Grove Andersen Ghiringhelli PT

Patient Medical History

Name:_____Referring Physician:_____
Date of Injury:_____Date of next Doctors visit for this injury:_____
Have you had surgery for this injury:____Yes____No Date of Surgery:_____
Are you currently taking any prescription or non prescription medications?: ____Yes ____No
Please list all medications you are currently taking, please include dosage:_____
_____
_____
_____

Do you now have or have you ever had ANY of the following?

	YES	NO		YES	NO
Asthma, Bronchitis, or Emphysema	____	____	Numbness or Tingling	____	____
Shortness of breath/Chest Pain	____	____	Dizziness or Fainting	____	____
Coronary artery disease or angina	____	____	Bowel or Bladder problems	____	____
Do you have a pacemaker?	____	____	Weakness	____	____
High blood pressure	____	____	Weight loss/Energy loss	____	____
Heart Attack or Surgery	____	____	Hernia	____	____
Stroke/TIA	____	____	Varicose Veins	____	____
Congestive Heart Disease	____	____	Allergies	____	____
Blood Clot/Emboli	____	____	Any pins or metal implants	____	____
Epilepsy/Seizures	____	____	Joint replacement surgery	____	____
Thyroid Disease or Goiter	____	____	Neck Injury/Surgery	____	____
Anemia	____	____	Shoulder Injury/Surgery	____	____
Infectious diseases	____	____	Elbow/Hand Injury/Surgery	____	____
Diabetes	____	____	Back Injury/Surgery	____	____
Cancer or Chemotherapy	____	____	Knee Injury/Surgery	____	____
Arthritis	____	____	Leg/Ankle/Foot Injury/Surgery	____	____
Osteoporosis	____	____	Are you pregnant?	____	____
Gout	____	____	Do you use tobacco?	____	____
Sleeping Problems/Difficulties	____	____	If yes how long have you used tobacco?		___
Emotional/Psychological Problems	____	____	_____		
Severe or frequent headaches	____	____	How often do you use tobacco?		_____
Vision or hearing difficulties	____	____	_____		

List any other information that would assist us in your care:_____
_____
What are your rehabilitation expectations/goals while in this program?_____
_____
_____

Patient/Guardian Signature:_____Date:_____

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CURRENT MEDICATIONS LIST REPORT

PATIENT NAME: **DATE:**

LIST ALL OF THE PRESCRIPTION MEDICATIONS YOU ARE CURRENTLY TAKING			
NAME OF MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL OVER-THE-COUNTER MEDICATIONS

NAME OF MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

LIST ALL HERBALS, VITAMINS, MINERALS, NUTRITIONAL SUPPLEMENTS

NAME OF MEDICATION	**DOSAGE** (how many or how much you take)	**FREQUENCY** (how often do you take it)	**ROUTE** (how do you take it, i.e., by mouth, injection etc.)

Grove Andersen Ghiringhelli PT

TO: Medicare Patients

RE: Medicare Changes

Dear Patient:

This letter is to inform you of a change that has occurred in Medicare outpatient rehabilitation service coverage. Medicare has notified us that effective January 1, 2018 there is a $2,010 cap per beneficiary (patient) per calendar year. Please understand that Medicare regulates these changes which affect all therapy providers.

This $2,010 limit applies to physical therapy and speech language services combined with a separate $2,010 limit on occupational therapy services. Our recommendation is that you work closely with your clinic to determine where you are with your cap usage.

Medicare has provided an exception process in cases of medical necessity. Please ask your therapist if you qualify for an exception if you anticipate exceeding the therapy cap.

Please be aware that if services continue past the $2,010 cap amount and you do not qualify for an exception, that you, the patient, becomes responsible for payment. This is why it is critical that you notify us if you have seen a physical, occupational or speech therapist prior to your visit with us.

Our goal is to provide you with the care and education you need to obtain your greatest functional outcome. Your therapist will work with you to develop a plan to best utilize your visits.

I HAVE READ AND UNDERSTAND THE MEDICARE CHANGES. I UNDERSTAND THAT I HAVE FINANCIAL RESPONSIBILITY FOR MEDICARE CO-PAYMENTS, $183 ANNUAL DEDUCTIBLE, AND ALL CHARGES EXCEEDING THE $2,010 CAP LIMIT.

_____

SIGNED PLEASE PRINT NAME DATE

Grove Andersen
Ghiringhelli PT

This is to certify that this injury/illness is not due to a work related condition.

Signed _____

Date _____

Grove Andersen Ghiringhelli PT

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

As part of my health care, PRN Physical Therapy creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among PRN Physical Therapy personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and treatment to my bill.

I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for PRN Physical Therapy that provides a more complete review of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices before signing this consent.

I understand that PRN Physical Therapy may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours of each medical office and at the central billing office.

I understand PRN Physical Therapy for **Worker's Compensation Cases**, will release the minimum necessary PHI/ePHI to my employer, my worker's compensation insurance carrier, third party administrator, rehab nurse or nurse case manager unless otherwise restricted below.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that PRN Physical Therapy is not required to agree to the restrictions requested. The procedure to request **restriction** on information use and disclosure is contained in the Notice of Privacy Practices. Please complete the following that apply.

[__] I **DO NOT** authorize release of my information with the following individuals or organizations (enter names below and initial the box to left):

[__] I **DO** authorize sharing of my information with the following individuals or organizations (enter names below and initial the box to left):

[_____] Spouse/Children:_____

[_____] Other: _____

These restrictions and/or authorizations to release information will remain in effect until terminated in writing.

Appointment Communication Preference: I prefer to be contacted in the following manner:

[__] Home Phone [__] Work Phone [__] My Mobile Phone [__] Email

Provide email address or phone number:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of PRN Physical Therapy and that the full version is posted at my treatment facility and available upon request. I agree to the liability limitations explained therein.

_____ _____ _____

Signature of patient or legal representative Date Relationship to Patient

_____

Printed name of patient

Grove Andersen Ghiringhelli PT

Consent and Statement of Financial Responsibility

1. **CONSENT FOR TREATMENT:** I consent to and authorize my physical therapist, occupational therapist and other healthcare professionals and assistants who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my physician(s)/health care provider(s). I acknowledge that no guarantees have been made to me about the results of treatment.

2. **APPOINTMENT ATTENDANCE AGREEMENT:** I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15 minutes late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when I need to cancel or reschedule an appointment and that cancellation of less than 24 hours or not showing up for an appointment will likely result in a cancel/no show charge of $25 based on appointment type.

   WORKER'S COMPENSATION PATIENTS: We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments. It is also required that all missed visits be rescheduled.

3. **RESPONSIBILITY FOR PAYMENT:** All co-payments are due at the time of service. I acknowledge that in consideration of the services provided to me by Grove Andersen Ghiringhelli PT, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Grove Andersen Ghiringhelli PT with current insurance information and to familiarize myself with my insurance plan and its policies. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. My health insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my deductible, co-payment, co-insurance or charges not covered or denied by my health insurance, Medicare, or other programs for which I am eligible.

   Please note that refusal to sign this form does not change responsibility for payment in any way.

4. **ASSIGNMENT OF BENEFITS:** I hereby assign to Grove Andersen Ghiringhelli PT all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

5. **CONSENT FOR EMERGENCY CONTACT INFORMATION**
   Person to contact in case of an emergency:

   _____ _____ _____
   Name Telephone Number Relationship

6. **MEDICARE PATIENTS:** Have you received any prior physical/occupational therapy this year? (circle) YES NO
   Have you received any home healthcare services this year? (circle) YES NO

By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

_____ _____
Signature of Patient or Legally Responsible Person Date

_____ _____
Printed Name of above Date

Grove Andersen Ghiringhelli PT

Authorization for Text/Email Reminders

Indicate the types of messages you agree to receive by checking the boxes below. If you select more than one method for a message type, you will receive the message by all of the methods selected.

☐	Appointment reminders	TEXT
☐	Appointment reminders	EMAIL
☐	On Demand	TEXT (allows you to correspond with your therapist for exercise instruction, recommendations and/or advice)

You acknowledge that text alerts will be sent to the MOBILE phone number you provided. Such alerts may include limited personal information and whoever has access to the mobile phone or carrier account will also be able to see this information. Once you enroll, the frequency of text alerts we send to you will vary. You will typically receive text alerts when we have information for you about your therapy prescriptions or other healthcare information. We do not impose a separate charge for text alerts; however, your mobile carrier's message and data rates may apply depending on the terms and conditions of your mobile phone contract. You are solely responsible for all message and data charges that you incur. Please contact your mobile service provider about such charges. The following carriers are supported: AT&T, Sprint, Boost, Verizon Wireless, U.S. Cellular and T-Mobile.

You may opt out of text alerts at any time. To stop receiving text alerts, reply STOP. After you submit a request to unsubscribe, you will receive one final text alert from our clinic confirming that you will no longer receive text alerts. No additional text alerts will be sent unless you re-activate your enrollment.

Authorization for Credit Card on file (Patient Wallet)

I _____do hereby authorize Grove Andersen Ghiringhelli PT to keep my credit card on file in Patient Wallet for the purpose of processing my patient cost shares. I understand that I can remove this option by informing the front desk staff at any time.

_____ _____

Patient Signature Date