Alves & Martinez
Physical Therapy & Athletic Performance

MEDICARE
PATIENT INFORMATION

Name: _____ Birth date: _____ Sex: ☐ Male ☐ Female

SSN: _____ - _____ -_____ Driver's License #: _____ State: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other What's your Primary Language? _____

Home Address: _____ City _____State _____ Zip _____

Mailing Address (if different from home address):
_____ City_____ State_____ Zip_____

**** Please provide your contact phone numbers and check your preference (primary):**

☐ Home Phone: _____ ☐ Cell Phone: _____ ☐ Other #: _____

Email Address: _____

How would you like to receive appointment reminders? ☐ Voice Call ☐ Text ☐ Email

How did you hear about our clinic? _____

Referring Doctor: _____ Referral Date: _____

Is this a work-related injury? ☐ yes ☐ no

1. Are you <u>currently</u> receiving home care services (therapy, nursing, home health aide)? Yes No

2. Have you <u>recently</u> received home care services, (therapy, nursing, home health aide)? Yes No

If you answer is "Yes" to any of the two questions above. Please provide the following information:

Name of Agency: _____ Phone: _____ Discharge Date: _____

INSURANCE COVERAGE INFORMATION

PRIMARY Insurance: <u>MEDICARE</u> ID#: _____ Effective Date: _____

Insured/Guarantor: _____ Insured/Guarantor DOB: _____ Relationship to patient: _____

<u>MEDICARE INSURANCE DISCLAIMER</u>

As of January 1, 2015, CMS instituted a cap on all outpatient physical therapy. Treatment is capped at $1,920 per calendar year. There is an exception process to this based on medical necessity, but the exception is not applicable in all cases. Please note that any services rendered beyond the annual cap of $1,920 may be your financial responsibility.

SECONDARY Insurance: _____ Insurance Phone: _____

Insurance ID#: _____ Group#: _____

Insured/Guarantor: _____ Insured/Guarantor DOB: _____ Relationship to patient: _____

TURN OVER

CONSENT FOR TREATMENT/ASSIGNMENT OF BENEFITS

I, the undersigned, do hereby agree and give my consent to and authorize my physical therapist and other healthcare professionals and/or assistants at Alves & Martinez Physical Therapy and Athletic Performance who may be involved in my care, to provide medical care and treatment prescribed and considered necessary by my physician(s). I acknowledge that no guarantees have been made to me about the results of treatment.

APPOINTMENT ATTENDANCE AGREEMENT

I understand the importance of attending therapy consistently and arriving promptly for my appointment(s). In case of running or arriving late, I acknowledge that I may be rescheduled if its more that 15 minutes late of the appointment time. This is for the benefit of me and other patients being treated. I also understand the importance of scheduling appointments in advance and acknowledge that appointment(s) times given one week do not automatically follow through to subsequent weeks. I agree to provide at least 24 hours notice when cancelling or rescheduling an appointment.

RESPONSIBILITY FOR PAYMENT

I acknowledge that in consideration of the services provided to me at Alves & Martinez Physical Therapy and Athletic Performance, I am financially responsible for payment of my bill. That it is my responsibility to provide Alves & Martinez Physical Therapy and Athletic Performance with my current health insurance information and to familiarize myself with my insurance coverage or benefits for physical therapy in accordance with my insurance plan. My insurance plan may provide that a portion of the charges and balance will remain my personal responsibility, such as my annual deductible, visit co-payment, co-insurance or charges not covered or denied by my health insurance or other programs for which I am eligible. ***Please note that refusal to sign this form does not change responsibility for payment in any way.***

ACCESS TO AND RELEASE OF HEALTH INFORMATION

I understand that Alves & Martinez Physical Therapy and Athletic Performance may document medical and other information related to my treatment electronically and other forms, and that such information will be used in the course of my treatment. This will be for the purpose of carrying out treatment, obtaining payment, evaluating the quality of services provided, and any administrative operations related to treatment or payment. I authorize my physical therapist and/or administrative staff at Alves & Martinez Physical Therapy and Athletic Performance to contact other healthcare professionals that may have information related to my prior and current health condition(s). I acknowledge that I have received *Alves & Martinez Physical Therapy's Notice of Information Practices* and that it outlines how my health information will be used and disclosed and how I may gain access to and control my health information.

HIPAA AUTHORIZATION

In compliance with the HIPAA regulations, I authorize the following individuals to receive verbal information regarding my care at Alves & Martinez Physical Therapy and Athletic Performance and/or the billing of my account.

1._____ 2._____ 3._____
Name/Relationship Name/Relationship Name/Relationship

CONSENT FOR EMERGENCY CONTACT INFORMATION

Person to contact in case of an emergency:

_____ _____ _____
Name Phone Number Relationship

By given my signature below, I freely and voluntarily certify that I have read, understand and fully agree to each of the statements in this document and that all of the information provided herein is true and correct.

Patient or Guardian Signature: _____ **Date:** _____