BEATON ORTHOPEDIC
PHYSICAL THERAPY

MALIBU REHABILITATION CENTER

Patient Name_____ **Birthdate**_____

Address_____
Street City State Zip

Home Phone #_____ **Email** _____

Cell Phone #_____ **Emergency Contact** _____

Relationship_____ **Contact's Phone #**_____

Type of Accident _____ **Surgery Performed** _____

I herby authorize Beaton Orthopedic Physical Therapy to perform any physical therapy treatment and evaluation, which are deemed necessary for my health care.

Patient/Guardian Signature_____ **Date**_____

Dear Patient:

All coinsurances, deductibles, and copays are expected at the time of service, no exceptions. Coinsurance and deductibles will be estimated based on an average visit cost and expected reimbursement from your insurance carrier. Beaton Orthopedic Physical Therapy will carry your account for sixty (60) days. If we are unable to collect payment from your insurance carrier, you will be responsible for the entire debt incurred for services rendered at Beaton Orthopedic Physical Therapy. Accounts remaining open after sixty (60) days are subject to a late charge. Unpaid accounts will be turned over to collections. This agreement is binding regardless of any legal transactions currently in progress or initiated during the course of physical therapy treatments, unless agreed upon in writing.

There will be a charge of $120 for NO SHOW appointments or cancellations with less than 24-hour notification. You will be personally responsible for any cancellation fees.

As a *courtesy* we send automated text message appointment reminders the day before your appointment, if you do not get a text you are still responsible for knowing your appointment times. If you cannot make your appointment do not respond to the text (*we will not receive it*) Please call the office to reschedule and we will be happy to accommodate.

Patient/Guardian Signature_____ **Date**_____

I authorize Beaton Orthopedic Physical Therapy to charge my credit card for the amount due at each visit

Credit Card Number _____ Expiration_____ CVV_____

Signature _____ Date_____

Medicare Confirmation of Benefits

Company Name:
Patient Name: Date:

As you begin your course of treatment with us, we would like you to be acquainted with our policies and procedures regarding payment:
This is a summary of your benefits as quoted by a representative of your insurance company and not a guarantee of payment. Eligibility and benefits will be determined at the time your claims are processed.

You May Leave This Section Blank

Insurance Carrier Primary: Medicare ID#:
Secondary: ID#:

Deductible Amount Primary: Medicare $ 185 Has it been met?
Secondary: Has it been met?

Your policy covers: Medicare pays 80% of $ 2040 annual combined maximum for physical and speech therapy

Estimated Patient Copayment/Portion: Any amount not covered by insurance or exceeding limit

Limitation and/or Exclusions: Medicare $ 2040 annual combined maximum for physical and speech therapy
Services over $ 2040 are subject to the Medicare Exception Process
Services over $ 3000 are subject to the Medicare Pre Payment Review Process for Medical Necessity

Has any been used? Insurance Rep Providing Information:

____1. If you have insurance you are still responsible for payment of services rendered, regardless of any coverage. We will make every effort to keep track of your total visits, but it is your responsibility to be aware of the limitations of your policy. **You are hereby notified in advance that you will be financially responsible in full for any services beyond those allowed or denied for any reason by your insurance carrier.** Should you require treatment or procedures beyond the benefit offered by your insurance company, you may negotiate with them for additional coverage. Any reports, documentation and/or phone calls beyond those considered usual and customary will be subject to a fee.

____2. We will make every effort to verify your coverage with your carrier and inform you of your deductible and copayment responsibilities. We verify benefits as a courtesy to our patients and we are at no time to be held responsible if incorrect information has been obtained. Please remember that the information we get from your carrier is only an estimate, and we cannot be sure of the exact amount until we submit a claim and receive an Explanation of Benefits. Your insurance company will process your claims as in or out of network according to your insurance policy.

____3. Once your deductible, if any, is met, we will collect only your estimated copayment and will bill your insurance carrier for the balance. We will make every reasonable effort to assist in expediting insurance payment; however, you will be responsible for negotiating any eligibility or payment disputes directly with your insurance carrier.

____4. If your insurance company has not acknowledged any portion of your account within 60 days, the balance is due and payable in full. You will be responsible for the entire debt incurred for services rendered. Accounts remaining outstanding after sixty (60) days will be subject to a 1.5% per month finance charge. Unpaid accounts will be turned over to collection.

____5. ***You are responsible for paying your copayments at the time of each visit***. If you cannot do this, you must make special financial arrangements with our business office. Failure to meet your financial responsibilities may result in termination of your treatment.

____6. There will be a charge of $120.00 for NO SHOW appointments or cancellations with less than 24-hour notification. You will be personally responsible for any cancellation fees.

____7. Please note you are personally responsible for payment for any supplies you receive such as: electrodes, theraband, gym balls, etc… Payment is due at the time of service.

This year have you received any physical and/or speech therapy services in Part B Skilled Nursing Facility (SNF), Comprehensive Outpatient Rehabilitation Facility (CORF), Outpatient Rehab Facility (ORF), Private Practice, Home Health Agency, and/or Hospital Outpatient Departments, Critical Access Hospitals (CAH)? _____ *Yes* _____ *No*

If yes, how many visits/how much? _____

Are you enrolled or receiving Home Health _____ *Yes* _____ *No*

If yes specify dates: _____

I have read and fully understand all of the above information and hereby agree to comply as outlined.

Patient Signature _____ Date_____

BEATON ORTHOPEDIC PHYSICAL THERAPY

MALIBU REHABILITATION CENTER

Medical Information

Patient Name_____ **Age**_____ **Today's Date**_____

Rate your pain (*circle one*) (no pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst pain imaginable)

Health Habits

Do you currently smoke tobacco? Yes No

Have you smoked in the past? Yes No

Do you exercise? Yes No

If yes, describe the exercise (what type, how often, how much)

_____

_____

Family History – Have any family members (Parents, sibling, aunts/uncles, grandparents) had any of the following conditions? (Circle all that apply)

Heart Disease	Diabetes	Osteoporosis
High Blood Pressure	Psychological Conditions	Cancer
Stroke	Arthritis	Other Conditions

Medical History – Circle any and all of the condition listed below that you have ever personally had:

Arthritis	Blood Disorders	Diabetes
Seizures/Epilepsy	Allergies	Cancer
Heart Problems	Broken bones/Fractures	Osteoporosis
Hypoglycemia	High/Low Blood Pressure	Lung Problems
Stroke	Thyroid Problems	Multiple Sclerosis
Kidney Problems	Circulation Problems	Skin Disease
Parkinson Disease	Infectious Disease	Muscular Dystrophy
Developmental/Growth Problems		Depression

Men Only: Prostate Disease Yes No

Women Only: Gynecological Difficulties:

Trouble with your Period? Yes No

Have you given birth in the last 5 years? Yes No

If yes, did you have any complications with pregnancy/delivery?

_____

_____

Have you ever had surgery? Yes No

If yes, please describe and give dates:

_____

_____

Do you have any METAL anywhere in your body (other than tooth fillings) such as pins, plates, pace makers? If so, what and where.

_____

_____

List medications by name you are presently taking:

_____

_____

_____

List any allergies including Drug and Medication Allergies:

_____

_____

Circle any of the following that you have had <u>within the past year</u>:

Chest Pain	Hoarseness	Nausea/vomiting
Swelling	Difficulty walking	Difficulty sleeping
Dizziness	Heart palpitations	Shortness of breath
Numbness	Loss of Consciousness	Hearing problems
Headaches	Coordination problems	Loss of balance
Joint pain	Weakness in arms/legs	Difficulty swallowing
Cough	Urinary problems	Fever/chills
Asthma	Loss of appetite	Bowel problems
Pain at night	Weight loss/gain	Vision problems

Other _____

Are you pregnant? (**Women only**) Yes No

Current Condition/s

Describe the problem for which you seek physical therapy:

_____

_____

_____

When did the problem begin? _____

How did it begin? _____

_____

What if anything causes your pain to worsen? _____

_____

What if anything causes your pain to improve? _____

_____

Have you ever had the problem before? Yes No

What are your goals in attending Physical Therapy?

_____

_____

HIPAA

Notice of HIPAA Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Updated: February 16, 2017

Uses and Disclosures

We will use your protected health information (PHI) for the purposes of treatment, payment and health care operations. Treatment includes the disclosure of health information to other providers who have referred you for services or are involved in your care. This may include doctors, nurses, technicians and other physical therapists. For example, we may feel that a stroke patient we are treating would benefit from an evaluation by a speech-language pathologist to address a swallowing difficulty. The health information we share with the speech-language pathologist would be considered a treatment related disclosure.

Payment includes the disclosure of health information to your insurance company, including Medicare and Medicaid, so payment can be obtained for services rendered. Your insurance company may make a request to review your medical record to determine that your care was necessary. Health Care Operations includes the utilization of your records to monitor the quality of care being given at our facility or for business planning activities.

Other Special Uses

Our practice may use your PHI to send you an appointment reminder, to inform you of our other health-related products and services, or to request a contribution to our charitable activities.

Uses and Disclosures Required by Law

The federal health information privacy regulations either permit or require us to use or disclose your PHI in the following ways: we may share some of your PHI with a family member or friend involved in your care if you do not object, we may use your PHI in an emergency situation when you may not be able to express yourself, and we may use or disclose your PHI for research purposes if we are provided with very specific assurances that your privacy will be protected. We may also disclose your PHI when we are required to do so by law, for example by court order or subpoena. Disclosures to health oversight agencies are sometimes required by law to report certain diseases or adverse drug reactions. We may use and disclose health information about you to avert a serious threat to your health or safety or the health or safety of the public or others. If you are in the Armed Forces, we may release health information about you when it is determined to be necessary by the appropriate military command authorities. We may also release information about you for workersí compensation or other similar programs that provide benefits for work-related injury or illness.

Your authorization is required before your PHI may be used or disclosed by us for other purposes.

Your Privacy Rights Restrictions

You have the right to request restrictions on how your PHI is used, however, we are not required to agree with your request. If we do agree, we must abide by your request.

Confidential Communications

You have the right to request confidential communication from us at a location of your choosing. This request must be in writing.

Access to PHI

You have the right to request a copy of your medical record. You must make this request in writing and we may charge a fee to cover the costs of copying and mailing.

Amendments

You have the right to request an amendment be made to your PHI, if you disagree with what it says about you. This request must be made in writing. If we disagree with you, we are not required to make the change. You do have the right to submit a written statement about why you disagree that will become part of your record. We may not amend parts of your medical record that we did not create.

Accounting of Disclosures

After April 14, 2003, you have the right to request an accounting of the disclosures made in the previous six years. These disclosures will not include those made for treatment, payment, or health care operations or for which we have obtained authorization.

Complaints

If you feel that your privacy rights have been violated, you have the right to make a complaint to us in writing without fear of retaliation. Your complaint should contain enough specific information so that we may adequately investigate and respond to your concerns. If you are not satisfied with our response, you may complain directly to the Secretary of Health and Human Services.

Our Duty to Protect Your Privacy

We are required to comply with the federal health information privacy regulations by maintaining the privacy of your PHI. These rules require us to provide you with this document, our Notice of Privacy Practices. We reserve the right to update this notice if required by law. If we do update this notice at any time in the future, you will receive a revised notice when you next seek treatment from us.

Privacy Contact

If you would like more information about our privacy practices or to file a complaint you may contact: Gregory Beaton | 310.456.9332

By signing below, I acknowledge that I have received a copy of The HIPAA Privacy Practices Notice.

_____

Print Name Sign Date