Capitol Physical Therapy

Intake Form

Date:_____

Are you a former CPT patient or a friend/family member of a former patient? ☐ Yes ☐ No

I. Personal Information

Name: _____ Address: _____

Home Phone: (___) _____ Cell Phone: (___) _____ May we leave a message? Yes No

DOB: _____/_____/_____ Age:_____ Sex: Male / Female Marital Status: S / M / D / W

Work Phone: (____) _____ E-mail: _____

Occupation: _____ Employer: _____

Emergency Contact: _____ Relation: _____ Phone: (____) _____

Tobacco use: Yes No Alcohol use: Yes No Vitamin D supplement: Yes No

Describe your usual exercise routine:_____

Primary Insured: _____ DOB: ___/____/_____ Employer: _____

Are you a former Capitol PT patient? Yes No A friend/family member/colleague of a former patient? Yes No

II. Current Symptoms

Problem(s) you are here for: _____

What date (roughly) did your symptoms start? _____

What do you think started your symptoms? _____

Are your symptoms related to a work injury? Yes No Or a motor vehicle accident? Yes No

Symptoms are currently: ☐ Getting better ☐ Getting worse ☐ Staying about the same

☐ Come and go ☐ Constant ☐ Constant, but change with activity

Treatments so far for this problem (injections, chiropractic, etc.): _____

Have you had an X-ray, MRI, or other imaging for this problem? Yes No

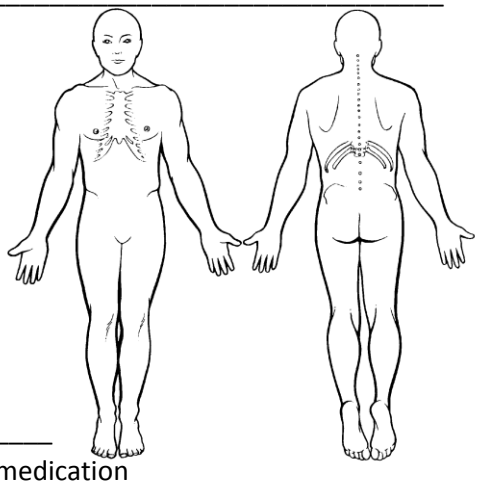
If yes, please list, including date: _____

Have you ever had this before? Yes No If yes, when and how it was treated: _____

What is your personal goal for therapy? _____

Body chart:

- Please mark **all** areas where you feel symptoms on the chart to the right



What makes your symptoms **better**? _____

_____

What make your symptoms **worse**?

_____

How are you able to sleep at night? Fine Moderate difficulty Only with medication

On the scale below, please mark the number which best represents the severity of your pain over the past 24 hours:

0 1 2 3 4 5 6 7 8 9 10

No Pain Worst pain imaginable

SINCE YOUR SYMPTOMS BEGAN, have you noticed any of the following?

(Check all that apply)

- ☐ **None of these apply to me**
- ☐ Fatigue
- ☐ Generalized muscle weakness
- ☐ Pain at night
- ☐ Leg swelling
- ☐ Weight loss/gain
- ☐ Difficulty maintaining balance when walking
- ☐ Changes in bowel or bladder function
- ☐ Changes in cognition
- ☐ Numbness or tingling
- ☐ Falls
- ☐ Shortness of breath
- ☐ Heartburn/indigestion
- ☐ Difficulty swallowing
- ☐ Headaches
- ☐ Changes in appetite
- ☐ Heart palpitations
- ☐ Fever/chills/sweats
- ☐ Nausea/vomiting
- ☐ Abdominal pain
- ☐ Fainting
- ☐ Cough
- ☐ Chest pain especially with sweats
- ☐ Skin changes
- ☐ Other

III. Medical History: Have you ever been diagnosed with or do you have any of the following conditions?

(Check all that apply)

- ☐ **None of these apply to me**
- ☐ Cancer
- ☐ Heart problems
- ☐ Chest pain/angina
- ☐ Circulation problems
- ☐ Blood clots
- ☐ Stroke
- ☐ Anemia
- ☐ Chemical dependency (i.e. alcoholism)
- ☐ Depression
- ☐ Anxiety
- ☐ Lung problems
- ☐ Tuberculosis
- ☐ Sexually transmitted disease/ HIV
- ☐ Rheumatoid Arthritis
- ☐ Arthritis
- ☐ Bladder/urinary tract infection
- ☐ Kidney problems/infection
- ☐ Cholesterol high/low
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Multiple Sclerosis
- ☐ Epilepsy
- ☐ Hepatitis
- ☐ Ulcers
- ☐ Liver problems
- ☐ Allergies/asthma
- ☐ Pacemaker
- ☐ Blood thinners
- ☐ Fibromyalgia
- ☐ Broken bones
- ☐ Recent infection /illness (explain)
- ☐ Other

_____

Past surgical history (list & date): _____

Significant family medical history: _____

During the past month have you been feeling down, depressed, or hopeless? Yes No

During the past month have you been bothered by having little interest or pleasure in doing things? Yes No

Is this something you would like help with? Yes Yes, but not today No

Do you ever feel unsafe at home, or has anyone tried to hit or injure you in any way? Yes No

If you are over 65, how many falls have you had in the last 6 months? _____

Are you taking any medications? Yes No If yes, please list, or add a list you brought along to this paperwork:

Medication name: Amount: Dose:

_____

_____

_____

_____

IV. How did you hear about our clinic?

☐ My doctor's office ☐ I am referring myself for PT ☐ Family/friend/colleague recommended ☐ My insurance company said you were in my network ☐ I did a search on the internet ☐ My trainer ☐ Other_____

Please tell us who we can thank for sending you our way:_____

Consent to Treatment

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.

2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational, administrative, and/or facility approved purposes when my personal identity will not be revealed.

3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.

4. Worker's Compensation - I hereby authorize Capitol Physical Therapy to receive my records related to my work injury.

Photo/Video Authorization

I grant to Capitol Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

☐ Agree or ☐ Decline

Notice of Privacy Practices

By signing this form, I acknowledge that Capitol Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concerning this Privacy Notice with Capitol Physical Therapy representatives.

PT Benefits Provided by Your Insurance Company

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Capitol Physical Therapy if I do not understand my benefits, have questions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment.

In the unlikely event your account would be turned over to a collection agency you would be responsible for all filing, collection, and legal fees necessary to obtain full recovery of any unpaid balance due CPT. There will also be interest added to invoices with balances over 30 days.

I agree to allow CPT to file my Health Insurance should my worker's compensation, auto, or third party insurance deny the claim, exhaust the benefits, or fail in any want to pay the claim.

Release of Information

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing:

Name:	Relationship:

Authorization

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Print Patient Name:

_____

Patient or Guardian Signature:

_____

CPT Employee Signature:

_____

Date of Authorization: _____

Capitol Physical Therapy

Central Billing Office

411 Prairie Heights, Dr. Ste 101

Verona, WI 53593

Clinic:_____

Date: _____

MEDICARE FINANCIAL LIMITATION NOTIFICATION FORM

Effective January 1, 2017 the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling $1,980.00 for Medicare Part B outpatient services for Physical, Occupation 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 will 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 will share on $1,980.00 financial limitation (Cap) for both therapies combined.**
- **Occupational Therapy services will have separate $1,980.00 financial limitation.**
- **These financial limitations will be effective until December 31, 2017 unless otherwise changed or suspended by CMS.**

These limits are based on the Medicare fee schedule allowed amount after your $188.00 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 $1,980.00 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 $1,980.00 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 $1,980.00 financial limitation is your annual Medicare insurance benefit, regardless of which non-hospital based therapy providers deliver the service. If you 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 Scheduling Coordinator of any physical, occupational or speech therapy services you have received between January 1, 2017 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.

<u>Medicare Therapy Cap Exceptions</u>

Congress is in negotiations for provisions for exceptions to the Medicare Cap for which, once they are decided upon, 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 2017 calendar year, your therapist will discuss your ability to qualify for further treatment under and exception (if the exceptions are approved by Congress) after your evaluation or re-evaluation. If you do qualify for an exception, you will be financially responsible for continued care beyond the limitation. 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 $1,980.00.

Capitol Physical Therapy

Clinic: _____

Patient Name:_____ Date: _____

Referring 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 you answered **Yes**, please provide:

Attorney name:	Address:	Phone:

6. 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** ☐

7. Are you currently employed? **Yes** ☐ **No** ☐ Date of retirement: _____

a) Is your spouse currently employed? **Yes** ☐ **No** ☐ Date of retirement: _____
b) Do you have a group health plan (GHP) as 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** ☐

If you answered **Yes** to questions #3, #4 or #7 above, please complete the following information:

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

Patient Signature:	Date:
Responsible Party:	Relationship:

Capitol Physical Therapy

APPOINTMENT CANCELLATION POLICY

All appointment cancellations must be made by 12:00 a.m., the night before your scheduled appointment. This can be done either in person, on the phone, or by leaving us a voicemail at the number listed below. If you do not cancel your appointment by 12:00 a.m., or if you do not show for your appointment, you will be charged $25.00 regardless of whether or not you have received reminder(s) from our office.

_____

Signature Date

VERONA CLINIC:	608-848-6628
MOUNT HOREB CLINIC:	608-437-0222
SUN PRAIRIE CLINIC:	608-318-1357
WAUNAKEE CLINIC:	608-850-7275
UNIVERSITY AVE CLINIC:	608-467-3537