ENVISION PHYSICAL THERAPY MEDICARE INTAKE

Name: _____ Today's Date: _____

Date of Birth: _____ Contact Phone: _____

Address: _____ Email: _____

_____ Emergency Contact: _____

City/State/Zip: _____ Emergency Phone: _____

Referring Physician?: _____ Referring Physician Phone: _____

Have you had any physical or speech therapy this calendar year (including other facilities)? □ No □ Yes

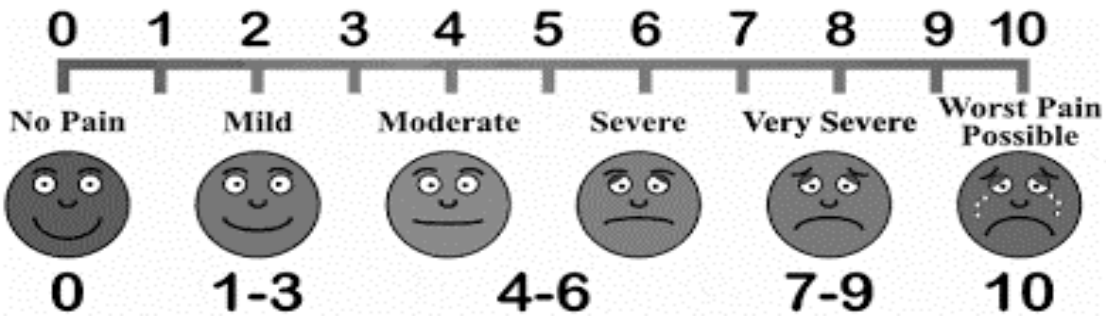
How did you hear about us? _____

Use the following section to briefly describe your symptoms/reason for visit? _____

_____

_____

IF THIS VISIT IS RELATED TO PAIN, please indicate your pain rating using the following scale:



If applicable, pain rating when you are feeling your best (lowest level of pain): _____

If applicable, pain rating when you are feeling your worst (highest level of pain): _____

Is there anything that increases your symptoms?: _____

Is there anything that decreases your symptoms?: _____

Have you fallen in the last 3 months? □ No □ Yes; _____

MEDICAL HISTORY (please check all that apply):

□ Allergy to Latex, Food, or Medication
□ Angina/Chest Pain
□ Anxiety and/or Depression
□ Arthritis
□ Asthma or Breathing Difficulties
□ Blood Pressure (specify): High Low
□ Cancer
□ Circulatory Disorder
□ COPD
□ Diabetes
□ Fibromyalgia
□ Headaches or Migraines
□ Heart Arrhythmia
□ Heart Attack or Heart Disease
□ Hepatitis
□ Hernia/Hernia Repair
□ HIV
□ Joint Replacement
□ Metal Implants
□ Multiple Sclerosis
□ Neuropathy
□ Osteopenia or Osteoporosis
□ Parkinson 's Disease
□ Peripheral Vascular Disease
□ Pregnant and/or Breastfeeding (currently)
□ Scoliosis
□ Seizure(s)
□ Smoker (current)
□ Stroke or TIA
□ Spinal Disk Herniation or Spinal Surgery
□ Thyroid Disorder
□ Vertigo/Dizziness

Please list any hospitalizations and/or surgical procedures: _____

_____

Please list ALL current medications and/or nutritional supplements: _____

_____

_____

_____

My signature acknowledges that the health history information provided above is accurate to the best of my knowledge.

Signature: _____ Date: _____

ENVISION PHYSICAL THERAPY

FEE SCHEDULE, PAYMENT POLICIES, ASSIGNMENT OF BENEFITS, AND RELEASE OF RECORDS

FEE SCHEDULE:

Physical Therapy Evaluation Low Complexity (97161), Medium Complexity (97162), High Complexity (97163)	Unit Rate: $250
Physical Therapy Re-evaluation (97164)	Unit Rate: $200
Therapeutic Exercise (97110) 15-minute treatment	Unit Rate: $70
Manual Therapy (97140) 15-minute treatment	Unit Rate: $70
Neuromuscular Re-education (NMR) (97112)	Unit Rate: $70
Therapeutic Activity (97530)	Unit Rate: $70
Gait Training (97116)	Unit Rate: $70
Ultrasound (97035) or Electrical-Stimulation (G0283)	Unit Rate: $70

PLEASE REVIEW EACH STATEMENT AND INITIAL TO ACKNOWLEDGE:

CONSENT TO TREATMENT AND RESPONSIBILITY TO NOTIFY PROVIDER OF CHANGES IN CONDITION:
I understand participation in a physical, massage or exercise therapy program carries with it a risk that certain physiological responses may occur. These may include but are not limited to changes in blood pressure, fainting, irregular heartbeat or heart attack. It is my responsibility to communicate to my provider any injury or change in physical condition, including hospitalization or medical procedures, which may affect my ability to participate **prior** to beginning each treatment session. **Initials:** _____

CANCELLATION POLICY: Failure to cancel your scheduled appointment within 24 hours of the appointment time will result in a $35 cancellation fee. If applicable, your insurance company will not be charged for your missed appointment, you will be responsible for payment out of pocket. **Initials:** _____

RIGHT OF REFUSAL: We reserve the right to refuse service to anyone, including any request for treatment outside our scope of practice as well as to anyone under the influence of drugs or alcohol. We also reserve the right to charge for the session time, if above status applies. **Initials:** _____

ASSIGNMENT OF BENEFITS: I hereby direct my insurance company: _____ and instruct you to make payment directly to Envision Physical Therapy for medical claims submitted by them on my behalf for medically necessary treatment. Your denial or delay to do so in a timely manner will be considered just cause for myself or provider to file a complaint with the insurance commissioner. I hereby give my permission to the Envision Physical Therapy to file this complaint on my behalf if deemed necessary. **Initials:** _____

RELEASE OF RECORDS: I hereby authorize Envision Physical Therapy to release to any attorney, physician, or insurance company, involved in my case, any medical records or other information necessary to process my claim, which will be utilized for the ultimate recovery of benefits related to my injury/illness. **Initials:** _____

I understand the fee schedule for services provided by Envision Physical Therapy. I have read the facility policies, assignment of benefits, and release of records stated above and agree to abide by them.

Print Name: _____

Signature: _____ **Date:** _____

Envision Physical Therapy ● 956 International Parkway, Suite 1580 ● Lake Mary, FL 32746
Ph (407) 936-0314 ●Fax (407) 936-0316 ● Stephanie Baker, PT, Clinic Director

ENVISION PHYSICAL THERAPY

OTHERS INVOLVED IN MY HEALTHCARE

Patient Name: _____ Date of Birth: _____

Employees and its providers of Envision Physical Therapy **MAY DISCUSS** all aspects of my healthcare with:

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

Print Name: _____ Relationship: _____

As the patient, you may also request that any part of your private health information (PHI) not be discussed with others involved in your care or for notification purposes, this includes family members or friends, as described in the notice of privacy practices. Your request must be in writing and state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If your physician does agree to the restriction, we may not use or disclose your PHI in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.

Envision Physical Therapy providers or employees **MAY NOT DISCUSS** aspects of my healthcare with:

Print Name: _____ Relationship: _____

Specific restriction: _____

Print Name: _____ Relationship: _____

Specific restriction: _____

Print Name: _____ Relationship: _____

Specific restriction: _____

ENVISION PHYSICAL THERAPY

RECEIPT OF PRIVACY NOTICE

My signature, below, certifies I have received or reviewed a copy of the NOTICE OF PRIVACY PRACTICES.

Patient's Printed Name: _____

Signature: _____

Patient Date of Birth: _____ Today's Date: _____

Comments: _____

_____

ENVISION PHYSICAL THERAPY

Below are the telephone numbers that must be posted by each licensed FQA facility to comply with CORE 408.801(5)(a)1. And 2. See statute below.

The complaint number is our agency toll free # 1-888-419-4356

The abuse line is 1-800-96-ABUSE (962-2873)

_____

408.810(5)(a) On or before the first day services are provided to a client, a licensee must inform the client and his or her immediate family or representative, if appropriate, of the right to report:

1. Complaints. The statewide toll-free telephone number for reporting complaints to the agency must be provided to clients in a manner that is clearly legible and must include the words: "to report a complaint regarding the services you receive, please call toll free 1-888-4119-3456"

2. Abusive, neglectful, or exploitative practices. The statewide toll free telephone number for central abuse hotline must be provided to clients in a manner that is clearly legible and must include the words: "to report abuse, neglect or exploitation, please call toll free 1-888-96-ABUSE (962-2873)." The agency shall publish a minimum.

A. Notifier: Envision PT

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

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:

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.

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