Synapse Physical Therapy
Elevate Colorado, LLC.

ADMISSION FORM

MR Number:

PATIENT INFORMATION

Patient Name:_____ Date Injured: _____

Address:_____ SS#:_____Marital Status: S M D W O

City:_____State:_____Zip:_____ Date of Birth: _____ Sex: M F

Home Ph#:_____Work Ph#:_____ Cell Ph# _____

Email: _____ Workers Comp: Y N

Employer Name: _____ Auto Accident: Y N If yes, what State? _____

Employer Address: _____ **Have you received physical therapy at other locations this year? Y N**

City:_____State:_____Zip:_____ **If so, how many visits have you had?** _____

☐ **SELF**

Insured (Responsible) Party Name: ~~**PERSON WHO SIGNS CONSENT AND IS RESPONSIBLE FOR BILL**~~ Relationship to Patient: _____

_____ Address:_____ Date of Birth:

_____SS#: _____ City:_____State:___Zip: _____

Home Ph#:_____Work Ph#:_____ Employer Name: _____

PHYSICIAN INFORMATION

Referring MD:_____Phone #:_____Primary Care MD:_____Return to MD:_____

INSURANCE INFORMATION

If you are being seen for an injury related to ***work comp*** *or an* ***automobile accident****, please give us the name of your workers compensation /automobile carrier instead of your primary personal medical*

Primary Insurance:_____ Phone: _____

Group #:_____Subscriber/SS#: _____

Pt. Relation to insured: Self Spouse Child Other

Adjuster:_____Claim #:_____

Is your case in litigation? Y N

Attorney's Name: _____

Do you have Secondary Insurance? Y N

Name: _____

How did you hear about Synapse Physical Therapy? *(check all that apply)*

Friend/Relative? Who?_____Physician:_____Insurance: _____

Website: Other: _____

I authorize the release of any private health information necessary to process this claim.

I, the undersigned agree, whether signing as agent or as patient, that in consideration of the services rendered to the patient, to be individually obligated to pay the bill. Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fees.

I hereby assign payment directly to Synapse Physical Therapy/Elevate Colorado, LLC **BASIC BENEFITS** and/or **MAJOR MEDICAL** (catastrophe) **BENEFITS** herein specified and otherwise payable to me but not to exceed the regular charges for this period of treatment. I understand I am financially responsible for any charges not covered by this assignment.

I understand that upon discharge I may request, in writing, a copy of my records.

I have read, understand and signed the Synapse Physical Therapy/Elevate Colorado, LLC Financial Policy on the back of this page.

Signed: _____ Dated: _____
Insured and/or Responsible Party

Consent for Treatment

I hereby consent to participate in the Bumps and Bruises Assessment Program with Synapse Physical Therapy. I understand and agree that this assessment by a certified athletic trainer and / or licensed physical therapist will not provide a diagnosis of present or pre-existing condition and that the information provided by the assessment does not replace the evaluation and diagnosis of a physician. My participation in the Bumps and Bruises Assessment Program is to provide me with a consultative assessment of my current musculoskeletal condition by a certified athletic trainer and/or a licensed physical therapist.

Signed:_____ Dated: _____
Insured and/or Responsible Party

Synapse Physical Therapy
Elevate Colorado, LLC.

ADMISSION FORM

MR Number:

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

All patients must complete our *Information and Insurance Form* before seeing the therapist.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so, on a bi-weekly basis. Your contract for health insurance is between you and your insurance company. We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and Synapse PT. **It is ultimately your responsibility to see that your physical therapy bill is paid in full**. Agreements with insurance companies vary greatly and it is your responsibility to know what is their portion and what is yours. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying Synapse PT within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5% will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER: All co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

If you receive payment made out to both Synapse PT and you, please endorse the check and forward to us.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) accompanying a minor are responsible for full payment of the minor's treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid by cash or check at the time of service.

MISSED APPOINTMENTS

Because we commonly have a waiting list, unless cancelled at least 8 hours in advance, our policy is to charge for missed appointments. The charge is $50.00 for missed appointments. Insurance does not pay this charge. You are responsible. Please help us serve you better by keeping scheduled appointments, or call us to cancel, in a timely manner to allow another patient to have your scheduled time.

I have read the *Financial Policy*. I understand and agree to this *Financial Policy*.

HIPAA

I acknowledge the receipt of Synapse Physical Therapy's *HIPAA NOTICE OF PRIVACY PRACTICES*.

Signed:_____ Dated: _____

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

☐ Yes ☐ No If Yes, person's name:_____ Relationship:_____

Synapse Physical Therapy

PATIENT CANCELLATION AND "NO SHOW" POLICY

Your scheduled appointment is a specific time when your therapist will spend time with you. It is extremely important to be timely.

For Physical Therapy Services

If you are unable to attend, **YOU MUST NOTIFY THE CLINIC AT LEAST 8 HOURS IN ADVANCE AND RESCHEDULE TO MAKE UP THE MISSED APPOINTMENT**. Failure to attend your sessions may hinder your recovery process as well as disrupt the schedule of your therapist.

Cancellation or failure to attend three consecutive appointments will result in termination of your therapy program. To restart your therapy you must return to your physician for a new prescription and obtain additional authorization from your insurance company.

Work Comp Patients

In the event that you are covered by workers' compensation and fail to keep the appointments as recommended by your physician, the appropriate parties WILL BE NOTIFIED OF YOUR ABSENCE IN WRITING. Typically, the notification will be to your physician, insurance carrier, and employer and rehabilitation consultant. Each cancelled and "no show" appointment will also be noted in your chart. Please understand that failure to actively participate in your rehabilitation program may result in the impression that you are disinterested in your recovery or are better and able to return to work. Failure to attend therapy may have a negative effect on your workers' compensation coverage.

Fees

1. If you miss your scheduled appointment or cancel less than 8 hours in advance, you will be charged **$50** which is due at the time of your next appointment.

WE THANK YOU FOR RESPECTING THIS POLICY.

I, the undersigned, understand the *Patient Cancellation and No Show Policy* described above.

_____ _____

Patient Signature Date

_____ _____

Therapist Signature Date

Synapse Physical Therapy
11575 Main Street # 100
Broomfield, CO 80020
303-467-2288

Medical History

Name:

Existing or Relevant Previous Conditions

Allergies	◯ Yes ◯ No	Dizzy Spells	◯ Yes ◯ No	MRSA	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Emphysema/Bronchitis	◯ Yes ◯ No	Multiple Sclerosis	◯ Yes ◯ No
Anxiety	◯ Yes ◯ No	Fibromyalgia	◯ Yes ◯ No	Muscular Disease	◯ Yes ◯ No
Arthritis	◯ Yes ◯ No	Fractures	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No
Asthma	◯ Yes ◯ No	Gallbladder Problems	◯ Yes ◯ No	Parkinsons	◯ Yes ◯ No
Autoimmune Disorder	◯ Yes ◯ No	Headaches	◯ Yes ◯ No	Rheumatoid Arthritis	◯ Yes ◯ No
Cancer	◯ Yes ◯ No	Hearing Impairment	◯ Yes ◯ No	Seizures	◯ Yes ◯ No
Cardiac Conditions	◯ Yes ◯ No	Hepatitis	◯ Yes ◯ No	Smoking	◯ Yes ◯ No
Cardiac Pacemaker	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Speech Problems	◯ Yes ◯ No
Chemical Dependency	◯ Yes ◯ No	High/Low Blood Pressure	◯ Yes ◯ No	Strokes	◯ Yes ◯ No
Circulation Problems	◯ Yes ◯ No	HIV/AIDS	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No
Currently Pregnant	◯ Yes ◯ No	Incontinence	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No
Depression	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Vision Problems	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Metal Implants	◯ Yes ◯ No		

Describe any other conditions

If "Yes" to Any of the above, please explain and give approximate dates/Describe any other Conditions

Fall History

Injury as a result of a fall in the past year? ◯ Yes ◯ No

Two or more falls in the last year? ◯ Yes ◯ No

Patient is at risk for falls? ◯ Yes ◯ No

Surgical History

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Body Region: _____ Surgery Type: _____ Date: _____, _____, _____

Current Medications

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Drug: _____ Dosage: _____ Frequency: _____ Route: _____ Reason Taking: _____

Currently not taking any medications

SYNAPSE PHYSICAL THERAPY

To: Our Medicare Patients
Re: Medicare Coverage

Dear Patient,

This letter is to inform you of changes that occurred in Medicare outpatient rehabilitation service coverage. Medicare notified us that beginning January 1, 2017, there was a $1980 cap per beneficiary (patient) per calendar year. Please understand that Medicare regulates these changes that affect all therapy providers.

This $1980 limit applies to physical and speech therapy services with a separate $1980 limit on occupational therapy services. Our recommendation is that you assume that you have a "bank account of 10-20 visits that you can use per calendar year (January – December).

Medicare has provided an exception process in cases of medical necessity. Please ask your therapist if you qualify for an exception if you anticipate exceeding the therapy cap. *See next page for further explanation*

Please be aware that if services continue past the $1980 cap amount and you do not qualify for an exception, that you, the patient, becomes responsible for payment. ***This is why it is critical that you notify us if you have seen a physical, occupational or speech therapist prior to your visit with us.***

Our goal is to provide you with the care and education you need to obtain your greatest functional outcome. Your therapist will work with you to develop a plan to best utilize your visits.

Please feel free to direct all clinical questions to your therapist.
For all billing questions, please call 303-593-0696.

I HAVE READ AND UNDERSTAND THE MEDICARE CHANGES. I UNDERSTAND THAT I HAVE FINANCIAL RESPONSIBILITY FOR MEDICARE CO-PAYMENTS, $183 ANNUAL DEDUCTIBLE, AND ALL CHARGES EXCEEDING THE $1980 CAP LIMIT.

SIGNED PLEASE PRINT NAME DATE

A. Notifier: SYNAPSE PHYSICAL THERAPY

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

Advance Beneficiary Notice of Noncoverage (ABN)

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

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
PHYSICAL THERAPY SERVICES	**1. Medicare may not pay for PT Services over the $1980.00 beneficiary cap for 2017.** **2. Durable Medical Equipment (DME) and supplies are not covered benefits.**	

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. PHYSICAL THERAPY** 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. Physical Therapy** 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. Physical Therapy** 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. Physical Therapy** 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:

CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL THE PRESCRIPTION MEDICATIONS YOUR ARE CURRENTLY TAKING

NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE -COUNTER MEDICATIONS

NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS

NAME OF THE MEDICATION	DOSAGE (how many or how much you take)	FREQUENCY (how often do you take it)	ROUTE (how do you take it, i.e., by mouth, injection etc.)