



New Patient Registration

Patient Name		DOB	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Residence Address		City	State	Zip Code
Home Phone #	Cell Phone #	Work Phone #	Email	
If minor, parent or guardian's name		Social Security #	Driver's License #	Occupation
Name of Employer		Address		Phone #
Insurance Company Name		Address		Phone #
				Fax #
Subscriber's Name		Policy #	Certificate #	Group #
Secondary insurance Company Name		Address		Phone #
Subscriber's Name		Policy #	Certificate #	Group #
Physician's Name		Address		Phone # Fax #
Emergency contact		Relationship		Phone #

Patient Signature: _____ **Date:** _____

Patient History Form

Patient Name: _____ **Date:** _____

To best serve you, please answer the following questions as completely as possible.

1. Are you currently working? Yes No (If not, please indicate last day worked _____)

2. What is your occupation and describe the physical demands: _____

3. Describe your main complaints and symptoms: _____

4. Shade the human model to indicate painful areas.

5. Please rate your pain: 1 2 3 4 5 6 7 8 9 10

6. Which of the following words best describes your pain?

(Check all the apply)

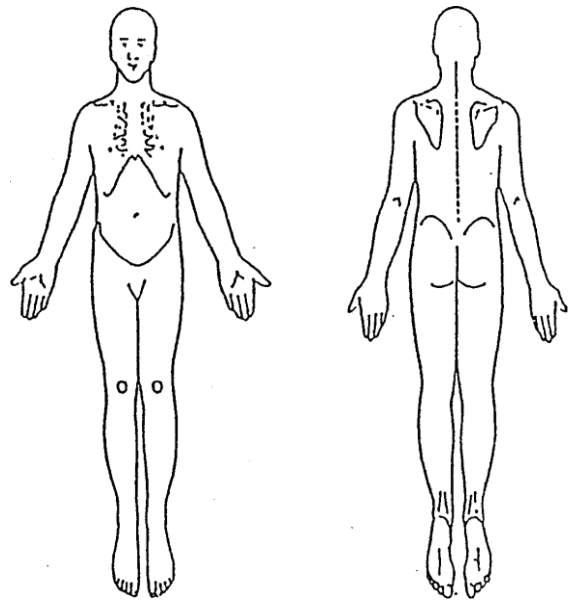
Sharp Dull Aching Tingling
Numb Constant Variable Radiating (moves)

7. How did the symptoms start?

8. What positions or activities make your pain worse?

9. What positions or activities make your pain better?

10. Have you received any treatment or taken any tests for this issue?





Past Medical History

Patient Name: _____ **Date:** _____

1. Have you ever had or been diagnosed with any of the following? If yes, please explain:

High Blood Pressure	Yes	No	_____
Heart Trouble	Yes	No	_____
Circulation Issues	Yes	No	_____
Seizures	Yes	No	_____
Dizzy Spells	Yes	No	_____
Diabetes	Yes	No	_____
Other Medical Issues	Yes	No	_____

2. Have you ever had surgery? Yes No If yes, please provide details below:

Procedure:

Date:

Notes:

(1) _____	_____	_____
(3) _____	_____	_____
(2) _____	_____	_____
(4) _____	_____	_____

3. Do you have metal implants? (Other than dental work) Yes No If yes, explain:

4. Do you have a cardiac (heart) pacemaker? Yes No

5. Please list any known allergies: _____

6. WOMEN: Are you pregnant? Yes No Date of last menstrual cycle: _____

7. Have you ever had Physical Therapy Treatments? Yes No If yes, please specify:

To the best of my knowledge, I certify that the above information is true and correct.

Patient Signature: _____



CONSENT TO TREAT

I, _____, hereby consent to routine physical therapy services as provided by From the Heart Physical Therapy under the supervision of a licensed Physical Therapist. I acknowledge that treatment may include any number of manual procedures, Myofascial Release techniques, exercises and/or modalities that will be rendered as part of the physical therapy treatment program provided by this office.

ACCEPTANCE OF OFFICE POLICIES & FINANCIAL AGREEMENTS

- A valid credit card is required to secure appointment reservations and will be held on-file for future visits. Visa and MasterCard are accepted. **Patient Initials:** _____
- Every Patient will be responsible for an administrative **Annual Service Fee of \$250** before booking an appointment each calendar year. **Patient Initials:** _____
- Patients must provide a 48-hour advance notification to cancel or reschedule appointments. If less than 48-hours' notice is given; the patient will be held accountable for the full amount of the service charged to the credit card on file. **Patient Initials:** _____
- Your appointment time is set-aside solely for you; therefore, we appreciate you being on-time. Late arrivals will result in abbreviated treatment time.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- For **private patients**, payment is required at the time services are rendered. We accept cash, debit, and credit cards.
- For **insurance patients**, I accept full financial responsibility if for any reason my insurance company does not reimburse From the Heart Physical Therapy for my treatments. I will communicate any changes made to my Medicare policy or coverage immediately. Our office will submit your claims to Medicare only up to the first cap of \$1980. As a courtesy to our patients we file your insurance at no charge if you provide all insurance information. If we receive a payment from your insurance company, we will issue a refund check to your address on-file.
- Patient Statements: All balances are due in full within 14 days of the statement date. We reserve the right to charge all accounts with a balance over 30 days from billing date a service charge of 1.5% per month. We reserve the right to submit your account in a collection program, report delinquent accounts to credit bureaus, assess a collection fee of up to 40% of the outstanding balance, take other collection action, and/or terminate you as a patient of this practice. In addition, if legal action is taken you will be responsible for the cost, which may be up to \$250.00 per hour.

I have read the Office Policies and Financial Agreements and agree to abide by all terms in this document:

Patient Signature: _____ **Date:** _____



Release of Medical Information

Patient Name: _____ **Date:** _____

Medical Facility: _____

You are hereby authorized and requested to furnish any and all medical information, history, records, diagnosis, reports and/or radiographs in your possession regarding the above named patient to From The Heart Physical Therapy.

Patient Signature: _____

If patient is a minor, please provide signature of parent or guardian and fill out below:

Printed name of parent or guardian: _____

Relationship: _____ **Date:** _____



Home Health Notification Policy
For All Medicare Beneficiaries

Patient Name: _____ **Date:** _____

Our company policy requires that you notify us of any changes concerning Home Health Services received while under our care. According to Medicare regulations, out- patient therapy services will not be covered for if you are enrolled in any Home Health agency. If you are or become enrolled in any home health services without notifying us, you will be personally responsible for all incurred therapy expenses from From The Heart Physical Therapy, Inc.

Patient Signature: _____

Witness Name: _____ **Date:** _____

Witness Signature: _____



Patient Name: _____ **Date:** _____

THERAPIST NOTICE

I am being advised by this document that my insurance will only pay for service(s) that it determines to be “medically necessary” and that are covered benefits. If my insurance company determines that a particular service(s), although it would be otherwise covered, is not medically necessary, nor a covered benefit, they will deny payment for that service(s). If any type of service from From the Heart Physical Therapy is not covered, I understand that From the Heart Physical Therapy will bill me for all services rendered and not paid by my insurance company and that I will be held personally and fully responsible for payment of all services rendered at From the Heart Physical Therapy.

Patient Signature: _____

BENEFIT AGREEMENT

I have been notified by my physical therapist that he/she believes that my insurance carrier is likely to pay From the Heart Physical Therapy for my medically necessary services; however, if my insurance company denies payment, I agree to be held personally and fully responsible for payment of all services rendered at From the Heart Physical Therapy.

Patient Signature: _____

WAIVER

I acknowledge that if my insurance does not show me eligible for coverage with the physical therapist I am seeing today at From the Heart Physical Therapy, for any reason including enrollment in Home Health Services, that I will be responsible for pay all my medical services “in full”.

Patient Signature: _____



A. Notifier:

B. Patient Name:

C. Identification Number:

Advance Beneficiary Notice of Noncoverage (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
Outpatient Physical Therapy Services @ From The Heart Physical Therapy, INC.	A. If you have exhausted your \$1980 Physical Therapy Cap OR B. If you have exhausted \$3700 Physical Therapy Cap using KX modifier	\$130.00-\$150.00 per visit

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 also receive a copy.

I. Signature:	J. Date:
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According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.



PATIENT MEDICATION LOG

Patient Name: _____ **Date:** _____

Please provide an accurate record of any/all medications that you are currently taking:

Medication Name	Dosage	Frequency
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____
(4) _____	_____	_____
(5) _____	_____	_____
(6) _____	_____	_____
(7) _____	_____	_____
(8) _____	_____	_____
(9) _____	_____	_____
(10) _____	_____	_____
(11) _____	_____	_____
(12) _____	_____	_____
(13) _____	_____	_____
(14) _____	_____	_____
(15) _____	_____	_____

To the best of my knowledge, I certify that the above information is true and correct. It is my responsibility to inform From The Heart Physical Therapy of any changes to this information.

Patient Signature: _____



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)**

Patient Name: _____ **Date:** _____

1. Authorization: I authorize **From The Heart Physical Therapy** to use and disclose the protected health information described below to _____ (individual or entity seeking the information).

2. Effective Period: This authorization for release of information covers the period of healthcare from:

a. _____ to _____.

****OR****

b. all past, present, and future periods.

3. Extent of Authorization:

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

****OR****

b. I authorize the release of my complete health record with the exception of the following information:

Mental health records

Communicable diseases (including HIV and AIDS)

Alcohol/drug abuse treatment

Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative: _____

Printed name of personal representative and his or her relationship to patient:



From The HeartTM

PHYSICAL THERAPY

Pain Disability Index

Name: _____

Date: _____

Family/Home Responsibilities: It includes chores or duties performed around the house and errands or favors for family members (ex. driving the children to school).

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Recreation: Hobbies, sports, and similar leisure time activities.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Social Activity: Activities that involve participation with friends and acquaintances other than family members. It includes parties, theater, concert, dining out, and other social functions.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Occupation: Activities that are a part of or directly related to one's job. This includes nonpaying jobs as well, such as that of a housewife or volunteer worker.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Sexual Behavior: Refers to the frequency and quality of one's sex life.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Self-Care: Refers to bathing and dressing

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability

Life-Support Activity: Eating, sleeping, and breathing.

No Disability 0 1 2 3 4 5 6 7 8 9 10 Worst disability