Dear Patient,

We are pleased that you have chosen SCOR Physical Therapy for your physical therapy needs.

Please take time to fill these forms out completely **prior** to your scheduled appointment so that the therapist can spend the full appointment with you.

On the day of your appointment, please bring:

*Completed Forms

*Insurance Card(s)

*Physical Therapy Referal/Persciption

**Please arrive 15 minutes early to allow sufficient time to check in.

The team at **SCOR PHYSICAL THERAPY**

SCOR PHYSICAL THERAPY

PATIENT INFORMATION

****Please present your insurance card for copying****

Patient Name:	Date of birth:	Age:	Gender:
Employment Status (circle one): Employed. Unemployed Retired Student	Email Address:		Marital Status:
Address:	City, State, Zip:		
Home Phone: Okay to leave a message? Yes No	Work/Cell Phone: Okay to leave a message? Yes No	Employer:	
Referring MD		Primary Care MD	
Financial Party (other than the patient)	Relationship:	Home Phone:	Work Phone:
Address:	City, State, Zip:		
Emergency Contact:	Relationship:	Home Phone:	
Address:	City, State, Zip:	Work Phone:	

CANCELLATION POLICY AND CONSENT TO TREAT

We at SCOR Physical Therapy want to provide the best possible care for our patient and attending your scheduled appointment is a necessary part of the treatment process. If there is no notice of cancellation 24 hours before the scheduled appointment, a $50 cancellation charge will be billed directly to the patient for each cancellation. If you do not show up for a scheduled appointment, this same $50 charge will be assessed.

By signing below, you acknowledged that you have read, understand and agree to abide by our cancellation policy as described. You also acknowledged the above patient information is correct to the best of your knowledge.

I grant permission for the staff of SCOR PHYSICAL THERAPY to perform the procedures as prescribed by my physician including a physical therapy evaluation. During the evaluation, the nature of the procedure that will be performed as well as the potential risk of care will be explained to me.

If I become ill, while undergoing treatment. I give permission to the staff to administer treatments which they consider necessary to my well-being. **My signature below indicate that I understand and give consent to be treated as Explained above.**

Patient Signature	**Guardian Signature (if patient is <18 years old):**	**Date:**
_____	_____	_____

NAME:	AGE:	CONCERN/PROBLEM	DATE OF ONSET

SECTION ONE-HEALTH HISTORY
Have you ever been diagnosed with any following conditions (Fill in appropriate circles)

1. *Cancer*	YES	NO	Type(s) : include Date of Diagnosis:		
	☐	☐			
2. *Infection*	YES	NO	3. *Cardiovascular*	YES	NO
Chronic Urinary Tract/kidney Infection	☐	☐	Heart Disease	☐	☐
Pneumonia	☐	☐	Pacemaker	☐	☐
Bone/Joint Infection	☐	☐	Arterial Blockage or DVT	☐	☐
Viral Conditions	☐	☐	High Blood Pressure	☐	☐
Other Infection (please list):	☐	☐	Stroke/TIA	☐	☐
			Other	☐	☐
4.General Medical Conditions	YES	NO	Life Factors	YES	NO
Rheumatologic / Arthritic Disorders	☐	☐	Daily Exercise	☐	☐
Heart or Lungs Disorders	☐	☐	Sleep 7-8 Hours Per Night	☐	☐
Pelvic, Incontinence, Urogenital Disorder	☐	☐	Over Ideal Body Weight	☐	☐
Gastrointestinal Disorders	☐	☐	Depression or Anxiety	☐	☐
Neurologic Disorders, Dizziness or Falls	☐	☐	Stress or Headaches(more than 1x/week)	☐	☐
Dermatologic Conditions	☐	☐	Pain Lasting Longer Than Three Months	☐	☐
Allergies	☐	☐	Prior Failed Treatment for Current Problem	☐	☐
Vision or Hearing Difficulty	☐	☐	Belief That Activity Will Worsen Problem	☐	☐
Diabetes	☐	☐	Lack Of Optimism Regarding the Future	☐	☐
Other Condition (please list):	☐	☐	Lack of Support At Home or Work	☐	☐

SECTION TWO - CURRENT MEDICATIONS
Please List All Medication Including Frequency and Dosage (Both Over The Counter And Prescribed)

MEDICATION NAME	FREQ	DOS	*MEDICATION NAME*	FREQ	DOS
1.)			7.)		
2.)			8.)		
3.)			9.)		
4.)			10.)		
5.)			11.)		
6.)			12.)		

SECTION THREE-SURGERIES/HOSPITALIZATION
Please List All Pervious Surgeries And Hospitalization You Have Had

TYPE/LOCATION	DATE
1.)	
2.)	
3.)	
4.)	
5.)	

SECTION FOUR-OTHER CURRENT CONDITIONS
Please Fill in Circle

	YES	NO
Recent, Unplanned Weight Loss	O	O
Unexplained Night Pain	O	O
Fever or Night Sweats	O	O
Nausea / Vomiting	O	O
Unexplained Weakness or Fatigue	O	O

Section Five-Health Related Habits
Please Fill in the circle

SMOKING	YES	NO	ALCHOLE USE	YES	NO
Do You Smoke?	☐	☐	DO YOU DRINK?	☐	☐
If yes, <1 Pack Per Day	☐	☐	If Yes, <1 Drink Per Day	☐	☐
If yes, >1 Pack Per Day	☐	☐	If Yes, >1 Drink Per Day	☐	☐
SENSITIVITIES	YES	NO	DRUG USE	YES	NO
Are You Latex Sensitive?	☐	☐	Do You Use Drugs Not Listed Above?	☐	☐
Are You Ice Sensitive?	☐	☐	If Yes, Daily	☐	☐
Are You Heat Sensitive?	O	O	If Yes, Occasionally	☐	☐
Prior Physical Therapy	YES	NO	Previous Falls	YES	NO
Please List Details	☐	☐	Please List Dates	☐	☐

I affirm that the above information is correct and true

Patient Signature : **Date:** **Therapist Review (initials) :**

SCOR PHYSICAL THERAPY

Office Payment Policy

It is the policy of SCOR PHYSICAL THERAPY that payment is due at the time of service unless other financial arrangements are made in advance. **We require all patients to pay their deductible, co-pay and/or co insurance payment at the beginning of each visit.** The Office Staff at your location will explain this information to you prior to or on your first visit. At the conclusion of your therapy with SCOR PHYSICAL THERAPY you may be billed for any outstanding balances.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the office staff and we will verify your coverage details, as a courtesy. You should NOT assume that employees or contractors of the insurance carrier will always provide SCOR PHYSICAL THERAPY with accurate information regarding your coverage. **Therefore, to be safe, you should also contact your insurance carrier and double-check your coverage for physical therapy.** Please remember that you are 100% responsible for all charges incurred: your physician's referral and our insurance verification do not guarantee payment by your insurance company.

Being referred to our clinic by a physician does not necessarily guarantee that your insurance will cover our services. Do not assume that you will not owe anything if you have more than one insurance policy. You are required to bring in your prescription from your physician, as well as your insurance card prior to being seen. All patient and insurance paperwork must be filled out completely or SCOR PHYSICAL THERAPY will charge you as a cash-paying patient.

If you need special payment arrangements, please discuss this with the office staff **before** starting your treatments.

Please initial your payment method and sign below that you have read, understand, and agree with all of the information on this page:

__1. **PRIVATE HEALTH INSURANCE (PPO):** Some insurance plans require authorization or a referral from your primary physician. Most insurance plans have a patient responsibility (deductible or amount paid by the patient before the insurance policy begins payment for services) and/or a co-pay (set dollar amount per visit) or coinsurance (a percent of the allowed charges). **Deductibles, copay, and coinsurance, are due at the time of service.** Should your insurance deny coverage, we will bill you for the outstanding amount.

__3. **MEDICARE:** SCOR PHYSICAL THERAPY is a certified Medicare provider. All Medicare covered patients are subject to an annual deductible and a cap to physical therapy benefits.

__4. **Secondary Medicare Insurance Provider:** _____

__5. **NO INSURANCE (CASH):** If you do not have insurance you may be eligible for an administrative discount if payment is received at time of service. Please notify the office staff that you do not have insurance so that payment plan can be discussed.

__6. **WORKER'S COMPENSATION CLAIMS:** Authorization from your insurance adjuster is required before you can begin treatment. Please provide the office manager with the name and the phone number of your adjuster, the date of your injury and you claim number, and any other pertinent information.

__ 7. **OTHER:** Please list the other type of payment: _____

----8. SUPPLIES: Pillows, tubing, braces, etc are to be paid for when items are received.

__9. ELECTRODES: Insurance companies do not provide reimbursement for individual electrodes for electrical stimulation/iontophoresis. We charge patients directly for these electrodes. This ensures that you will have personalized, clean electrodes for your individual use. Each packet lasts for approx. 15 visits. THE FEE IS $20 FOR EACH SET OF PADS.

I have reviewed this office payment policy and discussed it with the office. All my questions have been answered to my satisfaction and I understand all the information that has been explained to me.

Patient Signature:	**Guardian's Signature**(If patient is <18 years old)	**Date:**

SCOR PHYSICAL THERAPY

NOTICE OF PATIENT INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED HOW YOU CAN GET ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

SCOR PHYSICAL THERAPY'S LEGAL DUTY

SCOR PHYSICAL THERAPY is required by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

SCOR PHYSICAL THERAPY uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

SCOR Physical Therapy may also use or disclose your personal health information without prior authorization for emergencies. We also provide information when required by law. In any other situation, our policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

SCOR Physical Therapy may change its policy at any time. When changes are made, a new notice of Information Practices will be posted in the waiting room and patient exam areas will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances.

CONCERNS AND COMPLAINTS

If you are concerned that we many have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our Privacy Officer at the address listed below. You may also send a written complaint to the US Department of Health and Human Services.

For further information on our health information practices or if you have a complaint, please feel free to contact us as 949-496-0122

******Please retain this copy for your records******

SCOR PHYSICAL THERAPY

ACKNOWLEDGEMENT OF PATIENT INFORMATION PRACTICES

I have read and fully understand SCOR Physical Therapy's Notice of Patient Information Practices. I understand that SCOR Physical Therapy may use or disclose my personal health information for purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment, I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment and administrative operations if I notify the practice.

I hereby consent to the use and disclosure of my personal health information for purpose as noted in SCOR Physical Therapy's Notice of Patient Information Practices. I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.

_____

Patient Name

_____

Signature (Guardian if patient is a minor)

_____

Date

2022 Medicare Threshold Amounts on Therapy Services

Home Health Services & Outpatient Therapy:	
Beneficiaries <u>currently receiving</u> ANY type of home health services are <u>ineligible</u> for outpatient physical therapy until they have been discharged.	
❑ Yes ❑ No	Are you currently receiving ANY home health services?
❑ Yes ❑ No	Have you received ANY home health services (nursing, therapy, etc...) in the last six months? If Yes, indicate: Date services ended:

2022 Therapy Threshold Summary:	
Medicare has placed a financial limitation of $2,150 on the combined amount of physical therapy and speech-language pathology services and $2,150 on the amount of occupational therapy services for dates of service January 1, 2022 through December 31, 2022. The threshold excludes services provided at hospitals. The threshold is based on Medicare allowed fees. Based on our typical visit patterns, you may reach the threshold after approximately 18 visits. If you are close to reaching the threshold we will review the available options with you. Medicare has defined automatic and manual exceptions. We will inform you if you appear to be eligible for an exception and will institute the appropriate steps with Medicare. We believe that continuity of care is critical to reaching maximum function and returning you to an active lifestyle. Therefore, we have developed special programs to assist our patients that have reached the cap in continuing care here at SCOR. We will keep you informed about your options.	
❑ Yes ❑ No	Have you received ANY outpatient physical therapy or occupational therapy services since January 1, 2022? If Yes, indicate: Where: When:
❑ Yes ❑ No	Have you received ANY speech-language pathology services since January 1, 2022? If Yes, indicate: Where: When:

My signature below indicates that I have read and understand the above information regarding the Medicare Therapy Cap and have had all my questions answered.	
Signature:	Date:

Patient Options When Therapy Threshold Has Been Reached

The maximum benefit in allowed fees that Medicare provides for combined physical therapy and speech-language pathology services is $2,150 and/or $2,150 for occupational therapy for 2022. This form serves as the **Notice of Exclusions from Medicare Benefits (NEMB)** required by Medicare regulations.

There are items and services for which Medicare <u>will not pay</u>.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed decision about whether or not you want to receive these items or services, knowing that you will be responsible for paying. **Before you make a decision, you should read this entire notice carefully.** Ask us to explain if you do not understand why Medicare won't pay and/or how much these items or services will cost you (see the options below with estimated costs).

- Medicare will not pay for the following reason: Physical Therapy and/or Speech-Language Pathology services combined over $2,150 in 2022
- Medicare will not pay for the following reason: Occupational Therapy services combined over $2,150 in 2022

Your therapist may believe that continued physical therapy care is in your best interest due to functional limitations that remain. Our goal is to help you reach the maximum functional level. We recognize that continued care will have a financial impact on you and want to work with you to minimize that impact. Therefore, we have developed a number of options including reduced fees for cash payments, reduced frequency or length of visits, combined post-rehab fitness program with intermittent therapy or other options.

When we are familiar with you and your therapy needs, your therapist may believe that the following options would provide you the appropriate level of care to maximize your functional gains.

Continue with therapy at our special cash discount rate: $90.00 (plus occasional other fees)

Continue care at a hospital outpatient department that is not limited by the cap. Patient remains responsible for any co-payment amounts.

My signature below indicates that I have read and understand the above information regarding the Medicare Therapy threshold and have had all my questions answered.	
Signature:	Date:

A. Notifier:

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

Advance Beneficiary Notice of Non-coverage (ABN)

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

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Electrode Pads Electrode pads are used for electrical stimulation. Anyone who would like electrical stimulation would pay the $20 fee and would receive their own set of electrode pads for hygienic purposes.	Electrode pads are considered a supply	**$20.00**

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.** Electrode Pads 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.** Electrode Pads 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.** Electrode Pads 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.** Electrode Pads 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:

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.