WINNSBORO
PHYSICAL THERAPY

710 Prairie Street • Winnsboro, LA 71295
Phone (318) 435-3882 • Fax (318) 435-4306
www.WinnPT.com

Patient Name:_____

Street Address:_____

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Age:_____ SSN:_____

Please check one: _____Married _____Single _____Widowed _____Divorced

Place of Employment:_____ Job Title:_____

****** The following information is required for billing purposes ******

Spouse Name:_____

Spouse Date of Birth:_____ SSN:_____

Do you have supplement insurance? _____Yes _____No

Insurance Name:_____

Emergency Contact:_____

Relationship:_____ Phone Number:_____

Referred by:_____ Next Visit:_____

Primary Physician:_____

IF YOU HAVE MEDICARE AS A PRIMARY INSURANCE, ARE YOU CURRENTLY RECEIVING ANY HOME HEALTH SERVICES? _____Yes _____No
IF YES, NAME OF HOME HEALTH:_____

Is your visit today due to an accident? _____Yes _____No

If due to an accident, describe:_____

Have you retained an attorney? _____Yes _____No

If yes, Attorney's name:_____ Phone Number:_____

Patients receive EOBs from Medicare; therefore, Winnsboro Physical Therapy is not responsible to provide financial records. It is each patient's individual responsibility to obtain and keep financial EOBs from Medicare. Winnsboro Physical Therapy will provide health records to patients as needed, but will not provide financial statements. There is a charge for health record copies.

I HAVE READ AND UNDERSTAND THIS STATEMENT. I GIVE PERMISSION TO BE TREATED BY WINNSBORO PHYSICAL THERAPY, INC., AS ORDERED BY MY PHYSICIAN.

_____ _____

Patient Signature **Date of Signature**

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Primary Insurance

Name of Subscriber:_____ Birth date:_____

Relationship to Patient: Self Spouse Parent Other:_____

Phone Number:_____ SSN:_____

Insurance Company:_____

Subscriber Number:_____ Phone Number:_____

Subscriber's Employer:_____

Secondary Insurance If you have no secondary coverage, initial here:_____

Name of Subscriber:_____ Birth date:_____

Relationship to Patient: Self Spouse Parent Other:_____

Phone Number:_____ SSN:_____

Insurance Company:_____

Subscriber Number:_____ Phone Number:_____

Subscriber's Employer:_____

I give my permission for Winnsboro Physical Therapy to leave messages per the following:

Answering Machine/Voicemail? Yes No Phone Number:_____

Email? Yes No Email Address:_____

Text Messages? Yes No Phone Number:_____

Patient's Signature:_____

I give my permission for Winnsboro Physical Therapy to discuss my medical condition with:

Name:_____ **Relation:**_____

Home Phone:_____ **Cell Phone:**_____

Patient's Signature:_____

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Medical History

Existing Conditions					
Allergies	☐Yes ☐No	Depression	☐Yes ☐No	Multiple Sclerosis	☐Yes ☐No
Anemia	☐Yes ☐No	Diabetes	☐Yes ☐No	Osteoporosis	☐Yes ☐No
Anxiety	☐Yes ☐No	Dizzy Spells	☐Yes ☐No	Parkinsons	☐Yes ☐No
Arthritis	☐Yes ☐No	Emphysema/Bronchitis	☐Yes ☐No	Rheumatoid Arthritis	☐Yes ☐No
Asthma	☐Yes ☐No	Fractures	☐Yes ☐No	Seizures	☐Yes ☐No
Cancer	☐Yes ☐No	Gallbladder Problems	☐Yes ☐No	Speech Problems	☐Yes ☐No
Cardiac Conditions	☐Yes ☐No	Hepatitis	☐Yes ☐No	Strokes	☐Yes ☐No
Cardiac Pacemaker	☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Thyroid Disease	☐Yes ☐No
Chemical Dependency	☐Yes ☐No	Incontinence	☐Yes ☐No	Tuberculosis	☐Yes ☐No
Circulation Problems	☐Yes ☐No	Kidney Problems	☐Yes ☐No	Vision Problems	☐Yes ☐No
Currently Pregnant	☐Yes ☐No	Metal Implants	☐Yes ☐No		

Describe any other conditions or precautions

Fall History

Injuries as a result of a fall in the past year? ☐Yes ☐No
Two or more falls in the past year? ☐Yes ☐No

Surgical History

Body Region:_____ Surgery Type:_____ Date:_____

Body Region:_____ Surgery Type:_____ Date:_____

Body Region:_____ Surgery Type:_____ Date:_____

Body Region:_____ Surgery Type:_____ Date:_____

Current Medications

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

Drug:_____ Dosage:_____ Frequency:_____ Route:_____ Reason Taking:_____

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Financial Policies

Please read each of the detailed policies below. If you have any questions, please discuss them with our staff. If you understand and accept each policy, please initial the blank provided, sign, and date below.

_____**HEALTH INSURANCE FILING POLICY:** Your health insurance will be billed periodically as you receive treatment. A statement will be mailed to you reflecting the payments received from your insurance company and the balance owed. Prompt payment with in thirty (30) days is expected.

_____**COLLECTION POLICY:** Delinquent accounts are very costly. Therefore, to avoid any misunderstanding, our procedures in notifying our patients of their financial responsibility are:

- Three (3) attempts by regular mail will be made to contact you. If our mail is returned as undeliverable, attempts will be made to contact you through additional information in your chart.
- If our attempt to contact you fail and your account remains unpaid, your account will be turned over to our Collection Agency. Upon assignment to our Collection Agency, a service charge of 32% will be added to your account balance.
- In the event of a lawsuit must be filed to collect your account balance, you will be required to pay attorney fees and court costs.

_____**CASH PAYMENT POLICY:** A cash payment policy is available to patients whose insurance does not cover physical therapy or if there is limit coverage insufficient for the patients needs. Payment will be required at the time of treatment under this plan and MUST be discussed PRIOR to treatment.

PATIENT RESPONSIBILITY: I have read the above detailed financial policies. I understand that I am fully responsible for any and all charges indicated to be patient responsibility.

_____	_____	_____
Patient Signature	Witness	Date

Liability Patients

Were you referred for physical therapy due to an accident? _____Yes _____No

If you checked 'yes', our policy is as follows:
We will not file your health insurance unless that insurance requires we file through Subrogation. (An explanation of "subrogation" is available upon request.) Should you retain an attorney or involve an accident insurance company, we will be glad to wait until the case is settled to recoup our billing charges. This is not a new policy; we have extended this option. However, should we file your health insurance which requires we accept an adjustment to our charges, we retain the right to recoup the adjustment from the patient if a settlement is reached through other channels. **If our billed charges are used to reach settlement, we are due 100% of our billing charges. NO EXCEPTIONS.**

I have read the above policy for liability patients and understand my obligations regarding payment.

_____	_____	_____
Patient Signature	Witness	Date

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Release of Medical Records

I HEREBY GRANT PERMISSION TO _____
TO RELEASE MY MEDICAL RECORDS OR OTHER INFORMATION ABOUT ME, TO WINNSBORO PHYSICAL THERAPY, INC.

I ALSO HEREBY RELEASE WINNSBORO PHYSICAL THERAPY, INC TO RELEASE TO ANY INSURANCE COMPANY, ATTORNEY, OR PHYSICIAN, ON MY BEHALF, ANY RECORDS OR BILLS THAT PERTAIN TO ME OR MY TREATMENT.

_____
Patient Signature

_____
Patient Name (Please Print)

_____
Patient Date of Birth

_____
Witness

_____
Date

PLEASE FAX _____ TO THE FAX NUMBER REFERENCED ABOVE. THANK YOU!

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Notice of Patient Information Practices

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

WINNSBORO PHYSICAL THERAPY'S LEGAL DUTY

Winnsboro Physical Therapy is require by law to protect the privacy of your personal health information, provide this notice about our information practices and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION:

Winnsboro Physical Therapy uses your personal health information primarily for treatment; obtaining payment for treatment; conducting internal administrative activities and evaluating the quality of care that we provide. For example, Winnsboro Physical Therapy may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or health related benefits that could be of interest to you.

Winnsboro Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes for auditing purposes, for research studies and for emergencies. We also provide information when required by law. In any other situation, Winnsboro Physical Therapy's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop any future disclosures at any time.

Winnsboro Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in waiting room and patient exam areas and will be provided to you on your next visit. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time, You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances when we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information for treatment, payment and administrative purposes except when specifically authorized by you, when required by law or in emergency circumstances. Winnsboro Physical Therapy will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Winnsboro Physical Therapy may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Winnsboro Physical Therapy's health information practices or if you have a complaint.

I have read and fully understand Winnsboro Physical Therapy's Notice of Information Practices. I understand that Winnsboro Physical Therapy may use or disclose my personal health information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment or payment. I understand that I have the right to restrict how my personal health information is used and disclosed for treatment, payment, and administrative operations for restriction on a case by case basis, but does not have to agree to requests for restrictions. I hereby consent to the use and disclosure of my personal health information for purposes as noted in Winnsboro Physical Therapy's Notice of Information practices. I understand that I retain the right to revoke this consent by notifying the practice in writing.

_____ _____

Patients Signature Date

_____

Printed Name

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2018 Medicare Reimbursements Facts

In an effort to provide you with quality service, we have outlined the Medicare guidelines regarding reimbursement for outpatient physical therapy. Please read the following in reference to billing for you therapy treatment.

2018 Medicare Deductible: $183.00 per year
2018 Outpatient Physical Therapy/Speech Therapy Combined Limit: $2,010.00 per year

If you have not met your yearly deductible at the time of your services with us, we are required to collect your yearly deductible. After your deductible is met, Medicare allows you to receive $2,010.00 per year in physical therapy/speck therapy services combined. Since this is a drastic reduction from previously allowed therapy reimbursement amounts, we are forced to make adjustments in our treatment protocols.

We intend to provide you with a complete treatment regimen with implementation of Home Exercise Program as quickly as possible so as not to exhaust your limited amount of therapy. We know that some patients may have need for outpatient rehabilitation on more than one occasion throughout the year, thus the implementation of Home Exercise Program to aid the patient in recovery without exhausting the yearly therapy limits at one time.

Medicare will pay 80% of the AFTER the deductible is met. If you have a secondary insurance, they will pick up the 20% of allowable most of the time. In the event of any remaining charges, we are required by Medicare to collect the balance from the patient.

We hope this information is helpful to you in addressing the reimbursement issues of Medicare of outpatient physical therapy/speech therapy combined. Please feel free to contact us with any questions.

I have read and understand the above information:

_____ _____

Patient Signature Date of Signature

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Patient Signature Date of Signature

Patient Copy

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Abbreviated ABC Scale

How confident are you that you will not lose your balance or become unsteady when you:

		0	10	20	30	40	50	60	70	80	90	100
1	Stand on tiptoes and reach above your head?											
2	Stand on a chair and reach for something over your head?											
3	Are bumped into by people as you walk through the mall?											
4	Step onto or off an escalator while you are holding onto a railing?											
5	Step onto or off an escalator while holding onto parcels such that you cannot hold onto the railing?											
6	Walk outside on an icy sidewalk?											

Fall Risk Assessment

1) Are you wheelchair bound, non-ambulatory?
☐ **Yes** If yes, please answer questions 2, 3 and 4.
☐ **No** If no, continue to 2.

2) Have you fallen in the last year?
☐ **Yes** If yes, continue to 3.
☐ **No** If no, continue to 5.

3) Did you sustain an injury in the fall?
☐ **Yes** If yes, continue to 4.
☐ **No**

4) Have you had two or more falls in the past year?
☐ **Yes**
☐ **No**

5) Do you have any of the following in your home? Please select all that apply to you.

☐ **Clutter where you walk**
☐ **Exposed electrical cords**
☐ **Poor lighting**
☐ **Furniture or other sharp-edged items in the normal pathways throughout your home**
☐ **Raised doorway thresholds**
☐ **Slippery floors**
☐ **Steps and stairways**
☐ **Throw rugs**

6) How many medications do you currently take?

☐ **None** ☐ **One** ☐ **Two** ☐ **Three or four** ☐ **Five or more**

7) Were you taking any of the following medications at the time of your fall(s)? Select all that apply.

☐ **Any central nervous system, psychotropic medication**
☐ **Sedatives, hypnotics (sleeping medications)**
☐ **Antidepressants (especially tricyclics)**
☐ **Benzodiazepines (“nerve pills”)**
☐ **Diabetes Medication**
☐ **Cardiovascular drugs**
☐ **Diuretics**
☐ **Antiarythmics**
☐ **Cardiac glycosides**

8) If you were taking any of the above at the time of your fall(s), are you still taking the medication?

☐ **Yes** ☐ **No**