Performance Physical Therapy
909 Eagles Landing Pkwy, Suite 430
Stockbridge, GA 30281

Performance Physical Therapy
1617 Hwy 20 West
McDonough, GA 30253

Understanding the Medicare Cap

- The cap is $1,940 in allowed fees (not charges) for combined Physical Therapy and Speech Therapy in 2015
- There is a separate cap of $1,920 for Occupational Therapy
- Medicare pays 80%, and the beneficiary or secondary insurance pays 20%
- Medicare as primary has a $147 deductible for 2015

If the cap is reached:

- At this time there is an exceptions process – your Physical Therapist will decide if you need to continue and if you qualify for an exception to the cap amount.
- We will monitor your benefits and notify you of the amount used
- Some secondary carriers may begin to pay as primary after Medicare stops paying
- Once your benefits are exhausted, you can go to a hospital outpatient department and pay the co-insurance
- If you wish to continue your care with Performance Physical Therapy in 2015, we will offer a cash rate once Medicare stops paying

Please notify us if you have had any Physical Therapy or Speech Therapy in 2015, prior to the start of your treatment at Performance Physical Therapy.

Please sign below once the Medicare Cap and Benefits have been explained to you and your questions have been answered. You may request a copy of this form for your records.

If you have any questions, please contact our office at:

(770) 506.6993 (Stockbridge)

(770) 898.9993 (McDonough)

Name: _____ Date: _____

PATIENT INFORMATION FORM

Social Security #	First Name	MI	Last Name	Sex M/F	DOB / /
Home Telephone # ( )	Best Contact Telephone # ( )	E-mail Address		Marital Status	
Address (Street)		PO Box	City	State	Zip Code
Emergency Contact Name	Emergency Contact Phone # ( )	Relationship to Patient			
Current Employer	Employer Telephone # ( )	Policy Holder's Social Security #			
Policy Holder's Name	Policy Holder's DOB / /	Policy Holder's Employer			
Have you received services from a home health agency within the last 30 days? YES NO	Have you received any outpatient physical therapy this year? YES NO	Current Work Status (Circle One) Full Part Student Retired			

PAYMENT AND INSURANCE FILING

Payment Policy

Payment is requested at the time of service unless other arrangements are made prior to treatment. Payment may include a co-pay or estimated patient balance depending on your insurance type. Payment can be made by cash, check, MasterCard, Visa, Discover, American Express or Care Credit.

Insurance Filing

Performance Physical Therapy (PPT) will file your primary and secondary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance and you are responsible for the payment of that balance.

Our participation in an insurance program is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim. If your insurance does not pay, you should contact your insurance company. PPT will NOT negotiate the settlement of a disputed insurance claim.

Legal Cases

PPT cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered unless prior arrangements for payment have been made.

CONSENT FOR TREATMENT AND AUTHORIZATION

I do hereby consent for treatment at Performance Physical Therapy. I authorize PPT to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to PPT, PC when indicated on claim. I understand I am financially responsible for the services I received.

Signed:_____ Date:_____

Relationship to Patient:_____ Witnessed by:_____

Performance Physical Therapy

CANCELLATION & PRIVACY POLICIES

CANCELLATION POLICY

Your appointment time is important to you, your physical therapist and to others who are in need of our services. The following policy is in place to ensure everyone receives timely uninterrupted care.

- For cancellations please call us at least **24 hours** prior to your appointment time.
- There is a **$25.00 fee** charged if you do not attend your appointment and do not call to cancel at least 24 hours prior to your appointment time.
    - Future appointments will not be made until this fee is paid.
    - This fee is your personal responsibility and will not be billed to or paid by your insurance company
- If you are **more than 10 minutes late** for your appointment and there is not sufficient time left to complete your treatment, you may be asked to reschedule.

By signing below you acknowledge that you have read and understood this cancellation policy and agree to comply with it as written.

COMMUNICATION RELEASE

1. I hereby give permission to the PPT office staff to notify me for: (Check all that apply)

☐ Appointment changes by either personal message, recorded message or e-mail

☐ Appointment reminders by e-mail.

2. The individual(s) listed below is/are authorized to receive the above information on my behalf:

_____ _____

_____ _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICY

By signing below I confirm that I have received and reviewed a copy of the Notice of Privacy Practices from Performance Physical Therapy and understand the information as outlined.

By signing below I agree to the above statements and verify that the above information is accurate to the best of my knowledge.

Signed:_____ Date:_____

Relationship to Patient:_____ Witnessed by:_____

Performance Physical Therapy

Name:_____

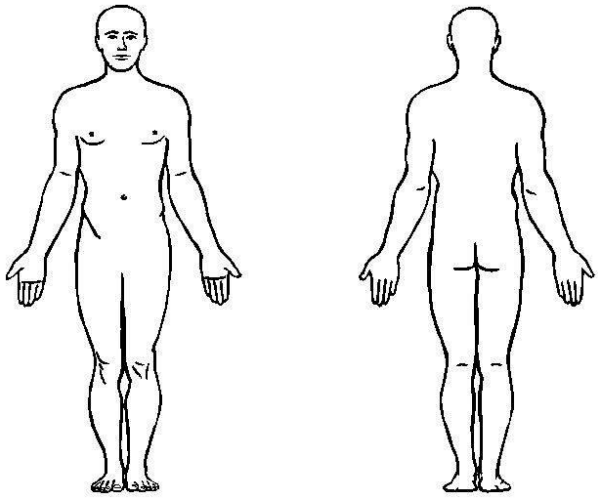
Date of Birth:_____

CURRENT COMPLAINTS

1. Please indicate the body part(s) to be treated today.
   ☐ Left ☐ Right

   ☐ Neck ☐ Shoulder ☐ Elbow ☐ Wrist/Hand
   ☐ Back ☐ Hip ☐ Knee ☐ Ankle/Foot
   ☐ Other:_____

2. On the diagram below please indicate where you are currently having pain:



3. When did the problem begin (date of injury)?
   _____

4. How did it happen?
   a. Injury? ☐ Yes ☐ No ☐ Unknown
   b. How did the injury occur?
      ☐ Accident ☐ Fall ☐ In competition
      ☐ Other _____
   c. Where did the injury occur? ☐ Work ☐ Home
      ☐ Other _____
   d. Surgery Performed? ☐ Yes ☐ No
      Date of surgery:_____

5. Have you had this problem(s) before? ☐ Yes ☐ No

   a. What did you do for the problem(s)?
      ☐ Physical Therapy ☐ Medication ☐ Physician
      ☐ Chiropractor ☐ Other _____

   b. Did the problem(s) get better? ☐ Yes ☐ No
   c. How long did the problem(s) last?_____

6. Have you had any of the following tests for your current problem?
   ☐ X-rays ☐ CT Scan ☐ MRI
   ☐ Bone Scan ☐ Nerve Conduction Study

7. Do you currently use any of the following?
   ☐ Cane ☐ Glasses ☐ Crutches
   ☐ Hearing Aid ☐ Walker ☐ Brace
   ☐ Pacemaker ☐ Wheelchair (Motor/Manual)
   ☐ Other:_____

8. Are you seeing anyone else for the problem(s)?
   ☐ Acupuncturist ☐ Orthopedist
   ☐ Cardiologist ☐ Osteopath
   ☐ Chiropractor ☐ Podiatrist
   ☐ Family Practitioner ☐ Psychologist/Counselor
   ☐ Internist ☐ Physiatrist
   ☐ Massage Therapist ☐ Rheumatologist
   ☐ Neurologist ☐ Other _____
   ☐ Ob/Gyn

9. Please list three activities that are difficult for you because of this current injury:
   1. _____
   2. _____
   3. _____

10. PLEASE USE THE PAIN SCALE TO ANSWER THE FOLLOWING QUESTIONS (*Circle one number for each*):

a.	What is your pain level NOW?	*No Pain*	0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*
b.	Pain at its WORST in the last week?	*No Pain*	0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*
c.	Pain at its BEST in the last week?	*No Pain*	0 1 2 3 4 5 6 7 8 9 10 *Worst Possible Pain*

PATIENT/GUARDIAN SIGNATURE: _____ DATE:_____

PHYSICAL THERAPIST SIGNATURE:_____LICENSE #:_____ DATE:_____

Performance Physical Therapy

Name:_____

Date:_____

MEDICAL/SOCIAL HISTORY FORM - MEDICARE

Please complete the following form to the best of your knowledge. If you are a returning patient you will be asked to complete this form once every **six months** to keep our records current.

MEDICAL HISTORY

1. Do you have any allergies? ☐ Yes ☐ No
   a. If yes, please list: _____
   _____
   _____

2. Please check if you have ever had any of the following:

- ☐ Alzheimer's disease
- ☐ Arthritis
  Type:_____
- ☐ Blood disorders
- ☐ Broken bones/fractures
- ☐ Cancer
  Type: _____
- ☐ Chemical dependency
- ☐ Circulation problems
- ☐ Depression
- ☐ Diabetes/High blood sugar
  - ☐ Type I Diabetes
  - ☐ Type II Diabetes
- ☐ Head Injury
  Type:_____
- ☐ Heart problems
  Type:_____
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Kidney problems
- ☐ Low blood sugar
- ☐ Latex allergy
- ☐ Lung problems
  Type: _____
- ☐ Multiple sclerosis
- ☐ Osteoporosis/Osteopenia
- ☐ Parkinson's disease
- ☐ Repeated infections
- ☐ Stroke
- ☐ Seizures/epilepsy
- ☐ Skin diseases
  Type: _____
- ☐ Thyroid problems
- ☐ Tuberculosis
- ☐ Ulcers/stomach problems
- ☐ Other:_____

3. Have you recently had any of the following symptoms?

- ☐ Bowel/bladder problems
- ☐ Chest pain
- ☐ Coordination problems
- ☐ Difficulty swallowing
- ☐ Dizziness/Lightheadedness
- ☐ Fatigue
- ☐ Fever/chills/sweats
- ☐ Loss of appetite
- ☐ Loss of balance
- ☐ Nausea/vomiting
- ☐ Pain at night
- ☐ Shortness of breath
- ☐ Unexplained weakness
- ☐ Unexplained weight loss/gain

4. Are you currently pregnant or think you might be pregnant? ☐ Yes ☐ No

CLINICAL TESTS

1. Within the past year, have you had any of the following tests? (Check all that apply.)

- ☐ Angiogram
- ☐ Biopsy
- ☐ Bone Density Scan
- ☐ CT Scan
- ☐ Doppler Ultrasound
- ☐ Echocardiogram
- ☐ EKG (electrocardiogram)
- ☐ EMG (electromyogram)
- ☐ Mammogram
- ☐ MRI
- ☐ Myelogram
- ☐ Nerve Conduction Test
- ☐ Pulmonary Function Test
- ☐ Stress Test
- ☐ X-rays
- ☐ Other:_____

SURGERY / HOSPITALIZATIONS

1. Have you ever had surgery? ☐ Yes ☐ No

2. Please list approximate dates and reasons for any surgery or other conditions (including childbirth) that required hospitalization:
   (a separate list may be provided)

Date	Reason for hospital stay
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

For Office Use

HEIGHT:_____ WEIGHT: _____ BP: _____ HR: _____ FALLS? ☐ YES ☐ NO _____

SOCIAL HISTORY

Work Status

1. Employment / Work (Job / School / Play)
   ☐ Working full-time ☐ Working part-time
   ☐ Regular duty ☐ Light duty

2. Occupation: _____

   ☐ Student ☐ Retired ☐ Unemployed ☐ Disabled

Cultural / Religious

1. Are there any customs or religious beliefs or wishes that might affect your care? ☐ No ☐ Yes

   a. Please explain:_____

Social/Health Habits

1. Smoking
   a. Do you currently use tobacco products? ☐ Yes ☐ No
      If yes: ☐ Cigarettes ☐ Cigars/Pipes ☐ Smokeless
      How many packs/day:_____
      If no: Have you used tobacco in the past?
      ☐ Yes ☐ No
      Year Quit:_____

2. Alcohol
   a. How many days per week do you drink beer, wine or other alcoholic beverages? _____

   b. If 1 beer, 1 glass of wine or 1 cocktail equals 1 drink, how many drinks do you have in average week? _____

3. Caffeine
   a. How much caffeinated coffee or caffeine containing beverages do you drink per day?_____

4. Exercise
   a. Do you exercise regularly?
      ☐ Yes Type: _____
      ☐ No
   b. On average, how many days per week do you exercise? _____
   c. For how many minutes, on an average day? _____

5. In the past month have you been feeling down, depressed or hopeless? ☐ Yes ☐ No

6. In the past month have you lost interest or pleasure in doing things you used to enjoy? ☐ Yes ☐ No

7. General Health Status. Please rate your health:
   ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Living Environment

1. With whom do you live?
   ☐ Alone ☐ Spouse only
   ☐ Spouse and others ☐ Child (not spouse)
   ☐ Other relative(s) ☐ Group Setting
   ☐ Personal Care Attendant
   ☐ Other:_____

Other

1. Primary Language:
   ☐ English ☐ Other:_____
   Do you need an interpreter ☐ Yes ☐ No

2. Learning Barriers
   ☐ None ☐ Vision
   ☐ Hearing ☐ Unable to read
   ☐ Unable to understand what is read
   ☐ Other _____

Patient/Guardian Signature: _____Date: _____

Physical Therapist Signature: _____License #:_____ Date: _____

Performance Physical Therapy

Current Prescription Medications

Name	Dosage	Frequency	Route of Administration	Reason for Taking
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	

Current Vitamins and Supplements

Name	Dosage	Frequency	Route of Administration	Reason for Taking
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	

Current Over the Counter (Non-Prescription) Medications

Name	Dosage	Frequency	Route of Administration	Reason for Taking
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	
			□ Oral □ Topical □ Other	

Reviewed by (PT):_____ License #:_____ Date:_____

FALLS EFFICACY SCALE

NAME:_____ DATE:_____

INSTRUCTIONS: On a scale from 1 to 10, with 1 being very confident and 10 being not confident at all, how confident are you that you are able to do the following activities without falling? Please reply thinking about how you usually do the activity. If you currently don't do the activity (example: if someone does your grocery shopping for you), please answer to show whether you think you would be concerned about falling IF you did the activity.

SCORE:

1 = Very Confident 10 = Not Confident At All

ACTIVITY:

1. Take a bath or shower

1 2 3 4 5 6 7 8 9 10

2. Reach into cabinets of closets

1 2 3 4 5 6 7 8 9 10

3. Walk around the house

1 2 3 4 5 6 7 8 9 10

4. Prepare meals not requiring carrying heavy or hot objects

1 2 3 4 5 6 7 8 9 10

5. Get in and out of bed

1 2 3 4 5 6 7 8 9 10

6. Answer the door or telephone

1 2 3 4 5 6 7 8 9 10

7. Get in and out of a chair

1 2 3 4 5 6 7 8 9 10

8. Getting dressed or undressed

1 2 3 4 5 6 7 8 9 10

9. Personal grooming (i.e. washing your face)

1 2 3 4 5 6 7 8 9 10

10. Getting on and off the toilet

1 2 3 4 5 6 7 8 9 10