GATC PHYSICAL THERAPY

An Affiliate of **DENVER PHYSICAL THERAPY**

# ADMISSION FORM

**PATIENT INFORMATION** **2015**

| | | | |
|---|---|---|---|
| Patient Name: | | Date of Birth: | Sex: Male / Female |
| Address: | | City, State, Zip | |
| Home Phone: | | Cell Phone: | |
| Work Phone: | | Email: | |
| SS#: MC or WC | | Marital Status: | Single Married Divorced Widow |

**INSURANCE INFORMATION:**

***Primary Insurance:***

| | | | |
|---|---|---|---|
| **Member ID #:** | | **Group #:** | |
| **Policy Holder:**<br>**Date of Birth:** | | **INS Phone:** | |
| **Claim Address:** | **PO Box** | **City, State, Zip** | |

***Secondary/Supplemental Insurance Information***

| | | | |
|---|---|---|---|
| Member ID #: | | Group #: | |
| Policy Holder:<br>Date of Birth: | | INS Phone: | |
| Claim Address: | | City, State, Zip | |

**W/C or Auto:**

| | | | |
|---|---|---|---|
| Employer/Car Ins: | | Claim Adjuster: | |
| Claim #: | | Phone:<br>Fax: | |
| Claims Address: | | City, State, Zip | |

***Physician Information:***

| | | | |
|---|---|---|---|
| **Referring MD:** | | **Phone:** | |

**How did you hear about us: _____**

## Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while a patient at GATC/Denver Physical, P.C. may use my patient treatment data for quality assurance and research purposes, and that my name or identity will not be connected with the data.

I understand that upon discharge I may request, in writing, a copy of my records.

I authorize the release of any private health information necessary to process this claim.

**Patient/Guardian Signature:_____ Date:_____**

# OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our *Financial Policy* that we require you to read and sign prior to any treatment.

REGARDING INSURANCE

We will gladly bill your insurance company directly if you have provided us with all the necessary information to do so, on a bi-weekly basis. **Your contract for health insurance is between you and your insurance company.** We are not a party to that contract. The physical therapy services that you receive and the bill, is an agreement between you and GATC Physical Therapy/Denver Physical Therapy. It is ultimately your responsibility to see that your physical therapy bill is paid in full. **Agreements with insurance companies vary greatly and it is your responsibility to know what your insurance covers and what portion you are responsible for**. Any remaining money unpaid by your insurance company will be your responsibility to pay in a timely manner. If your insurance company does not begin paying GATC Physical Therapy/Denver Physical Therapy within 5 weeks, it will be your responsibility to contact them. You will be notified by mail of the balance due on your account, and you may request a statement of account if necessary. It will reflect what your insurance company, upon verification, told us is your portion to pay. We expect this payment within 15 days. If payment is not received within this 15-day period, a finance charge of 1.5 will be assessed per month. In the event a check is returned for any reason, a $20.00 charge will be made to your account.

REGARDING INSURANCE PLANS WHERE WE ARE A PARTICIPATING PROVIDER:

**All co-pays and deductibles are due prior to treatment**. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to the above paragraph.

USUAL AND CUSTOMARY RATES

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurances.

ADULT AND MINOR PATIENTS

Adult patients are responsible for full payment at the time of service. The parents (or guardians) accompanying a minor are responsible for full payment of the minor's treatment. For unaccompanied minors, non-emergency treatment will be denied unless charges are paid by cash or check at the time of service.

**I HAVE READ THE FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

**SIGNATURE: _____ DATE: _____**

## HIPPA PRIVACY NOTICE

I ACKNOWLEDGE THE RECEIPT OF GATC/DENVER PHYSICAL THERAPY'S HIPPA NOTICE OF PRIVACY PRACTICES.

**SIGNATURE: _____ DATE: _____**

Is there anyone involved in your care, or payment of your care with whom we may share your medical information?

**Yes or No - If yes, Person's Name?_____Relationship?_____**

# 3.5.1B PRIVACY NOTICE

THIS ABBREVIATED NOTICE BRIEFLY DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

## PLEASE REVIEW IT CAREFULLY
## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

**For Treatment:** We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to personnel who are involved in taking care of you.

**For Payment:** We may use and disclose health information about you so that the services you receive from us may be billed to and payment collected.

**For Health Care Operations:** We may use and disclose health information about you for operations that are necessary to run our practice.

**Health-Related Services and Treatment Alternatives:** We may use and disclose health information to tell you about health-related services.

**Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

**Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs.

**Workers' Compensation:** We may release health information about you for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Health Oversight Activities:** We may disclose health information to a health oversight agency as authorized by law.

**Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order etc..

**Law Enforcement**: We may release health information if asked to do so by a law enforcement official.

## YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

**Right to Inspect and Copy:** You have the right to inspect and copy health information that may be used to make decisions about your care.

**Right to Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information.

**Right to an Accounting of Disclosures:** You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location.

**Right to a Paper Copy of This Notice**: You have the right to obtain a paper copy of this notice at any time.

*We reserve the right to change this notice at any time. We will post a copy of the current notice in our facility.* We will request that you sign a separate form or notice acknowledging you have received and reviewed a copy of this notice.

**Effective Date: March 1, 2003**

# CANCELLATION/NO SHOW POLICY

GATC Physical Therapy requires a **24 hour notice** for cancelling an appointment. Failure to contact our office within 24 hours of your appointment or if you No-Show for an appointment, it can result in a **$25.00 Charge.**

This charge will not be covered by insurance. If you cancel or no-show for 3 consecutive appointments, you may be discharged from therapy and your physician will be notified.

If you are an Industrial or Work Injury Patient, your claims manager will be notified about the missed visits.

We reserve the right to cancel or reschedule an appointment if you are more than 10 minutes late.

Thank you for your cooperation. It is our belief that this policy will help us to better serve each of our patients fairly and respectfully.

THE GATC PHYSICAL THERAPY STAFF

**PATIENT SIGNATURE**_____ **DATE**_____

GATC PHYSICAL THERAPY

## Intramuscular Manual Therapy – Trigger Point Dry Needling

The IMS treatment involves the insertion of very fine acupuncture needles into the tight muscle bands. IMS usually can't be felt when the needle is inserted into a normal muscle supplied by a healthy nerve. However, when the needle hits an area in the muscle that is tight, you will feel a cramping or tightening sensation. The technique takes just a few minutes to perform and usually the needles are taken out right away. You may feel immediate relief, or you may be discomfort for a few days where the needles were inserted. This should be followed by less pain, better movement, and a gradual return of function.
This technique can eliminate chronic pain and muscle tightness. Nerves and muscles work together to help your body move normally. When nerves become irritated or damaged, the muscles they control can become weak and painful. This condition is known as neuropathic pain. The IMS technique involves inserting tiny needles into the area of the muscle most affected by the nerve problem. While the procedure uses the same needles as traditional Chinese acupuncture, the technique is very different. IMS is a scientifically proven method for diagnosing and treating of chronic pain.

Like any treatment there are possible complications, though they are rare in occurrence, it is recommended you read through the possible risks prior to giving consent to treatment.

**How Does It Work?**
Nerves drive muscles. When the chemical relationship between the two is altered by problems in the nerve, muscle pain and weakness can result. The immediate benefits of IMS are due to the mechanical effect of the needle. This allows "knots" to be broken up and the muscle to start working properly. The longer-term benefit comes from restoring the tiny injury in the muscle. As the treated area heals, it releases repair factors that create a normal relationship between the muscle and the nerve.

**Contraindications**
IMS is not recommended for patients who are pregnant, have had a recent surgery, have a local infection or are hemophiliacs. Please inform your therapist if you are taking any medications (such as blood thinners).

**Risks**
There are risks associated with IMS, as with any needling technique. There is a chance of infection. However the needles used are sterile, individually wrapped needles that are discarded after each use, and alcohol is used to clean the area treated. A small bruise can develop where the needle is inserted if a small artery or vein is hit when entering the skin. To avoid lung puncture or collapse, or internal bleeding, IMS is never performed over major organs such as the lungs, or kidneys. It is possible to be sore for a few days after treatment, followed by decrease in pain, and greater flexibility. Fortunately, all the risks are rare and absolute care is taken to avoid occurrences.

**<u>Please let your therapists know if you have had any experience with any of the following:</u>**

**Recent Surgery – Pregnant – Blood Disorder – Epilepsy/Siezure - Previous Fainting – Low Pain Tolerance**

Any known disease or infection that can be transmitted through bodily fluids: **YES** or **NO**
If yes, please discuss with your practitioner.

**Please sign for consent of IMS/TDN treatment and that you understand the treatment and its possible risks**.

| _____ | _____ | _____ |
|---|---|---|
| **PRINT NAME** | **SIGNATURE** | **DATE** |


TO: Medicare Patients
RE: Medicare Changes

Dear Patient:

This letter is to inform you of a change that has occurred in Medicare outpatient rehabilitation service coverage. Medicare has notified us that **effective January 1, 2015 there is a $1,940 cap per beneficiary (patient) per calendar year**. Please understand that Medicare regulates these changes which affect all therapy providers.

This $1,940 limit applies to physical therapy and speech language services with a separate $1,940 limit on occupational therapy services. Our recommendation is that you assume that you have a "bank account" of 20-22 visits that you can use per calendar year (January-December).

Medicare has provided an exception process in cases of medical necessity. Please ask your therapist if you qualify for an exception if you anticipate exceeding the therapy cap.

Please be aware that if services continue past the $1,940 cap amount and you do not qualify for an exception, that you, the patient, becomes responsible for payment. ***This is why it is critical that you notify us if you have seen a physical, occupational or speech therapist prior to your visit with us.***

**1. You MUST have a doctors referral dated within 30 days of your Evaluation.**
**2. Your prescription must be updated every 90 days.**
**3. A 30 day lapse in treatment requires a Re-Eval and a new referral.**

Our goal is to provide you with the care and education you need to obtain your greatest functional outcome. Your therapist will work with you to develop a plan to best utilize your visits.

I HAVE READ AND UNDERSTAND THE MEDICARE CHANGES. I UNDERSTAND THAT I HAVE FINANCIAL RESPONSIBILITY FOR MEDICARE CO-PAYMENTS, $147 ANNUAL DEDUCTIBLE, AND ALL CHARGES EXCEEDING THE **$1,940 CAP LIMIT**.

SIGNED PLEASE PRINT NAME DATE

**Name:** _____ **Age:**_____ **Date:**_____

**Occupation, including activities that comprise your workday:**_____

**Leisure activities, including exercise routines:**_____

**Are you on a work restriction from your doctor? Yes No** **Do you have a pacemaker? Yes No**
**Do you smoke**? **Yes No**
**FOR WOMEN: Are you currently pregnant or think you might be pregnant? Yes No**
**ALLERGIES: List any allergies you are aware of (including latex)**:_____

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**Have you RECENTLY noted any of the following (check all that apply)?**

- ❑ fatigue
- ❑ fever/chills/sweats
- ❑ nausea/vomiting
- ❑ weight loss/gain
- ❑ difficulty with balance/ # of falls _____
- ❑ numbness or tingling
- ❑ muscle weakness
- ❑ dizziness/lightheadedness/fainting
- ❑ heartburn/indigestion
- ❑ changes in bowel or bladder function
- ❑ headaches
- ❑ difficulty swallowing
- ❑ shortness of breath
- ❑ cough

**Have you EVER been diagnosed with any of the following conditions (check all that apply)?**

- ❑ cancer
- ❑ heart problems
- ❑ chest pain/angina
- ❑ high blood pressure
- ❑ circulation problems
- ❑ blood clots
- ❑ stroke
- ❑ anemia
- ❑ recent infection
- ❑ eye problem/visual disturbance
- ❑ chemical dependency (i.e., alcoholism/drug)
- ❑ sexually transmitted disease/HIV
- ❑ pneumonia
- ❑ lung problems
- ❑ tuberculosis
- ❑ asthma
- ❑ rheumatoid arthritis
- ❑ other arthritic condition
- ❑ spine problem
- ❑ osteoporosis
- ❑ gout
- ❑ bladder/urinary tract infection
- ❑ pelvic inflammatory disease
- ❑ thyroid problems
- ❑ diabetes
- ❑ multiple sclerosis
- ❑ epilepsy/seizures
- ❑ ulcers
- ❑ liver problems
- ❑ eating disorder
- ❑ depression
- ❑ hepatitis
- ❑ stomach problems
- ❑ Other:_____

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 with which you would like help? **YES YES, BUT NOT TODAY NO**

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**Please list any medications you are currently using (INCLUDING pills, injections, and/or skin patches):**

_____

_____

Have you ever taken steroid medications for any medical conditions? **YES NO**
Have you ever taken blood thinning or anticoagulant medications for any medical conditions? **YES NO**

**Please list any surgeries or other conditions for which you have been hospitalized, including dates:**

_____

_____

_____

**Please list special tests performed for this problem (x-ray, MRI, labs, etc.)** _____

_____

**What date (approximately) did your present symptoms start?** _____

**What do you think caused your symptoms?** _____

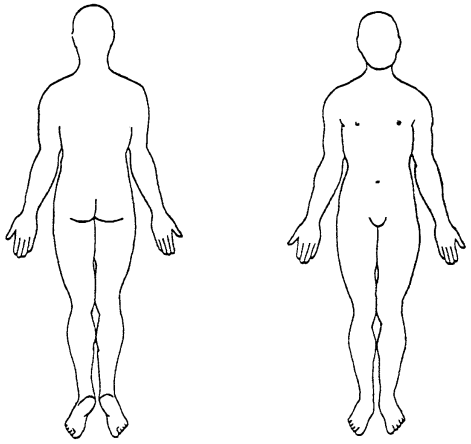
**Treatment received so far for this problem (chiropractic, injections, etc.)** _____

**Have you ever had this problem before: ❑ Yes ❑ No When_____Treatment Received_____?**

**How long did it take for you to feel better?** _____

**Body Chart:**

Please mark the areas where you feel symptoms on the chart to the right with an "X" for pain and "//" for numbness and tingling:



**How would you describe your symptoms?** _____

**My symptoms currently:** ❑ Come and go ❑ Are Constant ❑ Are constant, but change with activity

**Using the 0 to 10 the scale, with 0 being *"no pain"* and 10 being the *"worst pain imaginable"* please describe:**

*Average* for the last week:

0 1 2 3 4 5 6 7 8 9 10

*Best* for the last week:

0 1 2 3 4 5 6 7 8 9 10

*Worst* for the last week:

0 1 2 3 4 5 6 7 8 9 10

**Aggravating Factors:** Identify up to 3 important positions or activities that make your symptoms worse:

1. _____
2. _____
3. _____

**Easing Factors:** Identify up to 3 important positions or activities that make your symptoms better:

1. _____
2. _____
3. _____

**How are you currently able to sleep at night due to your symptoms?**

❑ No problem sleeping ❑ Difficulty falling asleep ❑ Awakened by pain ❑ Sleep only with medication

**If awakened by pain how long does it take to fall back asleep?** _____

**What is you sleep position?** _____

**When are your symptoms worst?** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise
**When are your symptoms the best?** ❑ Morning ❑ Afternoon ❑ Evening ❑ Night ❑ After exercise

**Goals for Physical Therapy:** _____