

MEDICARE PATIENT & PAYOR INFORMATION FORM

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: () - () - () - () -
Home Mobile Work Emergency

(2) Patient

Sex: M F

Birthdate: ___/___/___

S.S # ___/___/___

Legal Photo ID # _____
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy:

Did this Condition Result in Surgery? No Yes If Yes Date of Surgery ___/___/___

Did this Condition Result from a Work Injury? No Yes If Yes Date of Accident ___/___/___

Have You Had PT Anywhere this Year? No Yes If Yes Where? _____

Are You Currently Receiving Home Health? No Yes If Yes From Who? _____
(i.e. any healthcare worker, aide assisting or doing something to or for you?)

Do You Live in a Nursing Home? No Yes If Yes What Is Its Name? _____

Are You Covered Under Black Lung Disease? No Yes

Are You Covered by End Stage Renal Disease? No Yes

Are you Covered by Group Insurance? No Yes If Yes Name/Group # _____

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: Last First Initial Office Phone: () -
MD, DO, DDS, Other

Address: Street City,State Zip Code

(5) Payor Information Primary:

Primary Insurance Company: Medicare

Insured's Name: _____ Patient ID # _____ Group # _____

Regular Medicare: Yes No Rail Road Medicare: Yes No

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

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(6) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ Insured's Name: _____ Ins. Ph# _____

Insured is: ___ Patient ___ Spouse ___ Parent

Patient ID #: _____ Group. # _____ Policy/Plan #: _____

Claims Mailing Address: _____
Street City State Zip Code

Employer Name: _____ Employer Phone # () _____ - _____

Address: _____
Street City State Zip Code

(7) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(8) Payment Authorization: *(Initials required for all 3 statements)*

Assignment of Insurance Benefits

Initials I authorize that the payment of my insurance benefits be made directly to Brookline Physical Therapy for any services that are reimbursable by Medicare or my any other insurance company, if I have one.

Guarantee of Payment

Initials I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.

Certification of Information

Initials I certify that the information I have provided Brookline Physical Therapy for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(9) Signature/ Date:

Patient or Legal Representative's Signature

Today's Date

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

PAYMENT AUTHORIZATION

Assignment of Insurance Benefits

Initials

I authorize that the payment of my insurance benefits be made directly to **Brookline Physical Therapy** for any services that are reimbursable by Medicare, Medicaid or any third party payors.

Guarantee of Payment

I understand that all payments designated as "the patients responsibility" are due and payable at the time of service or billing. I guarantee that I will pay:

_____ My designated portion including co-pays/co-insurance and my deductible

Initials

_____ All amounts due for services that my insurance company has stated are not covered benefits (IF I have been advised by the **Brookline Physical Therapy** in advance of the service delivery and have authorized it in writing)

Initials

_____ All amounts due for services billed by **Brookline Physical Therapy** but paid directly to me

Initials

_____ All amounts due for services billed by **Brookline Physical Therapy** to a Workers' Compensation payor which was subsequently declared by my employer to be a non-eligible claim.

Initials

_____ All amounts due for claims submitted by **Brookline Physical Therapy** to my insurance company and not paid by 60 days

Initials

Medicare and Workers Compensation Information

_____ I certify that the information I have provided to **Brookline Physical Therapy** for payment under the Social Security Act (Medicare) or under the Workers Compensation Program is correct, including but not limited to any related accidents/illness or other insurers/payors available.

Initials

I, _____, understand the statements I have authorized above and
Printed Name declare their truthfulness

Patient or Authorized Representative for Patient Signature/Date

Initials

PAYMENT RESPONSIBILITY ACKNOWLEDGEMENT FOR INSURED PATIENTS

Patient Name: _____

Insurance Carrier/Company: _____

Covered At: _____ % In Network _____ % Out of Network

Covered At: _____ / Visit In Network _____ / Visit Out of Network

Deductible Amount: _____ Deductible Met: Yes No

Current Patient Balance: _____

Co-Pay or Co-Insurance Due Each Visit: _____

If this is only a portion of what your per visit payment responsibility is you will be billed monthly for the remaining portion.

Please note that Co-Pays are expected at patient sign-in.

If this policy causes a hardship, please see _____ in our billing office.

Patient Signature/Date

Business Office Staff Signature/Date

PHYSICAL THERAPIST/PATIENT COLLABORATIVE DECISION-MAKING & PLAN OF CARE CHECKLIST

All items listed below must be discussed with the patient by the evaluating therapist prior to treatment initiation. Confirmation of this discuss must be reflected in the evaluation or the initial note confirmed by the patient's signature or documentation of verbal concurrence.

Review physical findings

Review functional findings

Discuss proposed short term plan and expected goals (optional)

Discuss proposed long term plan and expected goals

Rehabilitation potential/prognosis

Rehabilitation diagnosis

Determine frequency and duration of treatment sessions

Discuss precautions and limitations

Discuss alternative and related outcomes

Discuss substantial risks

Obtain verbal or written consent to initiate treatment and plan of care

Sample language to include on the evaluation:

Collaborative Decision Making Statement: The patient and I reviewed his/her clinical and functional status, pros, cons and alternatives of care. We also discussed the plan of care which is outlined above. We conferred about his/her rehabilitation prognosis for improvement/recovery and consent to the plan of care and treatment interventions was obtained.

Therapist's signature/date

Patient's signature/date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Brookline Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Brookline Physical Therapy to release any of my protected healthcare information.

Patient's or Authorized Representative's Printed Name & Date

Patient's or Authorized Representative's Signature

HEALTH INFORMATION PRIVACY NOTICE FOR BROOKLINE PHYSICAL THERAPY

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

1. About Protected Health Information (PHI).

In this Notice, “we”, “our” or “us” means this facility and our workforce of employees, contractors and volunteers. “you” and “your” refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identify you. Because we must protect this health information we call this Protected Health Information---or “PHI”. In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

2. Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call “health care operations”. We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

Cont. 2. Uses and Disclosures

- Treatment

We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- Payment

After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- Health Care Operations

We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- Special Uses

We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

- i. Remind you of appointments
- ii. Carry out follow ups on home programs that you have been taught
- iii. Advise you of new or updated services or home supplies

Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

- i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
- ii. We may use your PHI in an emergency if you are not able to express yourself
- iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

- i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
- ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
- iii. To report neglect, abuse or domestic violence
- iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
- v. In judicial or administrative proceedings such as a response to a valid subpoena
- vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
- vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
- viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
- ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

We will follow any and all State regulations should they be stricter than these federal privacy regulations

3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication
You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing
- Your Right to Inspect and Copy
You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record

Cont. 4 Your Privacy Rights and How To Exercise Them

- Your Right to Know Who Else Sees your PHI
You have the right to request an accounting of certain disclosure that we have made over the past six years; however you may not ask for disclosures that occurred prior to April 14, 2003. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.
- Your Right to Complain
You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

If you have questions about this Notice, or if you have a complaint or concern, please contact:

Name: John Esguerra
Address: 26837 Tanic Drive Suite 101
Wesley Chapel, FL 33544
Phone: (813)527-6913

7. Effective Date: This notice takes effect on April 14, 2003