SCOR PHYSICAL THERAPY

RETURNING PATIENT INFORMATION

****Please present your insurance card(s) for copying.****

Patient Name:		**Date of Birth:**	**Age:**	**Sex:**
E-mail Address :	**Is this injury work related? :**		**Marital Status:** **Single** **Married** **Other**	
Address:	**City, State, Zip**			
Home Phone: OK to leave message? Yes No	**Work/Cell Phone:** OK to leave message? Yes No	**Employer:**		
Referring MD:	**Primary Care MD:**			
Emergency Contact:	**Relationship:**	**Home Phone:**		
Has there been any change in your health history since the last episode of care with us? Please explain:				

CANCELLATION POLICY and CONSENT TO TREAT

We at SCOR PHYSICAL THERAPY want to provide the best possible care for our patients and attending your scheduled appointments 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 acknowledge that you have read, understood and agree to abide by our cancellation policy as described. You also acknowledge the above patient information is correct to the best of your knowledge.

I grant permission for the staff of SCOR PHYSCIAL THERAPY to perform the procedures as prescribed by my physician including a physical therapy evaluation. During this evaluation, the nature of the procedures that will be performed as well as the potential risks 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 indicates that** I **understand and give consent to be treated as explained above.**

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

SCOR PHYSICAL THERAPY

Patient Medical History Form-For Clinic Use ONLY

Current Concern/Problem: **Date of Onset:**

I. Have you ever been diagnosed with any of the following conditions? FILL IN THE APPROPRIATE CIRCLES.

1. Cancer:	Yes	Type(s), include date of diagnosis:
	0	

2. Infection:	Yes	No
Chronic Urinary Tract/Kidney Infection	0	0
Pneumonia	0	0
Bone/Joint Infection	0	0
Viral Conditions:	0	0
Other Infection: (Please List)	0	0
I.		

3. Cardiovascular:	Yes	No
Heart Disease:	0	0
Deep Venous Thrombosis {DVT):	0	0
Arterial Blockage of the Legs	0	0
High Blood Pressure:	0	0
Stroke/TIA	0	0
Other:		

4. General Medical Conditions:	Yes	No
Rheumatologic Disorders:	0	0
Lung Disorders:	0	0
Liver/Kidney Conditions:	0	0
Gastrointestinal Disorders:	0	0
Neurological Disorders:	0	0
Anemia/Blood Disorders:	0	0
Thyroid Conditions:	0	0
Gout:	0	0
Diabetes:	0	0
Dermatologic Conditions:	0	0

4. General Medical Conditions:	Yes	No
Osteoarthritis:(Wear-and-Tear Arthritis)	0	0
Osteoporosis/Osteopenia:	0	0
Dizziness or falls:	0	0
Depression:	0	0
Bowel/Bladder Incontinence:	0	0
Headaches: (more than 1 per week)	0	0
Vision orhearing difficulty	0	0
Immunologic/Allergy Conditions:	0	0
Genitourinary/Gynecologic Conditions	0	0
Other conditions:		

II. Please List All Medications Including Frequency and Dosage: (both over-the-counter and Prescribed)

	Frequency	Dosage		Frequency	Dosage
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

III. Surgeries and/or Hospitalizations:	
1.	Date:
2.	Date:
3.	Date:
4.	Date:
5.	Date:

IV. Other Current Conditions:	Yes	
1. Recent, unplanned weight loss?	0	0
2. Unexplained night pain?	0	0
3. Fevers or night sweats?	0	0
4. Nausea/Vomiting?	0	0
5. Unexplained weakness or fatigue?	0	0

V. Health-Related Habits

Smoking	Yes	No		Yes	No
If yes,< 1 pack/day?	0	0	Do you have a Pacemaker?	0	0
If yes, > 1 pack /day?	0	0	Are you Latex Sensitive?	0	0
Ice Sensitive?	0	0	**Heat Sensitive?**	0	0

Previous experience with physical therapy?	0	0	**How many falls have you had in the last year?**	**Are you currently pregnant?___**

I affirm that the above information is accurate and true.

Patient Signature_____**Date**_____**Therapist Review (Initials)**_____

2023 Medicare Threshold Amounts on Therapy Services

Home Health Services & Outpatient Therapy:	
Beneficiaries currently receiving ANY type of home health services are ineligible 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:

2023 Therapy Threshold Summary:	
Medicare has placed a financial limitation of $2,230 on the combined amount of physical therapy and speech-language pathology services and $2,230 on the amount of occupational therapy services for dates of service January 1, 2023 through December 31, 2023. 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/RSMPT. We will keep you informed about your options.	
❑ Yes ❑ No	Have you received ANY outpatient physical therapy or occupational therapy services since January 1, 2023? If Yes, indicate: Where: When:
❑ Yes ❑ No	Have you received ANY speech-language pathology services since January 1, 2023? 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:

Daniel A. Souza PT, DPT
Craig A. Legacy PT, DPT

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 $2,230 and/or $2,230 for occupational therapy for 2023. 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 $2,230 in 2023

- Medicare will not pay for the following reason: Occupational Therapy services combined over $2,230 in 2024

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: SCOR Physical Therapy
B. Patient Name: _____ **C. Identification Number:** _____

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for D._____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._____** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
*Electrode Pads (for TENS, IFC, NMES) *Durable medical equipment (braces, pillows, weights/bands, tape, pulleys, cold/hot packs, putty, etc.) *Physical Therapy Treatment not covered by your insurance, including "denied" or "not medically necessary" determination after chart reveiw.	NOT COVERED SERVICE/ SUPPLY OR INDEPENDENT MEDICARE REVIEW OF CHART NOTES DEEMED TREATMENT AS MEDICALLY NOT NECESSARY	INQUIRE FRONT OFFICE ASSISTANT FOR SERVICE/ITEM PRICE

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._____** 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._____** 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._____** 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._____** 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 may ask to 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.