Medical History Questionnaire

Name	DOB	Age

Height _____Ft _____ inches	Weight

Are you currently receiving ***any*** services at home? ☐ No ☐ Yes- Please explain

Reason for Therapy	Date of Injury, Onset or Surgery
When is your next appointment with your referring physician?	Could you be or are you pregnant? ☐ No ☐ Yes

Have you had any falls in the past year? ☐ No ☐ Yes If so, how many?

Did you sustain any injuries due to fall(s)? ☐ No ☐ Yes - Please explain

Do you currently take Vitamin D supplement? ☐ No ☐ Yes

Do you have any allergies? ☐ No ☐ Yes, list allergies:

Do you now or have you ever had any of the following? Please check box if applicable.

Alzheimer's ☐	Head Injury / Concussion ☐	Previous Fractures ☐
Anemia ☐	Headaches ☐	Recent Weight Loss or Gain ☐
Anxiety ☐	Hearing Loss ☐	Seizures / Epilepsy ☐
Arthritis ☐	Heart Attack ☐	Shortness of Breath ☐
Asthma ☐	Heart Disease ☐	Spinal Cord Stimulator or any other device ☐
Cancer or Tumor ☐	Hepatitis ☐	Stroke ☐
Chest Pain / Discomfort ☐	Hernia ☐	Swelling in Ankles ☐
Chronic Cough ☐	High Blood Pressure ☐	Thyroid Problems ☐
Current Infections ☐	Hypersensitivity to Heat/Cold ☐	Tuberculosis ☐
Dementia ☐	Kidney / Bladder Problems ☐	Vascular Disease ☐
Deep Vein Thrombosis ☐	Metal in Body or Surgical Implants ☐	Other ☐
Diabetes ☐	Osteoporosis ☐	
Fainting Spells ☐	Pacemaker ☐	

Do you engage in physical activities regularly? If so, what and how often?

Are you presently taking any medications? ☐ No ☐ Yes, list any medications, dosage and specify frequency:

Drug Name:	Dosage:	Frequency:
Drug Name:	Dosage:	Frequency:
Drug Name:	Dosage:	Frequency:
Drug Name:	Dosage:	Frequency:

At the present time, would you say that your health is (check one): Excellent Very Good Fair Poor

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

Patient/Guardian Signature	Date
Therapist Signature	Date

Delray Care PHYSICAL THERAPY
"The results you want. The CARE you deserve."

2645 N Federal Highway
Suite 240
Delray Beach, FL 33483
561-562-8561 Fax 561-562-8563

PATIENT REGISTRATION

PLEASE PRINT

PATIENT INFORMATION

LAST NAME	FIRST	MI	DATE OF BIRTH	SOCIAL SECURITY	SEX

LOCAL ADDRESS APT #	CITY	STATE	ZIP CODE

HOME PHONE ( )	CELL PHONE ( )	MARITAL STATUS SINGLE ( ) MARRIED ( ) OTHER ( )

EMAIL ADDRESS

SEASONAL HOME ADDRE APT #	CITY	STATE	ZIP CODE

EMPLOYMENT STATUS EMPLOYED( ) FULL TIME STUDENT( ) PART TIME STUDENT( ) RETIRED (	EMPLOYER NAME	TITLE / POSITION

WORK ADDRESS	CITY	STATE	ZIP CODE	WORK PHONE

IN CASE OF EMERGENCY CALL

NAME	TELEPHONE ( )	RELATIONSHIP

REFERRING PHYSICIAN INFORMATION

REFERRING PHYSICIAN	TELEPHONE ( )	PRIMARY PHYSICIAN	TELEPHONE ( )

REASON FOR TODAY'S VISIT

PLEASE DESCRIBE INJURY / ACCIDENT / ILLNESS:

IS THIS CONDITION RELATED TO WORK: YES ( ) NO ( )	IS THIS CONDITION RELATED TO AN AUTOMOBILE ACCIDENT: YES ( ) NO ( )	PLEASE INDICATE THE DATE OF INJURY/ACCIDENT:

PLEASE PROVIDE NAME OF INSURANCE ADJUSTER OR CONTACT:	TELEPHONE ( )

PRIMARY INSURANCE COMPANY INFORMATION

PRIMARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

POLICYHOLDER (if other than patient)	RELATIONSHIP	DATE OF BIRTH

SECONDARY INSURANCE COMPANY INFORMATION

SECONDARY INSURANCE COMPANY NAME	IDENTIFICATION NUMBER	GROUP NUMBER

POLICYHOLDER (if other than patient)	RELATIONSHIP	DATE OF BIRTH

DO YOU CURRENTLY HAVE A LEGAL CASE PENDING FOR THIS CONDITION / INJURY: YES ( ) NO ( )

ATTORNEY NAME:	ATTORNEY ADDRESS:	ATTORNEY PHONE NUMBER:

ASSIGNMENT OF BENEFITS / AUTHORIZATION TO RELEASE MEDICAL INFORMATION / CONSENT TO TREATMENT

I HEREBY AUTHORIZE DIRECT PAYMENT OF MEDICAL BENEFITS TO DELRAY CARE PHYSICAL THERAPY, LLC. FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE. I HEREBY AUTHORIZE SAID ASSIGNEE TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF SAID BENEFITS. A COPY OF THIS ASSIGNMENT SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL. I AUTHORIZE THE REHABILITATION TEAM TO PERFORM THE TREATMENTS OR PROCEDURES APPROVED BY MY REFERRING PHYSICIAN. I ACKNOWLEDGE THAT NO GUARANTEES, EITHER EXPRESSED OR IMPLIED HAVE BEEN MADE TO ME REGARDING THE OUTCOME OF ANY TREATMENTS AND/OR PROCEDURES. I FULLY UNDERSTAND THAT IT IS IMPOSSIBLE TO MAKE ANY GUARANTEES REGARDING THE OUTCOME OF ANY MEDICAL TREATMENT OR PROCEDURE. I ATTEST THAT ALL OF THE ABOVE IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

AUTHORIZED SIGNATURE: X	**TODAY'S DATE:** / /

IS THERE SOMEONE WE ARE ABLE TO THANK FOR REFERRING YOU TO OUR FACILITY? IF SO, PLEASE PROVIDE NAME:

Delray Care PHYSICAL THERAPY

"The results you want. The CARE you deserve."

Medicare: Prior Treatment waiver

Patient Name:_____

Medicare will not pay for simultaneous therapy treatments at separate locations. If you are currently receiving treatment at any other location, you are not eligible to receive services at our facility. Please advise us if this is the case.

Within the current calendar year have you received any outpatient physical, speech or occupational, therapy treatment at any other facility? YES_____ NO_____

If yes, what services were given and what is the name, address, telephone number and dates services were provided at those facilities?

_____

_____

Since January 1, 1999, Medicare has placed a universal limitation on all Physical/Occupational/Speech therapy provided in an outpatient rehabilitation facility A total cap of $2,080.00 has been set for all physical and/or speech therapy combined. A separate $2,080.00 cap has been established for occupational therapy services. These limitations are established per beneficiary per calendar year regardless of the number or type of incident(s) you may have encountered.

At Delray Care Physical Therapy, LLC, we have worked very hard to establish efficient program protocols for treatment of all types of pathology with these Medicare guidelines in mind. This will allow us to provide you the most efficient care possible and maximize the results you achieve in therapy. With current guidelines there may be occasion where benefits become exhausted. In the event this occurs and you continue to require skilled therapy sessions, we offer several payment options for your consideration.

1. You may continue therapy on a private pay basis. Based on your therapist's recommendation, you may continue on a ½ hour, ¾ hour, or 1hour treatment plan. (This would depend on the amount of skilled therapy you may still require). Please speak with your therapist for details.
2. You may elect to switch over to as a personal training client or remote coaching client. These programs are NOT physical therapy and are offered to patients who are capable of proceeding independently on a strength/ROM/wellness/performance program based on the recommendation of your therapist/doctor. If Interested please speak with your therapist prior to discharge from therapy services.
3. You may elect discharge from services to a Home Exercise Program after consulting with your therapist/doctor.

I acknowledge that the information disclosed in this prior treatment waiver has been answered honestly and without intent to mislead. If Medicare determines the above information to be incorrect, I agree to be fully responsible for any unpaid benefits incurred at Delray Care Physical Therapy, LLC.

_____ _____/_____/_____

Signature of Patient Date

MEDICARE SECONDARY PAYER QUESTIONNAIRE

THESE QUESTIONS ARE REQUIRED BY MEDICARE

Below are for Beneficiaries age 65 and older, and is Required by Medicare in order to comply with
Medicare Regulation #42 CFR 489.20 (F)

1. **Are you currently working full or part time?** **Yes** **No**

2. **If married, is your spouse working full or part time?** **Yes** **No**

3. **Are you currently under any employer group health plan?** **Yes** **No**
   If yes, please provide the following information:

   Name of Insured _____

   Relationship to Patient _____

   Name of Employer _____

   Name of Insurance Carrier _____

   Policy # _____ **Group #** _____

4. **Are you entitled to Black Lung Benefits?** **Yes** **No**

5. **Is this service for treatment of a work related injury?** **Yes** **No**
   If yes, please provide the following information:

   Name of Insurer _____

   Name of Policyholder _____

   Date of Injury _____

   Claim # _____

6. **Is this service for treatment of an auto related injury?** **Yes** **No**
   If yes, please provide the following information:

   Name of Insurer _____

   Name of Policyholder _____

   Date of Injury _____

   Claim # _____

7. **Are benefits for services being submitted to any other party (other than Medicare and supplemental insurance) for reimbursement consideration?** **Yes** **No**

_____ _____
Patient Signature **Date**

_____
Patient Name (Please Print)

Medicare Financial Responsibility Disclosure

Thank you for choosing our clinic for your therapy needs. As a Medicare provider, we are required to inform you about your responsibilities as a Medicare beneficiary. Please read this notice carefully. If you have any questions, please contact one of our staff.

Patient Financial Responsibilities

Effective, January 1, 2020, you are responsible for an annual $189.00 deductible. (Medicare will only pay for services after expenses exceed $189.00). **Medicare's 2020 Physical & Speech Therapy (combined) benefit is $2,080.00.**

Medicare will pay 80% of the allowable charges. **You are responsible for the remaining 20%**. If you have secondary/supplemental insurance coverage and provide us with that information, we will bill your secondary/supplemental insurance as a courtesy to you. If you do not have secondary/supplemental coverage or your secondary/supplemental coverage fails to pay for your services, you are responsible for the payment of the 20%.

If Medicare denies charges because you have other insurance that is considered your primary insurance, you will be responsible for all incurred charges. It is your responsibility to inform us of any other insurance coverage that you may have.

Medicare as the Secondary Payer

There may be situations where Medicare is not your primary payer. Medicare law requires that we investigate all possible situations where other insurance, besides Medicare, might be the primary payer. If any of the following items below apply to you, Medicare may not be the primary payer.

- Black Lung Benefits
- Veterans Administration (VA)
- Workers' Compensation
- Automobile Accident, No Fault or Other Liability Insurance
- Employee Group Health Plan (EGHP)
- End Stage Renal Disease Benefits (ESRD)
- Disabled and covered by a Large Group Health Plan (LGHP)

Medicare Part C (Medicare Advantage or Medicare+Choice)

Please notify one of our office staff if your Medicare coverage is Medicare Part C coverage. Medicare Part C coverage is also known as Medicare Advantage Program or Medicare+Choice. Medicare Part C coverage is purchased and administered through a private insurance company and includes HMO, PPO, PFFS, PSO and MSA products. Medicare Part C beneficiaries pay premiums that typically provide them with more coverage than the "traditional Medicare programs" (Medicare Part A and B) at a lower cost. Failure to provide us with this information may result in non-payment of your health claims.

Medicare Home Health Services

Medicare has required that patients receiving Home Health Services must have outpatient therapy services consolidated with the Home Health Agency. Meaning that, if you are receiving Home Health Services at home, of any kind, you are considered "home bound" and therefore unable to attend Therapy services at our location during that time. Failure to provide us with this information may result in non-payment of your health claims by Medicare.

You will be asked to complete a Medicare Secondary Payer Questionnaire to ensure that we properly determine whether Medicare is the Primary or Secondary Payer in your case or if Medicare will not allow payment for our services.

Thank you for reviewing this important information regarding your Medicare coverage. If you have any questions, please contact one of our staff.

Delray Care Physical Therapy, LLC

2645 N Federal Highway, Suite 240
Delray Beach, FL 33483
(561) 562-8561 * Fax (561) 562-8563

VERY IMPORTANT!

If you are ***currently*** receiving services or treatment in your home **from anyone** for **any condition** (including blood draws, vital statistics, nursing services, injections, or any type of therapy (physical, occupational or speech therapy, etc.)
Medicare ***will not*** pay for OUR claims for outpatient services.
You will be responsible for payment.
You must be discharged from all home services
PRIOR TO STARTING YOUR TREATMENT HERE!

Not applicable _____ Discharge date _____

Signature _____ Date _____

Patient Name (Please Print) _____

Patient Authorization

Patient Name: Date of Birth:

Release of Information & Consent for Treatment

All information provided herein is true and correct.
I am aware of my diagnosis and wish to receive treatment at Delray Care Physical Therapy, LLC. I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care can include an evaluation, testing and treatment. No guarantees have been made to me about the outcome of this care.

I give permission to Delray Care Physical Therapy, LLC to release information, verbal and written, contained in my medical record, and other related information, to my insurance company, rehab nurse, case manager, attorney, employer, school, related healthcare provider, assignees and/or beneficiaries and all other related persons as it pertains to my treatment or payment for services provided.

I authorize Delray Care Physical Therapy, LLC to obtain medical records and/or professional information from my physician or other medical professional as it relates to my treatment.

The signature below certifies that I have read and understand the above information. **Initial:** _____

Assignment of Benefits

I authorize payment directly to Delray Care Physical Therapy, LLC for services. This is a direct assignment of my rights and benefits under this policy. A photocopy of this assignment shall be considered as effective and valid as the original.

Initial: _____

Notice of Privacy Practices (HIPPAA Acknowledgement/Consent)

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices for Delray Care Physical Therapy, LLC.

In addition, I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations.

Initial: _____

Payment Guarantee

I agree to pay Delray Care Physical Therapy, LLC, for services provided to me or the party named above. If any law, such as worker's compensation, or insurance contract prohibits payment for these services, I will cooperate and assist in the provision of information, authorizations, releases, or any type of information necessary to allow for speedy collection from my third-party payer. Where the law or an insurance contract does not prohibit payment by me, I acknowledge responsibility for any and all account balances.

The benefit verification is only an explanation of coverage obtained from my insurance company and it is not a guarantee of coverage/payment. If the information provided by my insurance company is not accurate or the insurance company changes its coverage, I will be responsible for payment of services.

I further understand that this agreement is binding regardless of any legal transaction currently in progress or initiated during or after the course of my treatments unless agreed to in writing by myself and a representative of Delray Care Physical Therapy, LLC.

Initial: _____

Patient or Guardian Signature: Date: