Patient Welcome Packet **New Patient Form**

Thank you for choosing our facility and Welcome to Theradynamics!

If you have ever been a patient at any Theradynamics facilities, please notify a secretary

Patient Information:

Last Name: _____ First Name: _____

Date of Birth: _____/_____/_____ SSN#: _____ - _____ - _____ Gender: _____

Address: _____ Apt #: _____

City: _____ State: _____ Zip Code: _____

Phone: Cell: (_____)_____ Home: (_____)_____ Work: (_____)_____

Marital Status: _____ Email Address: _____

Employment Status: ☐Full-Time ☐Part-Time ☐Retired ☐Unemployed ☐Student F/T ☐Student P/T

In Case of Emergency:

Contact Name: _____ Contact Number: _____ Relationship: _____

Primary Care Physician (PCP) Information:

PCP Name: _____ Phone: (____)_____ Fax: (____)_____

Referring Doctor Information: *if different from above*

MD's Name: _____ Phone: (____)_____ Fax: (____)_____

Insurance Information: *Please provide the secretary with a copy of all insurance cards upon 1st visit.*

Primary Insurance Provider: _____ Ins Telephone: (_____)_____

Insureds Name: _____ Insured DOB: ____/____/ _____ Insured SSN: _____-_____-_____

Relationship to Insured: _____ Policy ID#: _____ Group #: _____

Address (If different from above): _____

Employer: _____ Employer Address: _____

Primary Insurance Provider: _____ Ins Telephone: (_____)_____

Insureds Name: _____ Insured DOB: ____/____/ _____ Insured SSN: _____-_____-_____

Relationship to Insured: _____ Policy ID#: _____ Group #: _____

Address (If different from above): _____

Employer: _____ Employer Address: _____

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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 conditional start? _____

Referral Information:

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

☐Hospital ☐Insurance ☐Instagram ☐Google ☐Facebook

☐Twitter ☐Self-Referred/Walk-In ☐Other: _____

☐Referring MD: _____

Allergies: *Please list all allergies to medications (both prescription and non) and other allergens (i.e. latex):*

_____

_____

_____

Medications You are Currently Taking:

Prescription Medications

Use the chart below to list all the brand-name and generic prescriptions 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; 10mg, 50mg*)	How Often (*2x/day, 1x/ day*)

Non-Prescription Medications, Vitamins and/or Supplements

List all those that you take occasionally, such as aspirin for headaches, as well as those you take every day, such as multivitamins or nutritional supplements. Include and herds or alternative medicines that you take

Medication Name	Prescribing Doctor's Name	Reason for taking the medication	Dose (*example; 10mg, 50mg*)	How Often (*2x/day, 1x/ day*)

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Appointment Reminder & Communication Consent

Last Name: _____ First Name: _____

Phone: Cell: (_____)_____ Email Address: _____

This form gives permission to provide automatic appointment reminders & communications by email or by cell phone text message.

☐May send email messages to confirm upcoming appointments, electronic bills/statements or other communication.

☐May send cell phone text messages to confirm upcoming appointments, electronic bills/statements or other communication.

I recognize that normal text messaging/date 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 you carrier information below, if you would like text message reminders:

☒ALL Tel	☐Metrocall	☐T-Mobile/Sprint	☐AT&T	☐Verizon
☐MetroPCS	☐US Cellular	☐Boost Mobile	☐Nextel	☐QWest
☐Virgin Mobile	☐Cricket Wireless	☐Other: _____		

_____ _____

Patient/Guardian Acknowledgement Signature Date

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MIPS FORM

MIPS QUALIFICATION – CLINIC FORM

Please answer each of the following questions and return the completed form to our clinical staff.

NAME: _____ **DATE OF BIRTH (**MM/DD/YYYY**):** _____

What are you/the patient being seen for?

- ☐Neck of Upper Back (Neck Disability Index)
- ☐Should or Upper Arm (Quick Dash)
- ☐Elbow or Forearm (Quick Dash)
- ☐Wrist or Hand (Quick Dash)
- ☐Mid Back or Lower Back (Modified Oswestry Low Back Disability Questionnaire)
- ☐Hip or Thigh (Lower Extremity Functional Scale)
- ☐Knee (Knee Outcome Survey)
- ☐Lower Leg (Lower Extremity Functional Scale)
- ☐Ankle or Foot (Lower Extremity Functional Scale)

On/Around what date did you/the patient begin experiencing this issue?

(MM/DD/YYYY): _____

What is the Primary Payer for this episode?

- ☐AUTO (Ex: Allstate, Farmers)
- ☐COMMERCIAL (Ex: Blue Cross/Blue Shield/ Aetna)
- ☐INDUSTRIAL (Ex: Worker's Comp.)
- ☐MEDICARE (Ex: Part B, Managed Medicare Plans)
- ☐MEDICAID (Ex: CHIP, Managed Medicaid Plans)
- ☐SELF PAY

OFFICE POLICY INFORMATION

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WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST POSSIBLE CARE. IF YOU HAVE MEDICAL INSURANCE, WE ARE EAGER 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 ARE 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, COINSURANCE AND CO- PAYMENT, IF ANY. PAYMENTS ARE DUE AT THE BEGINNING OF EACH VISIT. WE WILL GLADLY DISCUSS YOUR PROPOSED TREATMENT AND ANSWER ANY QUESTIONS RELATING TO YOUR INSURANCE

PLEASE NOTE - 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 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 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 YOU CONCERNING YOUR INSURANEC 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 BALANCES OLDER THAN 30 DAYS MAY BE SUBJECT TO ADDITIONAL COLLECTION FEES AND INTEREST CHARGES OF 15% 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/Guardian 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 multiple 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 this 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 to obtain a copy of the current policy. I understand that I may request in writing that you restrict how my private information is utilized or disclosed to carry out my treatment. I also understand that you are not required to carry out my request. I have been given the right to review the 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.

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 Theradynamics to use and disclose the protected health information described below to:

_____

(individual seeking the information)

Patient name: _____

_____ _____

Patient/Guardian Acknowledgement Signature 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: _____

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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:

Theradynamics Rehab PT, OT & SLP, PLLC **Tax ID: 83-3078983**

280 West 231st St.

Bronx, NY 10463

If my current policy prohibits direct payment, then I hereby instruct and direct you to make the check payable to me and mail it as follows:

Name: _____ Address: _____

City/State/Zip Code: _____

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 any balance of said professional service charges over and above this insurance payment. I understand the above 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.

_____ _____ _____

Signature of the Policy Holder Signature of Claimant, If Other Than Policy Holder Date

INFORMED CONSENT

Physical / Occupational / Speech Therapy involves the use of many different types of physical evaluations and treatments. 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 these services.

Since the 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 modality or procedure. We are not able to guarantee 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 clinician what type of treatment they are planning based upon your history, diagnosis, symptoms, and testing results. You may also discuss with your clinician 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 risks associated with it. If you have any questions regarding the type of exercises you are performing and any specific risks associated with your exercises, your clinician will be glad to answer them.

I acknowledge that my treatment program has been explained by my clinician, 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/Guardian Acknowledgement Signature Date

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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. 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/Guardian Date

Printed Name of Patient/Guadian: _____

Relationship: _____

Date: _____

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ADVANCED BENEFICIARY NOTICE (ABN)

Explanation of Medicare Benefits

Theradynamics Rehab PT, OT & SLP, PLLC is a Medicare Participating Provider. Medicare cap for outpatient Physical/Speech Therapy services combined is **$2,330.00.** Medicare cap for outpatient Occupational Therapy services is **$2,330.00.**

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