ACCESS Physical Therapy, LLC

198 E. Wesmark Blvd., Suite 1
Sumter, South Carolina 29150
P: (803) 774-2781 F: (803) 774-2782

Name _____

Address _____ City _____ State ____ Zip Code _____

Date of Birth: _____ Age: _____ ☐ Female ☐ Male

Home Phone: _____ Cell Phone: _____

Text appointment reminders? ☐ Yes ☐ No If yes cell number: _____

May we leave a detailed message if we are unable to contact you? ☐ Yes ☐ No

Email Billing Statements? ☐ Yes ☐ No Email address: _____

Marital Status: ☐ Single ☐ Married ☐ Other

Primary Care/Referring Physician _____

Whom may we contact in case of an emergency? _____
Phone #: _____ Relationship _____

Are you currently employed? ☐ Yes ☐ No Employer _____
Occupation _____

Insurance Information

Primary Insurance _____ ID # _____
Policy Holder's Name _____ Relationship _____

Secondary Insurance _____ ID # _____
Are you covered under any other healthcare plan? ☐ Yes ☐ No

Who is responsible for this bill? _____

I have received services by another provider for which I seek treatment today and I will promptly disclose any necessary information to my insurance carrier necessary to resolve any issues they may have. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completed the above answers. I certify that this information is true and correct to the best of my knowledge and will notify you of any changes in my status or the above information.

Signature _____ Date _____

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PERSONAL MEDICAL HISTORY

Please complete the following information, sign, date and return to the receptionist.

Patient Information

Last name: _____ First Name _____

☐ Female ☐ Male Date of Birth: _____

Height _____ Weight _____

Medical Information

Do you smoke? ☐ Yes ☐ No Do you use alcohol? ☐ Yes ☐ No
Do you participate in physical exercise? ☐ Yes ☐ No How often? _____
Are you pregnant? ☐ Yes ☐ No ☐N/A If so, how many weeks? _____
Is this related to an automobile accident? ☐ Yes ☐ No Body area affected: _____

Please check the following conditions if you currently have or previously had:

General

☐ Recent weight change ☐ Pain ☐ Fatigue ☐ Diabetes ☐ Loss of sleep
☐ Cancer _____ ☐ Allergies _____
☐ Disabilities _____ ☐ Other _____

Skin

☐ Bruise easily ☐ Itching ☐ Skin Problems _____
☐ Other _____

Neurology

☐ Light Headedness ☐ Headaches ☐ Epilepsy/Seizures ☐ Memory Loss ☐ Multiple Sclerosis
☐ Weakness ☐ Difficulty Speaking ☐ Parkinson's Disease ☐ Numbness ☐ Difficult Swallowing
☐ Disorientation ☐ Tingling ☐ Tremors ☐ Loss of Coordination ☐ Stroke ☐ Fainting ☐ Difficult Walking
☐ Dizziness ☐ Concussion ☐ Migraines ☐ Other _____

Respiratory

☐ Throat Irritation ☐ Emphysema ☐ Asthma ☐ Chest Pain ☐ Shortness of Breath ☐ Bronchitis
☐ Lung Cancer ☐ Chronic Cough ☐ Pneumonia ☐ Other _____

Eyes & Ears

☐ Hearing Loss ☐ Ear Pain ☐ Ringing in Ear ☐ Vision Problems ☐ Glaucoma ☐Blurred Vision
☐ Sinus Problems Other _____

Cardiovascular

☐ Pressure over chest ☐ High Blood Pressure ☐ Excessive Sweating ☐ Pain down left arm
☐ Low Blood Pressure ☐ Heart Attack ☐ Nausea ☐ Ankle Swelling ☐ Irregular Heartbeat
☐ High Cholesterol ☐ Shortness of Breath ☐ Other _____

Musculoskeletal

☐ Neck Injury ☐ Bone Spurs ☐ Osteoporosis ☐ Muscle Weakness ☐ Birth Defect ☐ Joint Pain
☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Scoliosis ☐ Back Injury ☐ Head Injury ☐ Spondylolisthesis
☐ Spinal Trauma ☐ Muscle Pain ☐ Birth Trauma ☐ Broken Bones ☐ Other _____

Surgeries

Date Description

_____

_____

_____

Current Medications

Medication Dosage Frequency

_____

_____

_____

_____

_____

_____

Print Name _____ Date ___/___/____

Signature _____

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Statement of Patient Rights and Responsibilities

As a client of Access Physical Therapy, you have the right to:

- Choose your provider.
- Be given written and verbal notice about your rights and responsibilities before receiving care.
- Be given information about policies and procedures, frequency or proposed visits, and the name and qualifications of the person(s) providing your care, and be kept informed of the changes in services provided by the company.
- Be given appropriate and professional quality services without discrimination against race, color, religion, sex, age, national origin, disability, veteran status or ability to pay.
- Be treated with courtesy and respect in regards to you personally and your property.
- Be given complete and current information concerning diagnosis, treatment and to disclose in terms and language you can understand.
- Accept or refuse services and participate in planning and/or changing your plan of care.
- Receive no experimental treatment nor participate in any research without your documented, voluntary informed consent.
- Refuse treatment within the confines of the law and be informed of the consequences of your action.
- Be advised, before care is initiated, of the extent to which payment may be expected from Medicare or other sources of insurance, and the extent to which payment may be expected from the client.
- Be informed within a reasonable time of anticipated termination of services.
- Be assured that the staff will support and protect the human and legal rights of each individual including the right to confidentiality and privacy. You have the right to review your clinical record at your request.
- Vice grievances about your care or suggest changes in the services of staff without being threatened, restrained, or discriminated against.

As a client of Access Physical Therapy, you have the responsibility to:

- Give accurate and complete information concerning your past illnesses, medications, hospitalizations, allergies and other pertinent items.
- Assist in developing and maintaining patient confidentiality, a safe environment, and to treat Access Physical Therapy staff and property with respect.
- Participate in the development and update of your plan of care and adhere to the plan of care.
- Request further information concerning anything you do not understand and to give information regarding concerns and problems or dissatisfactions regarding services you may have to a staff member.

Patient Name _____ (Please Print)
Patient Signature _____ Date ___/___/_____

Consent to Care and Acknowledgment Form

I, _____, wish to have physical therapy services provided for me by Access Physical Therapy. By signing this document I am agreeing to the following:

1. I consent to the rendering of physical therapy services by Access Physical Therapy and its personnel according to my physician's authorized plan of treatment.
2. I understand that treatment may involve risk of injury and of adverse results. I hereby acknowledge that no guarantees have been made to me as to the results of treatments which I may undergo while receiving physical therapy services from Access Physical Therapy personnel.
3. I consent to emergency treatment if and when a physician or other medical personnel at Access Physical Therapy deems necessary and appropriate.
4. I understand that Access Physical Therapy is liable neither for accidents and/or injuries to me or others nor for loss of or damages to personal property while I am under the care of Access Physical Therapy.
5. I understand that I have the right to consent or refuse consent to any proposed procedure or therapeutic course of treatment. I may also terminate physical therapy services at any time by notifying an employee of Access Physical Therapy.
6. I hereby grant permission to Access Physical Therapy to obtain and/or release medical and health records, information and other necessary data regarding the above named patient as needed to provide care and for Medicare and insurance claims.
7. ASSIGNMENT OF BENEFITS: I hereby assign and authorize payment directly to Access Physical Therapy for any physical therapy benefits due to Access Physical Therapy from third parties for services rendered.
8. I certify that the information given by me in applying for payment is correct. If any of the information provided by me is incorrect, or if the third party insurance denies the claim, or if there are applicable deductibles or co-payments, I agree to be responsible for the payment of said services.
9. I understand that this consent is in effect until revoked by me.

Patient Signature: _____ Date: _____

Staff Member Signature: _____ Date: _____

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Cancellation Policy

We are committed to exceptional customer service and clinical care to expedite the healing and recovery process. To accomplish this, it is extremely important that you attend each of your scheduled appointments. If you know that you will be unable to make a scheduled appointment, ***PLEASE CALL THE OFFICE IMMEDIATELY*** for rescheduling, and allow us to fill your therapist's time slot.

- We require at least 24 hours advance notice of appointment cancellation.
- In the event of a late cancellation or "No-Show", your account may be assessed a $20.00 Cancellation Fee.
- Worker's Compensation patients are not charged for cancellations or "No-Shows", However, we are required to notify the patient's Physician, Case Manager and Employer of non-compliance with therapy.

Please be advised that we hold the right to terminate services due to inconsistent attendance at our discretion.

Patient Name: _____ (Please Print)

Patient Signature: _____ Date: ___/___/____

Staff Member Signature: _____ Date: ___/___/____

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- 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 choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself. **Before you make a decision, you should read this entire notice carefully.**
Ask us to explain, if you don't understand why Medicare won't pay.
Ask us how much these items or services will cost you (**Estimated Cost: $** DEDUCTIBLE + 20%).

Medicare will not pay for: PHYSICAL THERAPY OVER $ 1900.00

☒ **1. Because it does not meet the definition of any Medicare benefit.**

☐ **2. Because of the following exclusion * from Medicare benefits:**

- ☐ Personal comfort items.
- ☐ Most shots (vaccinations).
- ☐ Hearing aids and hearing examinations.
- ☐ Most outpatient prescription drugs.
- ☐ Orthopedic shoes and foot supports (orthotics).
- ☐ Health care received outside of the USA.
- ☐ Services required as a result of war.
- ☐ Routine physicals and most tests for screening.
- ☐ Routine eye care, eyeglasses and examinations.
- ☐ Cosmetic surgery.
- ☐ Dental care and dentures (in most cases).
- ☐ Routine foot care and flat foot care.
- ☐ Services by immediate relatives.
- ☐ Services under a physician's private contract.
- ☐ Services paid for by a governmental entity that is not Medicare.
- ☐ Services for which the patient has no legal obligation to pay.
- ☐ Home health services furnished under a plan of care, if the agency does not submit the claim.
- ☐ Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- ☐ Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- ☐ Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- ☐ Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- ☐ Services of an assistant at surgery without prior approval from the peer review organization.
- ☐ Outpatient occupational and physical therapy services furnished incident to a physician's services.

* **This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Signature

Date

Form No. CMS-20007 (January 2003)

ACCESS Physical Therapy, LLC

Acknowledgement of Receipt of Privacy Notice regarding Protected Health Information

I acknowledge that I have read the Access Physical Therapy Notice of Privacy regarding Protected Health Information. I have been provided an opportunity to discuss questions or concerns I may have regarding the privacy of my health information and understand the contents of the Notice.

Patient Name: _____ **Relationship:** _____

Patient/Representative's Signature: _____ **Date** ___/___/____

Staff Member Signature: _____ **Date** ___/___/____