Welcome to Therapy Solutions

PATIENT INFORMATION

PLEASE PRINT

FULL NAME: NICK NAME:

EMAIL:

ADDRESS: SOCIAL SECURITY #:

CITY, STATE, ZIP:

DOB: HOME PHONE: WORK PH:

OCCUPATION: EMPLOYER:

EMPLOYER'S ADDRESS:

GENDER: M F MARITIAL STATUS: S M D W

PRIMARY HOLDER OF YOUR INSURANCE:

NAME OF SPOUSE: DOB:

EMERGENCY CONTACT: RELATION: PHONE:

PRIMARY CARE PHYSICIAN: REFERRING PHYSICIAN:

HOW DID YOU HEAR ABOUT US:

DATE OF YOUR NEXT DOCTOR'S APPOINTMENT:

ACCIDENT/ INJURY/ILLNESS INFORMATION

DATE OF ONSET OF SYMPTOMS: IF ACCIDENT WAS IT: AUTO: ☐ WORK: ☐ OTHER: ☐

DATE OF SURGERY: BRIEFLY EXPLAIN WHAT HAPPENED:

IF THE PATIENT IS A MINOR

FATHER: PHONE:

MOTHER: PHONE:

I certify the above information is true and correct to the best of my knowledge.

_____

SIGNATURE DATE

Insurance Authorization for treatments beyond the initial evaluation

Some insurances only authorize further Physical Therapy visits after reviewing the initial physical therapy evaluation (i.e. Lovelace, Molina and TriWest,..). It often takes up to 3 weeks before they notify us if further visits are either approved or denied.

For this reason we advise patients to schedule their next appointments only after the authorization has been confirmed by their insurance company. Please wait for us to contact you to schedule future appointments. We will obtain these authorizations as soon as possible.

You can also decide to schedule your next appointments before your insurance authorization is confirmed. Please realize though that you will be ultimately responsible for the bill in the event that your insurance decides not to pay.

Co-pays and deductibles

Please pay co-pays and deductibles before the start of each treatment session.

Your co-pay is:_____

Your deductible amount for this year is: ☐ met ☐ not met

Amount not met:_____

The business office will accept credit cards, cash or checks. Please make certain to verify your benefits with your insurance company. Examples: current coverage, deductibles, co-pays, maximum benefits, limitation of visits, pre-existing conditions for which there is no current coverage, instances when secondary insurance is not applicable,and,others.

Signature: Date:

AUTHORIZATION FOR TREATMENT

I, the patient, or as agency, spouse, parent or guardian of the patient, hereby authorize and consent to the administration of treatment and modalities that are deemed necessary and/or desirable by staff and/or employees of Therapy Solutions LLC. I further authorize Therapy Solutions, LLC to make any appeals on my behalf for collection of such treatment. (Please sign at the bottom of this page)

Acknowledgement of being informed about the Notice of Privacy Practices

We care about your privacy

This is to acknowledge that you understand the Privacy Practices of Therapy Solutions LLC.

Your information will only be released to your insurance and your physician. The Privacy Practices information also covers other areas, which are displayed on the wall poster and in a folder in the waiting room.

Release of records

Patient: _____

Insurance Company:_____

I hereby authorize: Therapy Solutions LLC, my Health Care Provider/Facility, to release any and all medical information to the above named insurance carrier (s), or to my designated attorney now or in the future, and/or to my physician(s) if necessary for the purposes of payment of my medically related outstanding debts, administration and evaluation, utilization review and financial audit. This, authorization remains valid and effective from the date of this signing until revoked in writing, to both my insurance carrier and to this provider of services.

Signature: Date:

Payment Agreement

All charges are due at the time of service, unless other arrangements have been made in advance. All professional services rendered are charged to the patient and the patient is responsible for all fees, regardless of insurance coverage. I understand I am responsible to the above -mentioned facility/provider, for charges not covered by this assignment, including deductibles & co-payment requirements by my Insurance policy or certificate. I further agree that in the event of non-payment I will bear the expenses of collection and /*or* court costs and reasonable legal fees, should this be required.

Assignment of Benefits

I hereby assign Kent Chou/Therapy Solutions LLC, my Health Care Provider/ Facility, all money to which I am entitled for medically related expenses received at, or through the above mentioned facility. The payment shall not exceed my indebtedness. Any payment that facility /health care provider, receives from the Insurance Company beyond my indebtedness shall be refunded to me, when my outstanding balance with them are paid.
I understand that I may request a copy of any or all of my medical records for a reasonable fee or for a fee allowed by State Statute *or* Worker's Compensation Statute. Any copy of this document shall be as valid as if it were the original. I have read the above authorization to release medical records, assignment of benefits and payment agreement and hereby acknowledge that I understand it.
The payment agreement portion of this instrument may not be revoked in writing or otherwise.

Cancellation policy

All cancellations are expected to be made with a minimum notice of 24 hours. The patient will be charged $50.00 in case the cancellation occurs less than 24 hours before the appointment time. This amount will be paid before the start of the next treatment. It is understood that emergencies can occur. Each patient is granted one cancellation without 24 hours notice in the case of an emergency. The second time this happens, the patient will be charged $50.00 (this fee is **NOT** charged to the insurance it will be charged directly to the patient). The third time the patient will lose all future scheduled appointments and will need to reschedule appointments where they are available.

Signature Date:

Attention Medicare Patients

Please answer the following questions accurately since Medicare doesn't reimburse for outpatient physical therapy unless you are officially discharged from Home Health. In addition, Medicare has a $1940.00 therapy cap for each calendar year. This cap includes physical therapy and occupational therapy.

Have you had a Home Health Episode this year? ☐ Y ☐ N

a) If so, which facility did provide your have home health care?

_____

b) When where you discharged from home care?

_____

Did you have any physical therapy or occupational therapy during this calendar year? ☐ Y ☐ N

If yes how many visits did you have?_____

Signature: Date:

Attention NMHC Patients

Please answer the following questions accurately since Medicare doesn't reimburse for outpatient physical therapy unless you are officially discharged from Home Health. In addition, Medicare has a $1940.00 therapy cap for each calendar year. This cap includes physical therapy and occupational therapy.

Have you had a Home Health Episode this year? ☐ Y ☐ N

a) If so, which facility did provide your have home health care?

_____

b) When where you discharged from home care?

_____

Did you have any physical therapy or occupational therapy during this calendar year? ☐ Y ☐ N

If yes how many visits did you have?_____

Signature: Date:

Medical Intake Form

- Past Surgical History (please list all & dates):

_____
_____
_____

- Are you currently taking any blood thinners: Y/N Are you allergic to latex: Y/N
- Have you had any recent X-rays, MRI or other imaging study pertaining to todays complaint:

_____

- What is your current weight: ____ lbs Height: ____feet ____ inches

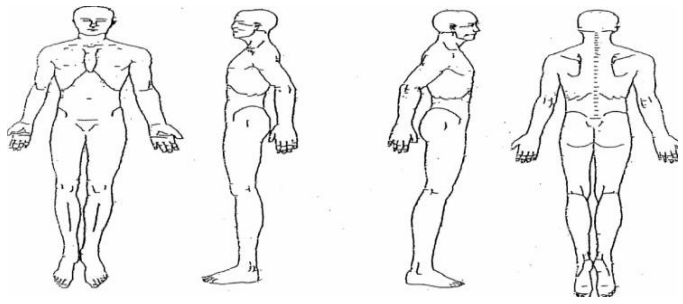
Please circle each condition that you have been told you have (or had)				
Cancer	Diabetes	Kidney Disease	Liver Disease	Stroke
High Blood pressure	Heart Disease	Angina/ Chest pain/ palpitations	Pacemaker	High Cholesterol
Circulation Problems/ Blood Clots	Shortness of breath	Osteoporosis	Osteoarthritis	Rheumatoid Arthritis
Autoimmune disease	Lung Disease	Thyroid problems	Gastro-Intestinal Issues	Fibromyalgia
Poor balance or recent falls	Dizziness/ fainting/ vertigo/ blackouts	Severe Headaches	Epilepsy/ Seizures	Allergies/ Asthma
Chemical Dependency/ Alcoholism	Lyme's Disease	Sexually Transmitted Disease	Gout	Mental Health Diagnoses

Otherconditions:_____

During the past few months have you often been bothered by feeling down/ depressed/ hopeless? Y / N
During the past few months have you often been bothered by little interest or pleasure in doing things? Y / N

Currently I'am experiencing:

Fever/ Chills/Sweats	Poor Balance	Unexplained Weight Loss	Fatigue
Numbness or Tingling	Change in appetite	Difficulty Swallowing	Depression
Shortness of breath	Dizziness	Nausea/ Vomiting	
Recent infections	Changes in Bowel or Bladder function	Increased pain at night	



Please mark the area on the chart where you feel pain/ symptoms

Signature: Date:

Please list all medications that you currently take including all prescriptions, over-the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements.
(Please PRINT)

*

Medication	**Dosage (mg)** (required by Medicare/Medicaid)	**Times per day** (required by Medicare/Medicaid)	**Oral** (required by Medicare/Medicaid)
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N
			Y/N

Signature: Date: