

PATIENT INFORMATION

→ _____ / ____ / ____
 ↑ Last Name, First Name, Middle Initial Date Of Birth

 Mailing Address City Zip Code (____) Home Phone

 E-Mail Address FEMALE MALE Circle One S M W D Marital Status

 Employer Employer Address City Zip Employer Phone

 Social Security Number Medicare Number

 How Did You Hear About Us? First & Last Name of Referring Physician Area Of Pain

 Emergency Contact Relationship Phone

GROUP HEALTH INSURANCE INFORMATION

 Primary Insurance Member ID # Group #

 Name Of Insured Relationship Insured's Date of Birth

 Secondary Insurance Name Of Insured & Date of Birth Member ID #

ACCIDENT INFORMATION

Is this visit the result of an injury? YES NO If so, date of injury: _____

Were you injured: _____ On The Job? _____ Auto Accident _____ Other?

(Please Explain) _____

Do you have prior authorization for pt benefits? YES NO Claim # _____

 Responsible Insurance Company Address City State Zip Name Of Adjuster

 Name Of Attorney Address Phone

I _____, hereby assign all medical benefits to include for services provided, including Medicare & other government sponsored programs, private insurance & any other health plans to _____. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby authorize _____ to release all information necessary to secure the payment of said benefits. I understand that this assignment of benefits is irrevocable unless advised by me in advance. If any portion of therapy is denied I give _____ permission to act as my representative in appealing.
CONSENT TO TREAT: I hereby consent to receive treatment from the Outpatient Clinic consistent with a Plan of Care authorized by my physician.

X _____
 ↑ SIGNATURE DATE

FOR OFFICE USE ONLY

ACCOUNT # CLINIC/HOME THERAPIST ONSET SOC

TREATMENT DIAGNOSIS: _____

MD NPI # _____ KX ALL _____ Pt. Info. Revised 10.08

MEDICAL HISTORY AND PHYSICAL CONDITION INFORMATION

Patient Name: _____

Chief Complaint / Area of Pain: _____

Have you had treatment for this problem before? Yes No
If yes, where: _____ When? _____

If you are a Medicare patient, have you recently had care from a Home Health Agency? ____
If so, please provide the following information:
Name of Health Care Provider: _____
Name of Agency: _____ Phone: _____
Address: _____
Date of Discharge from Home Health Agency: _____

Have you had surgery related to this problem? Yes No
Surgical procedure: _____ Date of Surgery: ___/___/___

List medications you are taking that could affect your ability to perform Physical Therapy:
1. _____ 2. _____
3. _____ 4. _____

Do you have a pacemaker? Yes No
Do you have any communicable diseases? Yes No
Do you have any metal implants? Hip (R/L) Knee (R/L) Shoulder (R/L)
 Back Other _____

Circle any condition you currently have or have had in the past:

- | | | |
|-----------------------|--------------------------|----------------------|
| Allergies | Arthritis | Balance Difficulties |
| Cancer | Cardiac Arrhythmia | Circulatory Problems |
| Cognitive Impairments | Congestive Heart Failure | Diabetes |
| Dizzy Spells | Headaches | Hearing Problems |
| Heart Attack | Hernia | High Blood Pressure |
| HIV/AIDS | Kidney Disease | Pregnancy |
| Seizures | Vision Problems | |

Please explain: _____

The above information is correct, complete and to the best of my knowledge.

X _____
Signature

Date

**NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS
(NEMB)**

Medicare only pays for covered benefits. Medicare does not pay for all of your health care costs. Some items are not Medicare benefits and Medicare will not pay for them.

When you receive a service that is not a Medicare benefit, you are responsible to pay for it personally or through any other insurance 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 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 services will cost you.**

I understand that Medicare will not pay for Physical and Speech Therapy services over \$1,810.00 per year. Medicare will pay 80% of the Medicare allowed amount and the patient is responsible for 20% of the Medicare allowed amount and the annual deductible of \$135.00. Medicare will not pay for Occupational Therapy services over \$1,810.00 per year. **I will be responsible for any charges denied by Medicare.**

- To the best of my knowledge, I have received Physical/Speech Therapy or Occupational Therapy services this year.
- To the best of my knowledge, I have not received Physical/Speech Therapy or Occupational Therapy services this year.

Patient Name

Patient Signature

Date

MEDICARE STATUS QUESTIONNAIRE

Is Medicare Primary or Secondary for your visit today?

EMPLOYMENT:

- | | | |
|---|-----|----|
| 1. Are you <u>currently employed</u> and covered by a group health plan? | Yes | No |
| 2. Are you <u>covered by any active group health plan</u> through your spouse or family member? | Yes | No |

ACCIDENTS:

- | | | |
|--|-----|----|
| 3. Is your visit today associated with a <u>work injury or illness</u> , either past or present? | Yes | No |
| 4. Is your visit today associated with an <u>automobile vehicle accident</u> ? | Yes | No |
| 5. Is your visit today associated with an accident, other than a vehicle? | Yes | No |

ENTITLEMENTS:

- | | | |
|--|-----|----|
| 6. Are you entitled to <u>Black Lung</u> benefits? | Yes | No |
| 7. Are you entitled to Medicare solely because of <u>SSA Disability</u> | Yes | No |
| 8. Are you entitled to Medicare solely because of <u>End Stage Renal Disease</u> ? | Yes | No |
| 9. Are you enrolled in the <u>VA Fee Basis Program</u> ? | Yes | No |

If all answers are NO, stop here.

If you answered "Yes" to any question, Medicare is probably the secondary payer (MSP). You will need to complete an additional MSP form. Please notify our Office Manager.

Patient Signature

Date

MEDICARE SECONDARY PAYER (MSP)

EMPLOYMENT (If "Yes" to questions 1,2,3 on Medicare Status Questionnaire.)

Insured's Name (Employee) _____
Injured's Date of Birth ____/____/____ Male Female
Employer: _____

ACCIDENTS (If "Yes" to questions 4,5 on Medicare Status Questionnaire)

Work Injury or Illness
 Auto Accident: Is there "Medical Payment" coverage? Yes No
 Home or other: Is there "Medical Payment" coverage? Yes No
Date of Accident: _____
Location of Accident: _____
How did it happen: _____
Attorney, if any: _____

ENTITLEMENTS (If "Yes" to questions 6,7,8,9 on Medicare Status Questionnaire)

SSA-Disability (Under age 65 and my company has over 100 employees)
 VA-Fees Basis Program
 Black Lung Benefits
 Kidney (Under age 65 with End Stage Renal Disease (ESRD))
 Part A entitlement date (from the card): _____
 Employer Name: _____

PRIMARY INSURANCE PAYER

Fill out this information for any of the above categories

Policy # _____ ID # _____
Insurance Plan or Name _____
Address _____
City _____ State _____ Zip _____
Insured's Name _____ Phone _____
Address _____
City _____ State _____ Zip _____
Completed by: _____ Date _____

INFORMATION RELEASE AUTHORIZATION

I hereby consent to the release and disclosure of my personal health information from:

Name: _____ to: Name: _____
Address: _____
City/State: _____
Zip Code: _____

For the following purposes:

This release authorization includes my personal health information consisting of: _____

I understand that the information outlined in this release will be disclosed according to the instructions of this release within two (2) business days of Corona del Mar Rehab having received this authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

PATIENT INFORMATION CONSENT / HIPAA NOTIFICATION

*I hereby consent to the use and disclosure of my personal health information for purposes as noted in **Corona del Mar Rehab's Notice of Information Practices**. (Posted on premises and on reverse) I understand that I retain the right to revoke this consent by notifying the practice in writing at any time.*

I do not wish that my personal health information be released for reasons other than treatment or billing.

Patient Signature: _____ Date: _____