P.T. Services Rehabilitation, Inc. 1800 W State Street · Fremont, OH 43420 · P: 419-332-6709 · F: 419-332-9738

Treatment & Attendance Record

Patient: _____ **DOB:**_____

Limitations:_____ **Insurance:**_____

Visit Authorizations: _____ **Account #:**_____

PROCEDURES	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE	DATE
Start Time												
End Time												
Total Time												
PT EVALUATION 97161 / 97162 /9 7163												
OT EVALUATION 97165 / 97166 /9 7167												
PT RE-EVALUATION 97164												
OT RE-EVALUATION 97168												
FLUIDOTHERAPY 97022												
E-STIMULATION-UNATTENDED GO283 / 97014												
PARAFFIN 97018												
MECHANICAL TRACTION 97012												
GROUP 97150												
Total Service-Based Units												
THERAPEUTIC EXERCISE 97110												
MANUAL THERAPY 97140												
NEUROMUSCULAR RE-ED 97112												
GAIT 97116												
THERAPEUTIC ACTIVITIES 97530												
WORK CONDITIONING W0710												
ULTRASOUND 97035												
E-STIMULATION - ATTENDED 97032												
IONTOPHORESIS 97033												
OTHER												
OTHER												
Total Time-Based Minutes												
Total Time-Based Units												
Total Units												
Provider initials:												

Provider Signature	Initials

Provider Signature	Initials

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Activity Flow Sheet

Patient:_____ **Precautions:**_____

DATE								
EXERCISE / PROCEDURE								
INITIALS								

Provider Signature	Initials

Provider Signature	Initials

P.T. Services Rehabilitation, Inc.
Excellence in Motion
1800 W State Street · Fremont, OH 43420 · P: 419-332-6709 · F: 419-332-9738

Welcome Letter and Attendance Policy

Welcome to P.T. Services Rehabilitation, Inc.!

On your first visit, a treatment plan will be set up, and goals established to help measure your progress. This Plan of Care will be sent to your referring physician. Please inform us of your next doctor's appointment so that we can accurately communicate your progress.

We will work with you and your physician to determine the appropriate frequency of your visits.

Please schedule and confirm your appointments with the front desk staff. If you must cancel an appointment, please provide a 24-hour cancellation notice. All other cancellations and no-shows are subject to a discretionary $30 charge.

Your attendance at therapy is crucial to successfully achieving your goals. Your attendance will be reported to your physician on our Plan of Care updates.

You will be subject to discharge from treatment if you:

- **Miss 3 consecutive visits without a phone call to cancel.**
- **Are not seen for therapy in 30 consecutive days.**
- **Attend less than 50% of your scheduled visits.**

Please note: If you are more than 10 minutes late for your appointment, your treatment session may be adjusted.

We give home exercises and instructions which you are expected to complete.

We are pleased to work with you toward your therapy goals.

Thank you!

I understand the above attendance policy.

Patient/Caregiver Signature:_____ **Date:** _____

P.T. Services Rehabilitation, Inc. 1800 W State Street · Fremont, OH 43420 · P: 419-332-6709 · F: 419-332-9738

Patient Information

PLEASE PRINT **Date:**_____

Patient Name: Last _____ **First** _____ **MI** _____

Address: Street _____ **P.O. Box**_____

City _____ **State** _____ **Zip** _____ **Phone:** (_____) _____-_____

Cell Phone: (_____) _____-_____ **Email Address:** _____

SSN#: _____-_____-_____ **Date of Birth:** ____/____/____ ☐ **Female** ☐ **Male**

Race:_____ **Marital Status:** _____

Guarantor/Responsible Party: _____ **Relationship:** _____

Address: _____ **Phone:** (_____) _____-_____

EMPLOYMENT INFORMATION

Employer: _____ **Employer Contact:** _____

Address: _____ **Work Phone** (_____) _____-_____

Occupation & Duties:_____

EMERGENCY CONTACT INFORMATION

Name: Last _____ **First** _____

Phone: (_____) _____-_____ **Relationship:** _____

PHYSICIAN/PROVIDER INFORMATION

Referring Provider: _____ **Phone:** (_____) _____-_____

Primary Care Provider: _____ **Phone:** (_____) _____-_____

INJURY INFORMATION

Date of Injury: ____/_____/_____ **Employment Related:** ☐ **YES** ☐ **NO** **BWC Claim:** ☐ **YES** ☐ **NO**

Have you received therapy/chiropractic services in this calendar year: ☐ **YES** ☐ **NO**

Are you receiving home care services: ☐ **YES** **Name of Agency:** _____ _____ ☐ **NO**

Auto Accident: ☐ **YES** ☐ **NO**

INSURANCE INFORMATION

Primary: _____ **Insured ID #:** _____

S.S.#_____-_____-_____

Name of Insured: _____ **Insured's Date of Birth:** ____/_____/_____

Insured's Employer: _____ **Relationship to Insured:** _____

Secondary: _____ **Insured ID #:** _____

Name of Insured: _____ **Insured's Date of Birth:** ____/_____/_____

Insured's Employer: _____ **Relationship to Insured:** _____

FINANCIAL AGREEMENTS

For and in consideration of services rendered or to be rendered to the above named patient by P.T. Services, Rehabilitation Inc. I agree, whether acting as an agent or patient, to pay the amount due this facility. I will make current payments as bills are rendered or I will assign my insurance benefits for direct payment to this facility, and I will pay copay amounts at the time service is provided and any uncovered differences upon receipt of a statement. I understand that I am financially responsible for all charges whether or not paid by said insurance. I have received and understand the attendance policy. I hereby authorize said assignee to release all information necessary to secure payment.

Patient Signature:_____ **Date:** _____

Witness: _____ **Date:** _____

P.T. Services Rehabilitation, Inc. **1800 W State Street · Fremont, OH 43420 · P: 419-332-6709 · F: 419-332-9738**

Notice of Privacy & Consent

- I understand that as part of my healthcare, P.T. Services Rehabilitation, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:
    - A basis for planning my care and treatment.
    - A means of communication among the many health professionals who contribute to my care.
    - A source of information for applying my diagnosis to my bill.
    - A means by which a third-party payer may verify that services billed were actually provided.
- I understand that I am given this notice prior to signing consent, and P.T. Services Rehabilitation, Inc. reserves the right to change their notice and practices upon a reasonable implementation and notification period. I understand that I have the right to object to the use of my health information, and I may restrict as to how my health information may be used or disclosed. However, P.T. Services Rehabilitation, Inc. is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance theron. In consideration of the statements above, please be advised that, P.T. Services Rehabilitation, Inc. has a legal obligation to protect your health information by following appropriate privacy practices.
- I hereby consent and authorize P.T. Services Rehabilitation, Inc. to administer treatment as ordered by the physician and deemed necessary in the treatment of this patient.
- I hereby consent and authorize P.T. Services Rehabilitation, Inc. to use or disclose information pertaining to my health record for the purposes of: conducting appropriate rehabilitative treatment, seeking payment for services rendered, or performing required healthcare operations activities such as, but not limited to, medical chart reviews or case conferences.
- The undersigned hereby authorizes P.T. Services Rehabilitation, Inc. and its employees and agents, to notify the designated person below regarding my treatment and/or in case of emergency:

Name:_____ **Home Phone:**_____

Address:_____ **City:**_____ **State:**_____ **Zip:** _____

- I understand that by signing this release, I expressly consent to allowing P.T. Services Rehabilitation, Inc., to convey confidential and sensitive information regarding my care and treatment to the above named person(s) via text, email or voice mail. I hereby release P.T. Services Rehabilitation, Inc. and its employees and agents, from any liability associated with leaving such messages with this person set forth above.

Signature:_____ **Date**:_____

Restricted Notification:

Please list the individuals that you do **not** want to receive any information regarding your care and treatment communicated by any means.

_____

_____

This authorization is valid until such time as the patient revokes it.

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Social Needs Evaluation

An illness, injury or pain changes a person's life in many ways. Check below any issues which you would like some assistance:

Daily Living Needs:

- ☐ Obtaining Meals
- ☐ Shopping
- ☐ Using Transportation Resources
- ☐ Managing Finances

Social Changes:

- ☐ Family member(s) neglect/abuse
- ☐ Family member(s) too helpful
- ☐ Losing friends
- ☐ Being unable to get to work/school
- ☐ Having sexual/marital difficulties
- ☐ Unable to continue usual recreational activities
- ☐ Having legal problems due to illness

Personal Changes:

- ☐ Feeling that the injury/pain is a kind of punishment
- ☐ Feeling concern about becoming a burden
- ☐ Feeling frustrated about slow progress
- ☐ Feeling that injury/pain keeps me from doing what I want to do
- ☐ Having negative feelings about my body
- ☐ Having negative feelings about equipment (i.e. walker, brace, wheelchair, etc.)
- ☐ Feeling worried about possible career change
- ☐ Feeling depression, hopelessness or anger

Check the support systems that you currently have or use:

☐ Immediate Family	☐ Friends	☐ Social Clubs	☐ Employee Assistance Program
☐ Extended Family	☐ Church	☐ Community Organizations	

Do you feel need professional counseling services to address the above needs? ☐ **YES** ☐ **NO**

Patient Signature:_____ **Date:** _____

Witness: _____ **Date:** _____

Social Worker (if need requested)**:** _____ **Date:** _____

P.T. Services Rehabilitation, Inc. Notice of Privacy Practices

Effective April 14, 2003

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

The terms of this Notice of Privacy Practices apply to P. T. Services Rehabilitation, Inc. and each of its subsidiaries, affiliates, and entities managed or controlled by P.T. Services Rehabilitation Inc., including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We arc required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by P.T. Services Rehabilitation, Inc. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, P.T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin, ·OH 44883.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review. Business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written or oral agreement we may from time to time disclose your personal health information to designated family, friends, and others who arc involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, P.T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin. OH 44883.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- Any purpose required by law.
- Public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- To the Food and Drug Administration to report adverse events, product defects, or to participate in recalls.
- To your employer when we have provided health care to you at the request of your employer.
- To a government oversight agency conducting audits, investigations, or civil criminal proceedings.
- Court or administrative ordered subpoena or discovery request;
- To law enforcement officials as required by law to report wounds and injuries and crimes;
- To coroners and/or funeral directors consistent with law;
- If necessary to arrange an organ or tissue donation from you or a transplant for you;
- If you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- To workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION

Access to Your Personal Health Information: You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person.

Amendments to Your Personal Health Information: You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We arc not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if wc believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical rcords.

Accounting for Disclosures of Your Personal Health Information: You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Workers' Compensation: For patients whose medical treatment is covered under a state workers' compensation program, please note the following: Disclosure of your protected health information (PHI) for purposes of providing treatment and obtaining payment under the state's workers' compensation is governed by the state workers' compensation regulations and procedures. Therefore, we are not obligated to secure a written authorization as otherwise required by HIPAA in order to disclose your PHI for workers' compensation purposes, nor may you restrict our use or disclosure of your PHI for workers' compensation purposes. Written consent to use or disclose your PHI may be required pursuant to our internal policies and/or state workers' compensation program rules in order to process your claims. Failure to provide any required written consent may result in your financial liability for medical services and supplies.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, P.T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin, OH 44883. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, P .T. Services Rehabilitation, Inc., P.O. Box 833, Tiffin, OH 44883.

Signature: _____ Date: _____
Patient (or representative)

P.T. Services Rehabilitation, Inc. 1800 W State Street · Fremont, OH 43420 · P: 419-332-6709 · F: 419-332-9738

Medicare Secondary Payer

Patient:_____ **Date:**_____
Medicare #:_____ **Provider #:**_____

1. Do you receive Veteran's benefits?: ☐ **YES** ☐ **NO**

2. Are you receiving benefits under the Black Lung Program? ☐ **YES** ☐ **NO**
If yes, date benefits began:_____
If yes, are the services you will be receiving related to a non-black lung condition? ☐ **YES** ☐ **NO**

3. Was this injury/illness due to a work-related accident/condition? ☐ **YES** ☐ **NO**
If yes, date of injury/illness: _____

4. Was this injury/illness related to an automobile accident? ☐ **YES** ☐ **NO**
If yes, date of accident: _____

5. Was this injury/illness related to an accident in which you intend to file a liability suit or litigation is pending? ☐ **YES** ☐ **NO**
If yes, please provide: **Attorney's Name:** _____
Address: _____
Phone: _____

5. Are you entitled to Medicare based on: ☐ **Age (65 & over) - go to question 7**
☐ **Disability - go to question 7**
☐ **End Stage Renal Disease**
Do you have group health plan (GHP) coverage? ☐ **YES** ☐ **NO**
Are you within the 30-month coordination period? ☐ **YES** ☐ **NO**

6. Are you currently employed? ☐ **YES** ☐ **NO** **Date of retirement:** _____
a) Is your spouse currently employed? ☐ **YES** ☐ **NO**
b) Do you have a group health plan (GHP) as a primary coverage based on your own or a spouse's current (or former) employment? ☐ **YES** ☐ **NO**
c) Does the employer that sponsors your GHP employ 20 or more employees? ☐ **YES** ☐ **NO**

7. If you answered YES to questions 3, 4 or 7 above, please complete the following information:

Insurance Company: _____
Address: _____
Policy/Cert #: _____
Group Name & #: _____

Patient's Name: _____ **Date:** _____

Responsible Party:_____ **Relationship:**_____

P.T. Services Rehabilitation, Inc.™
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Date of Evaluation:_____

Medicare Financial Limitation Notification Form

Effective January 1, 2021 the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling $2,110.00 for Medicare Part B outpatient services for Physical, Occupational and Speech therapy services.

The purpose of this notice is to help you make an informed choice about whether or not you wish to continue to receive outpatient Physical, Occupational, or Speech therapy, after the Medicare financial limitation has been met, knowing you may be financially responsible for these services.

CMS's financial limitation (Cap) will be applied in the following manner for your outpatient rehabilitation services:

- **Physical and Speech Therapy share one $2,110 financial limitation for both therapies combined.**
- **Occupational Therapy services have a separate $2,110 financial limitation.**
- **The 2021 full cap amount of $2,110 applies to the 12-month period of January 1 to December 31.**

Medicare will subtract your deductible and co-insurance from the $2,110 cap and pay $1,688, or 80%. The 20% coinsurance, or $420, will be paid by you or a supplemental insurance you may have. These limits are based off the Medicare fee schedule allowed amount after your deductible has been met. The cap will be based on services paid by Medicare at the allowable rate, not the provider's charges.

As Medicare providers, we are obligated to inform you of this financial limitation and Medicare's determination that once the financial limitation for Physical, Occupational, and/or Speech therapy benefit is met as described above, you will be financially responsible for any services provided, unless you qualify for a Cap exception as outlined below. As a courtesy, we will track the services you receive from us and notify you when the amount is close to meeting Medicare's financial limit. This will allow you to make an informed consumer decision regarding whether or not you want to continue therapy services and accept financial responsibility for the cost of any appropriate medically necessary continued care provided.

The financial limitation is your annual Medicare insurance benefit, regardless of which non-hospital based therapy providers deliver the service. If you have received Physical, Occupational, or Speech therapy prior to attending therapy at our center, please be aware that those services will be included in your financial limitation total. ***Please assist us in ensuring you stay within the cap limits by informing our Patient Service Specialist of any Physical, Occupational, or Speech therapy services you have received beginning the first of the year and today.*** We will be sure to include any self reported amount in your beginning balance and notify you when you have reached the cap at our facility so you may make an informed decision about continuing care that is medically necessary beyond the financial limitation.

Medicare Therapy Cap Exceptions

Congress has made provisions for exceptions to the Medicare Cap for which you may qualify when therapy services beyond the financial limitation (cap) are medically necessary. Your therapist will discuss your status with you as you near the cap. If you have already exceeded your financial limit (cap) for the calendar year, your therapist will discuss your ability to qualify for further treatment under an exemption after your evaluation or re-evaluation is performed. Keep in mind, not all patients qualify for an exception and will be financially responsible for continued care beyond the financial limit when you do not qualify for an exception. Ask our staff what the estimated cost of items and services will be in the event that you do not qualify for an exception.

Patient Signature:_____ **Date:** _____

This notice was adapted from CMS's "Notice of Exclusion from Medicare Benefits" form and is not an all inclusive list of excluded Medicare benefits. This notice pertains to Medicare's financial limitation and excluded benefits beyond Medicare's Therapy Cap.

Tax ID#: 34-1222395
NPI: 1972505576
Medicare ID#: 366618

ref #: _____

INSURANCE INQUIRY

Patient # _____

PATIENT NAME: _____ DATE OF BIRTH: _____

INSURANCE: _____ PLAN NAME: _____**POS / CAP / PPO / HMO / INDEMNITY**

ID/POLICY #: _____ GROUP #: _____ EFF DATE: _____

NAMED INSURED: _____ INSURED'S DATE OF BIRTH: _____

IN NETWORK YES NO DIAGNOSIS CODE: _____

DEDUCTIBLE: _____ DEDUCTIBLE MET: _____ DEDUCTIBLE REMAINING: _____

CO-INSURANCE:_____ CO-INS LIMIT:_____ CO-INS: MET: _____

OUT OF POCKET: _____ OOP MET: _____ OUT OF POCKET REMAINING: _____

CO PAY: _____ * Due at time of service Cal year Plan Year _____

LIFETIME MAX: _____ MET: **YES NO**

PATIENT TO PAY $_____ PER VISIT FOR _____ VISITS TOWARD DEDUCTIBLE

PATIENT TO PAY $_____ PER VISIT TOWARD CO- INSURANCE %

LIMIT ON VISITS: _____ VISITS USED: _____ LIMIT ON UNITS USED PER VISIT: _____

PHYSICAL THERAPY BENEFITS USED THIS YEAR: _____

OCCUPATIONAL THERAPY BENEFITS USED THIS YEAR: _____

DIAGNOSIS RESTRICTIONS: _____ SCRIPT/NOTES: **YES NO**

SELF REFERRAL ALLOWED: **YES NO**

PCP REFERRAL NEEDED? **YES NO** DOCTOR: _____ REFERRAL COMPLETED: **YES NO**

PRECERTIFICATION NEEDED? **YES NO** _____

PHONE # _____ SPOKE TO: _____ DATE: _____

AUTHORIZATION DATES: FROM _____ TO _____

OF VISITS: _____ AUTHORIZATION #: _____

Mailing Address: _____

Payor Contact: _____ Phone: _____ Date: _____

We have obtained this information from your insurance company. As a service to you, we will file your claims with your insurance company. Your insurance company may deny payment for our services, even after we have completed those services. Our billing department at our corporate office will be pleased to help you if they can be of assistance in resolving issues. Regardless of what your insurance pays, you are ultimately responsible for all fees related to your care.

Verification Done By: _____ Date: _____

Patient Signature: _____ Date: _____

P.T. Services Rehabilitation, Inc.
Excellence in Motion

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Patient Survey

Name (optional): _____ Physician/Provider:_____

Please tell us what you think so we can better serve you! Consider the following statements and circle the word/words that best represents the way you feel.

1. My overall experience with the P.T. Services staff was satisfactory.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

2. My problems and treatments were clearly explained to me.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

3. I was satisfied with the results of my therapy.

Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree
5	4	3	2	1

4. Would you use our services again? YES NO

5. Would you recommend us to others? YES NO

6. How did you hear about P.T. Services?

☐ Print ad ☐ Radio ☐ Social Media ☐ Physician/Provider ☐ Word of mouth ☐ Other_____

Please tell us about the quality of services you received: _____

_____

_____

_____

_____

_____

_____

_____

Please feel free to use the back of this form for further comments.

Does P.T. Services have permission to use your name and any comments above for news releases/articles, promotional materials and social media? _____ YES _____ NO

Patient Signature:_____ Date: _____

I would appreciate a phone call to discuss my comments/concerns. Phone:_____

FOR OFFICE USE ONLY: Score: _____ Phone Call: _____

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

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.

☐ **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:

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PT/OT Progress Note

Patient:	**Physician/Provider:**
Diagnosis:	**Onset Date** (must be within 6 mo.)**:**

DATE: _____ / _____ / _____ **VISIT #**_____ / _____ **TOTAL** ☐	**DATE:** _____ / _____ / _____ **VISIT #**_____ / _____ **TOTAL** ☐
Pain: _____ /10 **Subjective:**	**Pain:** _____ /10 **Subjective:**
TREATMENT:	**TREATMENT:**
OBJECTIVE/FUNCTIONAL MEASURES:	**OBJECTIVE/FUNCTIONAL MEASURES:**
EDUCATION: ☐ **HEP Review** ☐ **Patient** ☐ **Caregiver/Other**_____ **LEVEL OF UNDERSTANDING:** ☐ **Good** ☐ **Fair** ☐ **Poor**	**EDUCATION:** ☐ **HEP Review** ☐ **Patient** ☐ **Caregiver/Other**_____ **LEVEL OF UNDERSTANDING:** ☐ **Good** ☐ **Fair** ☐ **Poor**
TREATMENT TOLERANCE: ☐ **Tolerated Well** ☐ **Limited By**_____	**TREATMENT TOLERANCE:** ☐ **Tolerated Well** ☐ **Limited By**_____
☐ **Continue Current Therapy** ☐ **Advance per Protocol** ☐ **Changes:** _____	☐ **Continue Current Therapy** ☐ **Advance per Protocol** ☐ **Changes:** _____
x	**x**
x	**x**

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☐ Plan of Care ☐ Recertification ☐ Discharge

☐ Physical Therapy ☐ Occupational Therapy

Patient:	**Physician/Provider:**
DOB:	**Diagnosis:**
Cert. Dates: From: Through:	**Frequency:** /wk **Duration:**

Evaluations

☐ Evaluation ☐ Functional Capacity Evaluation ☐ Wheelchair Evaluation ☐ Re-Evaluation

Treatment Procedures

☐ Therapeutic Exercise
☐ Manual Therapy
☐ Neuromuscular Re-education
☐ Vestibular Rehabilitation
☐ Gait Training
☐ Orthotics/Splint/Brace Fitting & Training
☐ Therapeutic Activities
☐ Work Conditioning
☐ Activities of Daily Living
☐ Electrical Stimulation
☐ Ultrasound
☐ Traction
☐ Iontophoresis
☐ Fluidotherapy
☐ Paraffin Bath
☐ Cold/Hot Packs
☐ Other _____
☐ Recommended Changes _____

Short Term Goals:	Met	Partially Met	Not Met
1. Patient educated in HEP and POC with good understanding and safety noted.	☐	☐	☐
2.	☐	☐	☐

Long Term Goals:	Met	Partially Met	Not Met
1.	☐	☐	☐
2.	☐	☐	☐
3.	☐	☐	☐
4.	☐	☐	☐
5.	☐	☐	☐

Current Status/Recommendations: _____

_____

_____

_____

Attendance / Compliance: ☐ Good ☐ Fair ☐ Poor **Rehab Potential/Prognosis:** ☐ Good ☐ Fair ☐ Guarded

Evaluation & Plan of Care reviewed with patient, with understanding and agreement: ☐ YES ☐ NO

PT/OTR Signature: _____ **Date:** _____

I certify the medical necessity for these services under this Plan of Treatment and while under my care.

Physician/Provider's Signature: _____ **Date:** _____

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☐ **PT Evaluation** ☐ **OT Evaluation**

Patient:	**Physician/Provider:**
Diagnosis:	**Onset Date** (must be within 6 mo.)**:**
	Prognosis: ☐ Good ☐ Fair ☐ Guarded
Patient Aware of Diagnosis: ☐ YES ☐ NO	**Patient Aware of Prognosis:** ☐ YES ☐ NO

Precautions/Contraindications:

☐ Universal ☐ Weight Bearing ☐ Pacemaker ☐ Seizure ☐ Cancer_____

☐ Joint Replacement ☐ Fall Risk ☐ Cardiac ☐ Infectious Disease ☐ Other_____

Prior Level of Function: ☐ Independent/No Deficits ☐ Deficits _____

Pain: 0 1 2 3 4 5 6 7 8 9 10 **Location:** _____ **Type:** _____

Posture: ☐ WFL

ROM/Flexibility: ☐ WFL

Strength/MMT: ☐ WFL

Gait/Mobility/Weight Bearing: ☐ WFL

Special Tests:

Functional Testing/ADL: ☐ See Attached Standardized Test

Summary/Plan/Medical Necessity:

PT/OTR Signature: _____ **Date:** _____

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Patient History

Patient to complete the following questions:

1. When did this problem begin: _____
   - Was it caused by a specific incident: ☐ YES ☐ NO
   - If yes, please explain:_____
   - Have you had this problem before: ☐ YES, when: _____ ☐ NO
2. Activities you are presently having difficulty with: _____
3. Activities that aggravate your problem(s): _____
4. Activities that relieve/improve your problem(s): _____
5. Recent falls: ☐ YES, when: _____ ☐ NO
6. When did you last see your doctor: _____ When is your next appointment:_____
7. Special tests: ☐ X-Ray ☐ CT ☐ MRI ☐ Hearing ☐ Swallow ☐ Other: _____
8. Have you had surgery for this problem: ☐ YES, when: _____ ☐ NO
9. Medications you are currently taking: ☐ See Attached / List: _____

   _____
10. Medication or skin allergies: ☐ See Attached / List: _____
11. Check if you have any of the following medical conditions:

☐ Broken Bones	☐ Diabetes	☐ Cancer / Type:_____	☐ Neurological Problems
☐ Trauma	☐ Heart Disease	☐ Unexplained Weight Loss	☐ Stroke
☐ Metal Implants	☐ Pacemaker Implant	☐ Kidney Disease	☐ Seizures
☐ Total Joints	☐ Circulatory Problems	☐ Liver Disease	☐ Bowel / Bladder Control
☐ Rheumatoid Arthritis	☐ High Blood Pressure	☐ Infectious Disease	☐ Depression / Anxiety
☐ Osteoporosis	☐ Migraine Headaches	☐ Lung Disease	☐ Other:_____
☐ Vision	☐ Hearing	☐ Ear Infections	

12. Prior surgeries: _____
13. Recent hospitalizations: ☐ YES, when: _____ ☐ NO
14. Are you currently working? ☐ YES ☐ NO
    - Is this a work related injury? ☐ YES ☐ NO
    - Are you under restrictions? ☐ YES, explain:_____ ☐ NO
15. Females: Are you pregnant? ☐ YES ☐ NO
16. Any pregnancy/delivery complications? ☐ YES, explain:_____ ☐ NO
17. Goals for therapy:_____

    Patient Signature:_____ Date: _____

Subjective Information:

FOR OFFICE USE ONLY

PT/OTR Signature: _____ **Date:** _____

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Clinical Outcomes

Patient: _____ **# of Visits:** _____

Physician/Provider: _____ **Diagnosis:** _____

Date of Admission: _____ **Date of Discharge:**_____

Category	Upon Admission	Upon Discharge	DC Status
1.) Functional Level			Rehabilitated
2.) Power			Improved
3.) Pain			Unchanged
4.) Range of Motion			Deteriorated
5.) Speech/Language			

1.) Functional Level

10 – Can perform all ADL's, return to work without restriction
9 – Can Perform all ADL's, return to work with moderate restrictions
8 – Minimal Difficulty with ADL's, Light duty work
7 – Moderate difficulty with ADL's, leave home independently.
6 – Few ADL's unable to perform at home, walk 2-3 blocks, drive 30 minutes.
5 – Some ADL's limited, walk 1-2 blocks, drive short distances.
4 – Many home ADL's limited, walk short distances, no prolonged activities, cannot drive, requires part time supervision.
3 – Most home ADL's limited, limited endurance, require full time supervision.
2 – Needs assistance for most ADL's and self care, minimal walking, requires part time care giver.
1 – Needs assistance with ADL's and leaving home, walk short distances with support devices, requires a full time care giver.

2.) Power

10 – Normal	5 – Fair
9 – Good +	4 – Fair -
8 – Good	3 – Poor
7 – Good -	2 – Trace
6 – Fair +	1 – 0

3.) Pain

10 – Excruciating Pain	5 – Moderate Pain
9 –	4 –
8 –	3 –
7 –	2 – Slight Pain
6 –	1 – No Pain

3.) Range of Motion

10 – Full Range of Motion	5 –50% loss
9 – <5% loss	4 – 65% loss
8 – 10% loss	3 – 80% loss
7 – 20% loss	2 – 90% loss
6 – 35% loss	1 – 100% loss

5.) Speech/ Language

10 - Speech, language and comprehension skills are WNL at or above average age appropriate levels.
9 - Speech, language and comprehension skills are functional but are not at appropriate age or pragmatic levels
8 - Good comprehension of language and expression skills are intact; a disorder or delay of sounds production exists.
7 - Fair-good comprehension of language; expression deficits and delays exist (i.e. Word finding, grammar, syntax, etc.)
6 - Fair-good comprehension of language; expression affected by neurological changes.
5 - Moderately delayed or disordered receptive and expression skills.
4 - Severely delayed or disordered receptive and expression skills.
3 - Limited comprehension of real items and/or limited pointing and gestural system.
2 - Limited eye gaze: limited use of reflexive or meaningful sound system
1 - No functional comprehension/expression or meaningful intent to communicate.

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Progress Report

Patient: _____ **DOB:** _____ **SOC:** _____

Physician/Provider:_____ **Diagnosis:** _____

☐ **Physical Therapy** ☐ **Occupational Therapy** ☐ **SpeechTherapy**

COMPLIANCE WITH THERAPY: ☐ **Good** ☐ **Fair** ☐ **Poor**

CURRENT STATUS:

Therapist Signature:_____ **Date:** _____

Thank You for the opportunity to participate in this patients care and for your continued support of our services.

PHYSICIAN/PROVIDER COMMENTS:

Physician/Provider Signature:_____ **Date:** _____

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Communication Log

Patient Name: _____ **Account #:** _____

DATE	COMMENTS	INITIALS

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Appointment Information

Patient Name: _____ **Appointment Date/Time:** _____

Body Area for Treatment: _____ **DOB:** _____

Home Phone: _____ **Cell:** _____

Referring Physician: _____

Work Related: ☐ YES ☐ NO **C-9:** ☐ YES ☐ NO

Insurance Company #1: _____ **Phone:** _____

Insurance Company #2: _____ **Phone:** _____

ID #1: _____ **ID #2:** _____

Email: _____ **(if paperwork is to be emailed)**

Appointment Information

Patient Name: _____ **Appointment Date/Time:** _____

Body Area for Treatment: _____ **DOB:** _____

Home Phone: _____ **Cell:** _____

Referring Physician: _____

Work Related: ☐ YES ☐ NO **C-9:** ☐ YES ☐ NO

Insurance Company #1: _____ **Phone:** _____

Insurance Company #2: _____ **Phone:** _____

ID #1: _____ **ID #2:** _____

Email: _____ **(if paperwork is to be emailed)**