Flowers Physical Therapy

Patient Information

Last Name: _____ First Name: _____ Middle Initial:_____
Address: _____ City: _____ State: _____Zip: _____
Date of Birth: _____ Sex: _____ Social Security #: _____
Home #: _____ Cell #: _____ Email: _____
Marital Status: Single _____ Married_____ Divorced_____ Widowed_____
Emergency Contact: _____ Phone #: _____ Relationship: _____
Primary Care Physician/Family Doctor (s): _____
Are you currently under the care of a Home Health Agency? No___ Yes___ if Yes, Name of Co:_____
How did you hear about Neville Flowers P.T., P.C.? _____

Insurance Information

Medicare #:_____ Part B Effective Date: _____
Insurance Policy #: _____ Group #: _____
Policyholder's Name: _____ Relation to Patient: _____ DOB #: _____

****If Patient is a Minor****

Responsible party for bill if other than patient: _____ Relationship: _____
Responsible party's address (if other than above): _____ DOB: _____ SS#: _____

Consent to Release Medical Information:

I hereby authorize Neville Flowers P.T., P.C. to release any information acquired in connection with my therapy services including, but not limited to , diagnosis, clinical records, to myself, my insurance(s), physician(s) and _____.

Consent to Obtain Medical Information:

I authorize Neville Flowers P.T., P.C. to obtain and acquire any information that would be beneficial in connection with my therapy service, which may include X-rays, Cat Scans and MRI reports, along with Physician's Documentation.

Assignment of Insurance Benefits:

I hereby authorize payment to be made directly to Neville Flowers P.T., P.C.

Guarantee of Payment:

I agree to pay any charges that my insurance does not pay, I am responsible to pay any un-covered portion on the date services are rendered. I am responsible for any incurred costs on overdue balances including, but not limited to, late fees, interest fees and collection agency fees.

I hereby certify that I understand these rights as set forth.

Patient/Responsible Party Signature _____ **Date:** _____

Referring Physician

Physician's Name: _____ Tel #: _____

Address: _____

Address City State ZC

Work: _____

Are you currently working? Yes_____ No_____

If yes, how many hours a week? _____

What is your occupation? _____

Please describe what you do at your job _____

_____

Date of injury onset _____

Have you had any diagnostic test related to this problem? (i.e. MRI or X-Rays) Yes_____ No _____

Please Specify Where _____ When _____

Have you had any Physical Therapy in the past 12 months for this or any other problem Yes___ No ___

If Yes Where _____ When _____

Have you had a related surgery? Yes_____ No _____

If yes, what was the date? _____

Patient's Signature _____ Date _____

PAST MEDICAL HISTORY

Do you have, or have you had, any of the following?

___Anemia
___Allergies
___Asthma
___Balance
___Back pain
___Bowel / Bladder Issues (incontinence)
___Cancer
___Chest pains
___Depression
___Diabetes
___Disc Problem
___Headaches
___Dizziness / Fainting
___Epilepsy
___Excessive Fatigue
___Fever, higher than 100 degrees F.
___Heart Attack
___Heart Disease
___High Blood Pressure
___Hypoglycemia
___Infectious Disease
___Knee pain
___Kidney Problems
___Liver / Gallbladder Problems

___Low Blood Pressure
___ Low Exercise Level
___Metal Implants
___Nausea / Vomiting
___Neck pain
___Neck stiffness
___Open Wounds
___Osteoarthritis
___Osteoporosis
___Pacemaker or Defibrillator
___Perforated Ear Drums
___Radiation treatment within the last 3 months
___Rheumatoid Arthritis
___Ringing in Ears
___Seizures
___Shortness of Breath / Difficulty Breathing
___Skin Rashes
___Stomach or Intestinal Issues
___Stroke
___Thyroid Problems
___Tingling in Arms / Hands
___Tingling in Legs / Feet
___Typhoid / Cholera / Dysentery
___Vision Problem

Other Health Issues (please explain)

_____

_____

Are you taking any medication? Yes_____ No_____

If yes, please list medications _____

_____

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient,

Physical Therapy involves the use of many different types of physical evaluation and treatment. At Neville A. Flowers P.T., P.C. we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy.

Since the physical responses to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercises you are performing and any specific risks associated with your exercises, your therapist will answer them.

I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____	_____	_____
Patient Name	**Patient Signature**	**Date**
_____	_____	_____
Parent/Guardian Name	**Parent/Guardian Signature**	**Date**

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2020 MEDICARE BENEFIT EXPLANATION

This letter is to inform you of your Medicare Benefit for the year 2020.

- EACH PATIENT IS ALLOWED $2,080.00 PHYSICAL THERAPY CAP FOR THE **ENTIRE** 2020 YEAR.

(WE ASK THAT EACH PATIENT USE THEIR P.T. BENEFIT ONLY WHEN NECESSARY, TRY NOT TO USE ENTIRE BENEFIT AT ONCE IF IT IS **NOT MEDICALLY NECESSARY**.

- Medicare only covers 80% of physical therapy services leaving a 20% co-insurance, you will be responsible for the co-insurance if you do not have a secondary insurance carrier.

- Each patient will be responsible for a **DEDUCTIBLE** of $198.00 at the beginning of each calendar year. For those with a secondary carrier, the carrier MAY pick up Medicare deductible and or co-insurance. Please refer to your secondary carrier's policy to find out your Physical Therapy benefits.

(PLEASE NOTE SOME SECONDARY INSURANCE CARRIES A DEDUCTIBLE AND OR CO-INSURANCE OF THEIR OWN THAT YOU MAY BE RESPONSIBLE FOR).

- Medicare does have an exceptions process for additional visits. (THIS PROCESS IS NOT A GURANTEE MEDICARE WILL PAY). To use this exception process an ABM form (Advance Beneficiary Notice which is supplied by Medicare) will be presented to you for your signature each and every time you come into our office to be treated outside of the allowed number of visits. Payment for therapy service will be collected from you the patient on each visit. If and when Medicare pay for these services, your payments for services will be refunded.

This Notice is for you the patient's benefit, so you will be aware of your benefit under Medicare.

Patient Signature: _____ Date: _____

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MEDICARE PATIENTS

HOME HEALTH CARE ENROLLMENT

I _____am NOT enrolled with a home health care agency.

Patient Signature: _____ Date: _____

Please Note: As per Medicare policy guidelines patients who are enrolled with a Home Health Agency for **ANY** medical services **CANNOT** receive Physical Therapy treatment until patient is discharged from the agency. Failure to advise this office of your enrollment will result in all claims becoming your responsibility.

I _____am/was enrolled with a Home Health care agency as of _____and was discharged on _____.

I am aware that I must supply a discharge letter from the Home Health Agency to continue treatment.

Please Note: As per Medicare policy guidelines patients who are enrolled with a Home Health agency for **ANY** medical services **CANNOT** receive Physical Therapy treatment until patient is discharged from the agency, failure to advise this office of your enrollment will result in all claims becoming your responsibility.

Patient Signature: _____ Date: _____