BAUER PHYSICAL THERAPY
27071 Cabot Rd., #101
Laguna Hills, CA 92653
(949) 588-7278
(949) 588-7331 Fax

Patient Information Sheet

[ ] Cash [ ] Insurance [ ] Medicare
[ ] Personal Injury [ ] Auto Accident [ ] Workers

PATIENT

NAME _____
ADDRESS _____
CITY/ST/ZIP _____
PHONES Home _____ Cell _____ EMAIL _____
SS# _____ Date of Birth _____
DRIVERS LICENSE # _____ [ ] Male [ ] Female
Status: [ ] Single [ ] Married [ ] Divorced [ ] Widowed [ ] Life Partner [ ] Separated
EMPLOYER _____ Occupation _____ Work #_____
STUDENT _____ SCHOOL _____

PRIMARY INSURANCE INFORMATION

COMPANY _____ PHONE _____
NAME OF INSURED _____ Date of Birth _____
RELATIONSHIP TO PATIENT _____
EMPLOYER NAME _____
ID # _____ Group # _____
Annual Deductible $_____ Co-Pay $ _____

SECONDARY INSURANCE INFORMATION

COMPANY _____ PHONE _____
NAME OF INSURED _____ Date of Birth _____
RELATIONSHIP TO PATIENT _____
EMPLOYER NAME _____
ID # _____ Group # _____
Annual Deductible $_____ Co-Pay $ _____

REFERRING DOCTOR

NAME _____ PHONE _____ FAX _____
DATE OF INJURY / ONSET: _____ PRESCRIPTION RECEIVED: [ ] Yes [ ] No

EMERGENCY CONTACT

NAME _____ PHONE _____

Who may we thank for referring you? _____
Address / Email _____
_____

AUTHORIZATION

I authorize the release of any medical information necessary to process my claims to my insurance company shown above. I hereby Authorize payment of medical benefits due me to Bauer Physical Therapy. I understand that Bauer Physical Therapy will bill my insurance as a courtesy but that I am responsible for the payment of my account if my insurance does not cover the services Rendered to me by Bauer Physical Therapy.

_____ _____
Signature of Patient (Parent/Guardian of Minor) Date

Bauer Physical Therapy

MEDICAL HISTORY QUESTIONNAIRE

The following information will be used to establish a physical therapy treatment and fitness program to restore your functional ability. All information is considered confidential and will only be released with your written authorization.

PATIENT NAME: _____

EMAIL: _____
(For internal tracking, billing, progress reports, and direct correspondence only)

What is the primary reason for your visit? _____

Auto accident? Yes No
(If yes, **you** must determine which insurance will cover your care)

Have you previously been treated for this condition? Yes No
If yes, when and by whom?

_____

Have you had surgery related to this condition? Yes No

If yes, type of surgery and when? _____

Rate your pain level currently on a scale of 0 to 10 (0 = no pain): _____

Rate your pain level at the worst time on a scale of 0 to 10 (0 = no pain): _____

Rate your pain level at the best time on a scale of 0 to 10 (0 = no pain): _____

What medications are you presently taking (prescription, over-the-counter, other)?

_____

Have you had any medical problems or hospitalization in the past year? Yes No
If yes, please explain: _____

_____

Surgical History: Procedure: _____ Date: _____
Procedure: _____ Date: _____
Procedure: _____ Date: _____

Circle all that apply of any problems you have currently or have experienced:

Asthma	Weight Change	Numbness
Arthritis	Nausea / Vomiting	Osteoporosis
Cancer	Gastrointestinal disease	Pregnancy
Chemical dependency	Urinary frequency changes	Planning a pregnancy
Circulatory disease	Visual impairment	Stroke or TIA
Depression	Previous accidents	Thyroid problem
Diabetes	Angina	Tuberculosis
Dizziness	Heart attack	Weakness
Eating disorder	Heart disease	Night pain
Emphysema / COPD / ARDS	Hernia	Allergies
Epilepsy	High blood pressure	Incontinence
Fainting / fatigue	Kidney disease	Sleep dysfunction
Neurological disease	Metal / other implant	Hearing impairment
Headaches	Multiple sclerosis	Fever / chills / sweats
Hepatitis / AIDS	Nervous / anxiety disorder	Back pain
Peripheral vascular disease	History of falls	Balance problems
Seizures	Sensitivity to heat or cold	

Circle all that you are unable to do now due to the onset of your condition:

Sit	Lift 20# or more	Overhead Lift / Reach
Stand up	Prolonged standing	Walk / run
Bend	Grip with hand	Sleep
Dress or bathe	Drive	Walk up or down stairs
Kneel	Bladder control	Feeding yourself

Other (please explain): _____

Circle all the goals you hope to reach from the physical therapy treatment program:

Improved movement	Improved strength
Decreased pain	Improved posture
Improved balance	Increased work ability
Improved home ability	Improved walking
Improved balance	Other: _____

Wellness Survey

How satisfied are you with your overall health / wellness?

Not	0	1	2	3	4	5	6	7	8	9	10 **Very**

How satisfied are you with the way you deal with stress?

Not	0	1	2	3	4	5	6	7	8	9	10 **Very**

How satisfied are you with your nutrition and / or eating habits?

Not	0	1	2	3	4	5	6	7	8	9	10 **Very**

How satisfied are you with your physical fitness level?

Not	0	1	2	3	4	5	6	7	8	9	10 Very

How satisfied are you with your weight?

Not	0	1	2	3	4	5	6	7	8	9	10 **Very**

****

I certify that this information is accurate to the best of my knowledge.

_____ _____

Patient Signature Date

_____ _____

Evaluating Physical Therapist Signature Date

FINANCIAL POLICIES

Welcome to Bauer Physical Therapy!

To assist our patients with the most cost-effective treatments, Bauer Physical Therapy is a contracted provider with most major insurance health plans and Medicare. As a contracted provider, we have accepted a discounted rate from your health plan keeping your costs for treatment lower. You are only expected to pay for amounts as quoted by your insurance carrier.

Requirements for Patients with Health Insurance or Medicare coverage:

- **You are ultimately responsible for payment for all services rendered**, unless otherwise provided by law.

- **All Co-payments and deductibles** are expected at the time service is rendered. Co-insurance will be sent by statement monthly; payments are due within 30 days.

- A prescription is required from a physician and additional prescriptions if therapy is required beyond the time limit of the current prescription.

- Some insurance carriers require authorization of your treatment. Our office will make these arrangements. Occasionally, there will be a waiting period to receive this authorization. If this occurs, you may request a personalized private pay program so that your therapy progress continues.

- There is an initial comprehensive evaluation fee of **$150**. Your evaluation, along with any treatment received on this initial day, will be billed to your insurance carrier and your payment will be applied to your patient portion.

- All insurance plans will be verified as a courtesy to you. However, patients must understand that charges for services are charged to the patient and not to the insurance company. **If charges billed to your insurance on your behalf are not paid within a reasonable period, the overdue amount becomes your full responsibility and due immediately.** All additional out-of-pocket expenses will be your responsibility.

- If you have a **change of insurance**, please notify our office immediately.

- Equipment purchases are to be paid at the time of purchase. Our office will provide you with an itemized statement of your purchase should you want to submit this to your insurance carrier for reimbursement.

- To cancel or reschedule an appointment, **a minimum 24-hour notice** is required to avoid a **$75 cancellation fee.**

- We accept the following methods of payment: cash, money order, traveler's checks, Visa or Mastercard. There is a **$25 charge** for any returned checks. We do not hold accounts for payment.

- **Auto Accident** – You must notify the Front Desk if your reason for treatment is due to an auto accident. In most cases, your health insurance **will not cover** your treatment and deny payment for services. **You will be responsible for all payments in advance** until any/all liens in the dispute are resolved.

- **Liens and/or Personal Injury** – Bauer Physical Therapy determines acceptance on a case-by-case basis only. We cannot wait for settlements of a pending lawsuit for the payment of services required. We cannot deal with your attorney, or other legal representatives for payment.

I have read and agree to the financial policies outlined above. I agree to assign insurance benefits to Bauer Physical Therapy whenever necessary. I agree to pay any and all balances due.

_____ _____

Signature of Patient (Parent/Guardian) ***Date***

_____

Print Patient Name

Medicare Beneficiaries
from
Bauer Physical Therapy

As of December 1, 2016, Medicare is placing a limit on the amount they pay for outpatient physical therapy and speech therapy services. This allowed annual per beneficiary limit is **$1**96**0**. Medicare will pay **80%** of the allowed limit. This limit is for both physical therapy and speech therapy services combined.

Bauer Physical Therapy will not compromise your care in any manner. We will assist you in tracking your visits and limits. If you reach your limit, we will work with you on a self-pay basis to continue your care so that your functional outcome will be maximized. Upon reaching your allowable limit, you will also have the option of receiving covered services in a hospital outpatient therapy setting.

To assist us in tracking your available benefits, please answer the following questions:

Have you received any physical therapy since 1/1/16**?** **Yes** **No**
If yes, circle the location in which the treatment was received:
Hospital / Home health / outpatient clinic / Rehab facility / Doctor's office

Have you received any speech therapy since 1/1/16**?** **Yes** **No**
If yes, circle the location in which the treatment was received:
Hospital / Home health / outpatient clinic / Rehab facility / Doctor's office

If you are unsure about the above questions, please ask a staff member for assistance.

I have read and understand the above information.

_____ _____
Signature of Patient **Date**

_____ _____
Signature of Witness **Date**

Notice of Exclusions from Medicare Benefits (NEMB)

NOTE: There are items or services for which Medicare will not pay.

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

- When you receive an item or service that is not a Medicare benefit, you are responsible to pay for it, personally or through any other insurance that you may have.

The purpose of this form is to help you make an informed choice whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, 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 items or services will cost you **(Est. cost: $_____),** in case you have to pay for them yourself or through other insurance.

Medicare will not pay for:

[ ] 1. Because it does not meet the definition of any Medicare benefit.

[ ] 2. Because of the following exclusion* from Medicare benefits.

> Personal comfort items
> Most shots (vaccinations)
> Hearing aids and hearing examinations
> Most outpatient prescription drugs
>Orthopedic shoes and foot supports (orthotics)
> Health care received outside of the USA
> Services required as a result of war
> Routine physicals and most tests for screening
> Routine eye care, eyeglasses and examinations
> Cosmetic surgery
> Dental care and dentures (in most cases)
> Routine foot care and flat foot care
> Services by immediate relatives
> Services under a physicians private contract

> Services paid for by a governmental entity that is not Medicare
> Services for which the patient has no legal obligation to pay
> Home health services furnished under a plan of care, if the agency does not submit the claim
> Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997
> Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health & Human Services (except in a case of urgent need)
> Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital
> Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF
> Services of an assistant at surgery without prior approval from the peer review organization
> Outpatient occupational and physical therapy services furnished incident to a physician's services

*** - This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Advance Beneficiary Notice (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will NOT pay for:**

Items or Services

Reason:

The purpose of this form is to help you make an informed choice whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, 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 items or services will cost you **(Est. cost: $_____),** in case you have to pay for them yourself or through other insurance.

CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

[ ] OPTION 1. YES. I want to receive these items or services.

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out-of-pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

[ ] OPTION 2. NO. I do not want to receive these items or services.

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I not be able to appeal your opinion that Medicare won't pay.

_____ _____

Date **Signature of Patient** *(or Person acting on patient's behalf)*

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our office. If a claim is submitted to Medicare your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** _____ below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** _____ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
DURABLE MEDICAL EQUIPMENT		

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** _____ listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

[x] OPTION 1. I want the **D.** _____ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** _____ listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

BAUER PHYSICAL THERAPY

Medicare Patients:
Home Health Care Questionnaire

Name: _____

Have you been seen this year by a Home Health Care Provider

Yes ☐ No ☐

If yes, please provide name of Home Health Care Provider and the date of discharge:

Name:

_____

Discharge date:

_____

Notice of Privacy Practices

This information describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. The Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes:

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would include sending a bill to your insurance company for payment.

- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing, cost analysis, and customer service. An example would include internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and aide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to the Privacy Officer.

Notice of Privacy Practices (cont…)

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

For more information on HIPAA, contact:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Notice of Privacy Practices Acknowledgement

Bauer Physical Therapy
27071 Cabot Rd., #101, Laguna Hills, CA 92653
(949) 588-7278

I understand that, under the HIPAA of 1996, I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician communications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____

Reason: _____