BACKWAY'S PHYSICAL THERAPY, PLLC: **Speech & Language Therapy Medicare Client Information Form**

Welcome to our Practice! ***Sorry these forms are lengthy****, but they will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you. Please fill them in to the best of your ability.*

NAME____**AGE**_____**BIRTHDATE**__________**HT**_____**WT**_____**SEX**____

ADDRESS____**CITY**_________________**STATE**_____**ZIP**_________

Phone: Home____________________________ **Work**__________________ Ext_______ **Cell** ___________________________

Email: ____ **PROFESSION**__________________________

MARITAL STATUS: S M W D Sep. **Spouse's Name**____

YOUR SOC. SEC.#_______-______-_________ **SPOUSE'S SOC. SEC.#**_______-______-_________

EMERGENCY CONTACT: Name: _____________________________________**Phone#**_______________________________

DOCTORS' NAMES & PHONE #

1ST Dr.	2ND Dr.
Phone #	Phone #

Have you received any physical therapy, speech therapy, home health care or hospice care services? ☐Yes ☐No

If yes, when? __________________________________ Please explain: _____________________________________

INSURANCE INFORMATION:

✶✶ Please be sure to bring your insurance cards and your picture ID with you. ✶✶

The law requires that we copy them.

HEALTH INSURANCE: *(Please write in the Insurance Co. name, but only list the other information if it differs from your Card.)*

Primary Insurance Company Name:	**Secondary/Supplemental Insurance Company Name:**
Insured's Name:	**Insured's Name:**
Insured's Date of Birth:	**Insured's Date of Birth:**

****

PLEASE READ AND SIGN BELOW:

We believe that patients who understand and participate in their health care will achieve the best results. We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can. Please read the following financial, billing and office policies to understand what we expect from you; then sign below.

Financial Responsibilities & Payment Plans: You are responsible for paying your Medicare deductible and your co-pay/coinsurance at each visit, if not covered by your Supplemental/Secondary Insurance. If you cannot afford to pay at each visit, you will be expected to set up, and adhere to, a payment plan with Backway's Physical Therapy. Late fees may be charged on overdue account balances if you miss making regular payments. Cash, check & credit card payments accepted with an added fee for use of a credit card. ***Bank-returned checks*** incur a $25 fee. ***Credit Card payments*** are accepted for $50 or more and are subject to an added $5 PayPal handling fee.

Missed appointments: If you need to cancel an appointment, let us know before 8AM of the day prior to your scheduled appointment. If you cancel late, or if you do not attend your appointment, **you** will be charged a missed-appointment fee.

Refusal of Service: We expect patients to keep current on their financial accounts, keep their appointments, do their "homework," and treat us respectfully. We have the right to refuse service if these expectations aren't met or if, in the therapist's opinion, our services won't benefit you or are not medically necessary.

*******I have read and understand the financial, billing & office protocol information presented above. I hereby consent to treatment by Backway's Physical Therapy, PLLC.***

Signed____**Date**______________________________

Speech and Language Therapy: Initial Questionnaire: Present Problems

*It is important that you inform us of **ALL** medical/health conditions at your first appointment, and immediately inform us of any changes in your medical/health condition during your course of treatment.*

***The following forms** will tell us about your health conditions, medications, your insurance & contact information. Some of the forms ask for your signatures to give us permissions for billing, treatment, and communication purposes; and for signatures to indicate that you understand how your insurance, our billing, and the Privacy Act (HIPAA) work.*

*Please answer these questions to the best of your ability. **If something is confusing, leave it blank.***

Information About What Brought You Here:

How did you hear about our services? ____

What are the main symptoms that bring you to Speech Therapy today? __________________________

____

Are you seeking treatment for? (Please circle all that apply)

SPEECH VOICE SWALLOWING COGNITION APHASIA (language trouble)

Onset: When did your symptoms begin? ____

Was the onset sudden or was the onset gradual? ______________________

Previous Treatment: Have you had any previous **Speech Therapy** treatment for these symptoms?

Yes _____ No _____ If "yes," please describe_______________________________________

Other Services:

Have you received any **physical therapy, speech therapy, home health or hospice care services in the past year?** Yes _____ No _____ If yes, when? ____________________________

Please explain: ____

____

Please give names of *all* other Health Care Professionals you are seeing:

(Example: name of your Physical Therapist, Occupational Therapist, Psychologist, ENT, etc.):

____

____

Previous Level of Function: What were you able to do before these symptoms began, that you cannot do now?

____

____

Goals: What results do you want from Speech Therapy? ____

____

Symptoms:

Please indicate on the scale below the intensity of your symptoms or pain:

0 1 2 3 4 5 6 7 8 9 10

◆――――――――――――――――――――――――◆

None Mild Moderate Intense Severe Intolerable

Patient name: ________________________________ Date: ___________

Speech & Language Therapy: Initial Questionnaire: *Health History*

Please indicate if you now have, or in the past had, any of the following (check all that apply):

Voice & Speech
☐ Slurred / Mumbled Speech
☐ Voice Problems or Changes
☐ Naming Problems
☐ Difficulty Understanding
☐ Illegible Writing
☐ Other: *(write in any other complaint)*

Nervous System
☐ Head / Traumatic Brain Injury
☐ Stroke /TIA's
☐ Memory Loss
☐ MS
☐ Parkinson's
☐ Alzheimer's Disease
☐ Dementia
☐ Peripheral Neuropathy
☐ Epilepsy / Seizure Disorder
☐ other Neurologic problems *(list)*

Respiratory System
☐ Asthma
☐ Emphysema or COPD
☐ Pneumonia
How Recently? ___________
☐ Sinus surgeries
☐ Allergies
☐ other Lung problems *(list)*

Cardiac / Circulation System
☐ Heart Attack
☐ Angina or Chest Pain
☐ Irregular Heart Rhythm
☐ Anemia
☐ High Blood Pressure
☐ High Cholesterol
☐ Heart Surgery
When _________________
What __________________

Digestive & Eliminatory
☐ Swallowing Problems
☐ Changes in Appetite
☐ Unexplained Weight Change
☐ GERD / Heartburn / Reflux
☐ Esophageal Dysmotility/Strictures
☐ History of Feeding Tube
☐ Disordered Eating
☐ Difficulty Chewing
☐ IBS
☐ Frequent Loose Stools
☐ Frequent Constipation
☐ Hiatal Hernia
☐ Kidney Disease
☐ Liver Disease
☐ Urinary Incontinence

Endocrine & Immune System
☐ AIDS
☐ HIV positive
☐ Hepatitis A B C (circle)
☐ Diabetes Type 1 or 2 (circle)
☐ Thyroid Imbalance
☐ Low Blood Sugar
☐ Head and Neck Cancer
☐ Cancer (other)
Please describe:

Musculoskeletal & Connective Tissue Conditions
☐ Osteoarthritis
☐ Spinal Stenosis
☐ Herniated Disc Neck
☐ Osteoporosis or Osteopenia
☐ Compression Fractures
☐ Rheumatoid Arthritis
☐ Lupus
☐ Gout
☐ Fibromyalgia
☐ Migraine
☐ Frequent Headaches
☐ TMJ
☐ Teeth Grinding
☐ Other: *(list)*

General Challenges
☐ Falls. If yes, more than 2 in a year? ☐
☐ Shortness of Breath
☐ on exertion ☐ at rest
☐ Dizziness
☐ Balance Disturbance
☐ Hearing Loss
☐ Vision Loss
☐ Sleep Apnea
☐ Insomnia
☐ Unusual Fatigue
☐ Alcoholism
☐ Substance Abuse (current or past)
☐ Clinical Depression
☐ Mental or Emotional disorders
Please Explain:

Surgeries, Traumas, Other Illnesses, Accidents & Hospitalizations:

Please list any other information regarding your medical or health history that you believe we should know.
*Please include approximate dates **or** your age at the time.*

Thank you *for providing this information for us. Please, let us know of any health changes.*

Patient name: _________________________________ Date: ___________

Backway's Physical Therapy: Speech Intake Form **Patient Medication List & Recent Fall History**

Have you used any tobacco in the past 12 months? ☐Yes ☐No; **If yes, what kind?** __________ **How often?** __________/day

Please look at the labels on your medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements you take routinely, and/or on an as-needed basis.

Medication or Supplement Name	Dosage	How many times/day?	Is this taken by mouth or other route?	What condition is this for?	"May cause dizziness" label on it?	Does this med make you dizzy?
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ☐ Yes, ☐ No. If no, reason not completed: ☐ Pt refused ☐ Emergency ☐ Pt cog unable **(Initials: ________)**

Patient Name: ______________________ **Date:** ______________

Backway's Physical Therapy, PLLC (BPT) **AUTHORIZATIONS & CONSENTS FORM**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ____________ (please initial)

****

Optional: **Consent for Use of Information for Presentations, Research and/or Publications (optional)**
I grant permission, now and in future, to BPT, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by BPT personnel.

(Optional) Signature ________________________________Date ____________________________

****

All Authorizations below are Mandatory:

Authorization for release of information to Insurance Company & for payment from Insurance:
I authorize the staff of BPT to release information acquired in the course of my evaluation and treatment to my insurance company as needed to determine the benefits payable for the related service; and I request that any payment of authorized insurance benefits be made on my behalf to BPT, at their business address, for all services furnished that were not paid in full by me at the time services were rendered. **(_____ initials)**

Authorization for "Signature on File:" I authorize the staff of BPT to submit completed claim forms to my insurance company using the notation "signature on file" to indicate that I have signed this Authorization Form. This signature is valid for claims resulting from this and future services provided to me by BPT **(_____ initials)**

Financial Responsibility. I understand that I am responsible ***for paying*** deductible, co-pay and/or coinsurance. *Cash, check & credit card payments are accepted;* however ***credit card payments*** are subject to a $50 minimum payment, and an added $5 PayPal fee. **(_____ initials)**

Authorization to leave Messages: In the event that BPT cannot speak to me in person regarding the appointments or evaluation results, I give permission to BPT to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine ___________ Cell Phone ____________ or other location____________________

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding myself, or my dependent, between BPT staff members, and all professional practitioners involved in my healthcare, or that of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my health information: **(_____ initials)**

□ Spouse	Name:	phone#:
□ Child	Name:	phone#:
□ Parent	Name:	phone#:
□ Other	Name:	phone#:
□ Other	Name:	phone#:

Consent for Treatment: I hereby authorize the professional staff of BPT to evaluate and treat me or my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at BPT to use any and all techniques they have been trained to use, which they believe will benefit me, in order to help me recover. I have the right to refuse a specific technique or form of treatment, if I so choose. **(_____ initials)**

Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about me for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

➔**Patient's/Guardian's Signature** ____________________________________ Date ____________

Patient name: _______________________________ Date: ___________ *(ST: Initial Medicare Forms Page 5 of 6)*

2017 Medicare Coverage for Physical Therapy, Occupational Therapy & Speech Therapy Services

As a Participating Provider, Backway's PT is committed to giving you the best care possible under your Medicare benefits, and assisting you by billing Medicare and your secondary insurer. Medicare regulations change often and the following is an attempt to inform you of your current coverage and our/your responsibilities when using your benefits.

In 2017, **Medicare coverage** for Physical Therapy (PT), Occupational Therapy (OT), & Speech Therapy (ST) services, provided through any outpatient clinic, are subject to the following regulations:

1. **Doctor's Order is required:** A medical Rx, from a MD, DO, PA or NP, is required to receive PT, OT or ST.
2. **Medically Necessary Services:** Even if your doctor wants to you have PT, OT or ST, **Medicare <u>requires</u> that**:
   - You fill out special forms for the therapist, giving a full listing of your medications, your medical/health history, your pain levels & pain diagram (for PT), and your current functional abilities or limitations.
   - An evaluation be performed by the therapist and a report, called the Plan of Care, be sent to your physician, verifying that therapy services are medically needed, setting goals for your recovery and a plan to reach the goals.
   - Your doctor must agree to/sign the Plan within 30 days; and it must be renewed at least every 90 days.
3. **Calendar Year (CAP) Limitations:**
   Each Medicare patient may receive **$1980** worth of combined PT and ST services during 2017; and a separate $1980 worth of OT services.
   - This is known as the Yearly Monetary Capitation or "**CAP**" and is legislated & modified by Congress.
   - **$1980 worth of services** is equal to approximately 16-18 one-hour Physical, Occupational and/or Speech Therapy visits. This includes your initial evaluation, at least one reevaluation, and ongoing treatments.

   ******Ask our office staff for information regarding your account nearing the CAP allowance*. *****
4. **CAP Exemption Benefits:**
   Medicare knows that some patients need more therapy than the $1980 CAP allows, so they set up a "CAP Exemption" Program. This Program allows for PT, OT & ST services up to a <u>maximum</u> of $3700 per year in special cases. If your condition is considered medically complex, medically necessary, and you are being treated for certain diagnoses, you may be eligible for extended treatment. Check with your therapist or our office staff for more information.
5. **Non-covered or Dis-allowed Charges:**
   - **Although we do our best** to only provide and bill for services that Medicare covers, Medicare <u>does have the right to deny</u> payment for <u>any</u> services you receive from <u>any</u> provider. We'll let you know ***in advance*** if we plan to provide services to you that we <u>know</u> Medicare won't allow, so you may decide about receiving them. However, very rarely a portion or all of the services you receive may not be covered by Medicare. If this occurs, then you will be responsible for those charges.
   - **Supplies/Maintenance:** Medicare does **<u>not</u>** pay for supplies, orthotics, heel lifts or many 'maintenance' services.
   - **Services above the CAP:** If, after using <u>all</u> of your allotted $1980, you still feel you need PT/ST or OT, but you don't qualify for the CAP Exemption Program, you can pay privately for your PT/ST or OT at our clinic or another facility.
   - **Secondary Insurance Policies,** but **<u>not</u>** Supplemental or Gap Insurance, **may *partially*** pay for services you receive that Medicare does not allow. ***Ask us how to find out if your secondary covers what Medicare denies.***
6. **Billing Medicare and Medicare Explanations of Benefits:**
   We will bill Medicare and your secondary/supplemental insurance for the services we provide to you. If services above $1980 are billed to Medicare, they will, at first, refuse payment for these services. **<u>If</u>** you qualify for the CAP Exemption Program, we re-bill Medicare using a special code. Medicare will then reprocess these claims.

****

I have read the above information, and understand that my Physical/Speech Therapy & Occupational Therapy services are subject to a Yearly CAP of $1980; and that this CAP <u>may</u> be extended, under the CAP Exemption Program, to $3700 <u>if</u> it is medically necessary <u>and</u> my condition or diagnosis falls under the Exemption Program.

I have informed Backway's PT if I have received <u>any</u> other PT, ST and/or OT services in 2017, prior to starting treatment at their clinic, and I know I can ask the office staff for updates regarding my account nearing the CAP.

I understand that I may personally be responsible for payment of services provided to me above the CAP.

Signed ____ Date ______________________

Patient name: ____ *(ST: Initial Medicare Forms Page 6 of 6)*