medication	Dose(example is 10mg, 50mg)	How Often (2x/ day, once per day)

ADVANCED BENEFICIARY NOTICE (ABN)

Explanation of Medicare Benefits

JVS is a Medicare Participating Provider. Medicare cap for outpatient physical/ speech therapy services combined is **$2230.00.** Medicare cap for outpatient occupational therapy services is **$2230.00.**

Reimbursement for therapy services are covered at 80%, the remaining 20% is patient responsibility. If you have secondary insurance, we will bill your secondary insurance as a courtesy.

Physician follow-up:
Medicare requires that patients to follow up with their referring physician every 30 days. It is the patient's responsibility to obtain a new prescription from their physician.

Home Health Aid (home attendant), Visiting nurse/home health physical therapy:
It is extremely important for you to inform us if you have any type of Home Health Service. Medicare will not pay for out patient physical therapy services if you have any type of Home Health Physical Therapy, or have received it in the past, and have not been discharged, or disenrolled from the service.

Have you had any service this year by any Home Health Agency? Yes No

Have you had any type of outpatient physical therapy this year? Yes No

Payments:
All deductibles, co-pays, and co-insurance are the responsibility of the patient. When we receive notification from your insurance company regarding payment of your claims, and any responsibility of the patient, we will send you a statement regarding this.

Patient Name:_____

Patient Signature:_____ Date:_____

Treatment of Minors

Here are a few things you should know about the physical therapy of an under aged patient in JVS Clinic

Parent or guardian must sign the consent to treat a minor form at all times, scan into welcome package and file into chart

1. When the patient is ***under the age of 12*** they have to be accompanied by a parent or guardian at all times.
    a. This includes the waiting area, treatment/evaluation room and gym area.
    b. At no point during their time should they be alone or unattended.
    c. If you see a child alone notify the parent or guardian; if alone in the gym area inform the therapist
2. When the patient is ***13 years of age*** they are allowed to be in the treatment and gym area.
    a. Though they can be alone in the treatment room
    b. The parent or guardian must still but in the waiting area and need to sign the superbill for them to receive treatment.
3. When the patient is ***16 years of age*** they are allowed to come to the office alone and sign the superbill for themselves.
    a. But in order to do so aside from the Consent form previously signed they will also need the Permission for a Minor form.
    b. Once both forms are signed they are able to come alone.

******Reminder: Always confirm with the office head therapist on how a child has to be supervised on a case to case basis******

CONSENT OF TREATMENT FOR MINOR
(WITHOUT A PARENT OR GUARDIAN PRESENT)

Date: ____ /____ /_____

Patient Name: _____

Patient Birthdate: ____ /____ /_____

The undersigned hereby authorize JVS Clinic to examine and treat the above mentioned minor by employees of JVS without a Parent or Guardian present.

Parent / Legal Guardian Name:_____

Contact Info - Tel#: _____ Email: _____

Parent / Legal Guardian: _____
Signature

Witness Name: _____

Witness Signature: _____

Important Medical Information (Allergies, Medications, etc.):

_____

_____

_____

Telehealth Consent

By signing this form, I understand and agree with the following: Telehealth/Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists and/or subspecialists, nurse practitioners, registered nurses, medical assistants and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate in the telehealth/telemedicine service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions. By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understood the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

Signature of Patient or Patient's Legal Representative **Date**

Printed Name of Patient or Patient's Legal Representative Relationship to the Patient **Date.**