



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

(Check all that apply)

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

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 depression or anxiety something you would like help with today? 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? No Yes If yes, please list, or I've attached my own list to this paperwork:

Medication name:	Amount:	Dose:

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

Patient Signature

Date

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.): _____

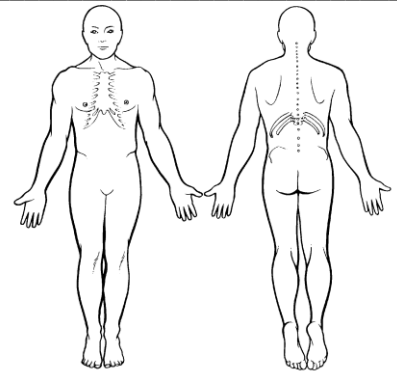
Have you had an X-ray, MRI, or other imaging for this problem? Yes No

If yes, please list, including date: _____

Have you ever had this problem 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**? _____

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)

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

Describe your usual exercise routine: _____

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

III. 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: _____

Patient Signature

Date

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 way 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: _____



Central Billing Office

416 E Verona Ave

Verona, WI 53593

Clinic: _____

Date: _____

MEDICARE FINANCIAL LIMITATION NOTIFICATION FORM

Effective January 1, 2020 the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling \$2,080.00 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 \$2,080.00 financial limitation (Cap) for both therapies combined.**
- **Occupational Therapy services will have separate \$2,020.00 financial limitation.**
- **These financial limitations will be effective until December 31, 2020 unless otherwise changed or suspended by CMS.**

These limits are based on the Medicare fee schedule allowed amount after your \$198.00 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 \$2,080.00 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 \$2,080.00 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 \$2,080.00 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, 2020 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 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 2020 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



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:
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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:



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