

Thank you for choosing HPT Physical Therapy Specialists!

Please read, fill out and sign the following paperwork and bring with you to your appointment, along with the following items: your insurance card(s), your photo ID and your doctors order for physical therapy (if you were given one). Please call us if you have any questions regarding your paperwork or appointment.

HEALTH QUESTIONNAIRE: Answer the questions by check-marking the boxes. Please list medications that you are currently taking, medicinal allergies, any surgeries you have had in the past year, and any other health or medical information we should know about.

CONSENT FORM: Signing this form gives us your permission to evaluate and treat you, release information to the insurance company and the referring doctor, and acknowledges your financial obligation.

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS: Medicare does not pay us for most personal comfort items or supplies that might be needed as part of treatment (a supply is anything that you would take from our office to use as part of your therapy). You may or may not need a supply; we just ask that if you do, you pay for it on the day that you receive it. Your insurance company will be billed for it and if they pay us, we will reimburse you.

HOME HEALTH SERVICES: Please verify if you have/have not had home health services in the past three months that have been billed to Medicare.

ACKNOWLEDGEMENT OF RECEIPT OF NOPP: We are required to provide you with our Notice of Privacy Practices. Please sign this acknowledgement to show that you received it.

Health Risk Questionnaire

	YES	NO
Do you have heart trouble or heart disease?		
Do you have high blood pressure?		
Has a parent or sibling had heart trouble or stroke before age 60?		
Do you have diabetes? Are you currently taking insulin?		
Do you smoke?		
Do you have asthma, bronchitis, or emphysema?		
Have you ever had rheumatic fever or tuberculosis?		
Do you often experience sudden, <i>unexplained</i> shortness of breath?		
Do you of experience sudden, <i>unexplained</i> rapid heartbeats?		
Do you have any bone or joint diseases or problems?		
Please list medications you are currently taking:		
Have you recently recovered from an illness (e.g. cold, flu, sinus infection)?		
Has a medical doctor informed you that you should not participate in an exercise program or physical activity?		
Is there any other health or medical information that we should know about that may affect your treatment?		
Please list allergies:		
Are you pregnant?		
List any operations/surgeries you have had <u>in the past year</u> and/or any operation you have ever had that pertains to the reason you are being seen today:		
Have you recently had a check-up from your physician?		
Other than your reason for being here today, are you in good health?		

Signature: _____ Date: _____

Consent to Treat

AUTHORITY TO EVALUATE AND PERFORM TREATMENT

I grant permission to HPT to perform treatment of physical therapy as deemed necessary by a Licensed Physical Therapist.

AUTHORITY TO RELEASE INFORMATION

I grant permission to HPT to release information concerning my physical condition to my insurance, attorney at law (with a current signed release), and any health care facility I may be transferred to or any health care facility from which I was referred.

AGREEMENT AND ASSIGNMENT

This date I have a contract with HPT Physical Therapy Specialists, Inc., 2240 5th Avenue, Huntington, WV 25703, for the furnishing of services rendered or to be rendered. I hereby direct my insurance to pay by check or electronic funds transfer payable to HPT without payment to me. I assign to HPT the rights to all present and future benefits due under my existing policy or policies of insurance.

VERIFICATION OF THIRD-PARTY BENEFITS

HPT does not accept third-party claims. We will consider your special circumstance, but please have other payment sources available.

PRE-APPROVAL FOR TREATMENT

I understand that I am responsible for obtaining pre-certification or pre-approval for treatment from my insurance carrier, if such pre-approval or pre-certification is required, and for charges not paid by my insurance carrier due to my failure to obtain such pre-approval or pre-certification. I understand the information given is merely a quote of benefits from my insurance company and I acknowledge that it is not a guarantee of payment. HPT is not responsible for ensuring payment from my insurance company. I agree to be an active participant in claims processing to ensure that there is no misunderstanding related to benefits or payment.

PAYMENT POLICY

AS A COURTESY TO YOU HPT WILL FILE YOUR CLAIM TO YOUR INSURANCE CARRIER, BUT YOU MUST HAVE THE PROPER ID CARDS OF ACTIVE INSURANCE, A DRIVER'S LICENSE OR STATE-ISSUED PHOTO ID, AND REFERRAL AT THE TIME OF SIGN-IN. WE WILL VERIFY WITH YOUR INSURANCE, PRIOR TO YOUR APPOINTMENT WHENEVER POSSIBLE, THAT YOU ARE ELIGIBLE FOR BENEFITS.

MEDICARE PATIENTS: We require payment on the day of service for medical supplies, which are not covered by Medicare.

MEDICAID PATIENTS: WV Medicaid limits physical therapy to 20 visits per calendar year. Ohio Medicaid allows a maximum of 30 visits per twelve months from the evaluation date of service. KY Medicaid does not participate with private practices; therefore, treatment is not covered. You do have the option to pay for each visit at the time of service, but your insurance will not be billed. **THE MEDICAL CARD DOES NOT COVER MEDICAL SUPPLIES AND PAYMENT IS DUE THE DAY THAT MEDICAL SUPPLIES ARE RECEIVED.**

If deductibles are not met you will be expected to pay at the time of service 100% of the charges at each visit until your deductible has been satisfied. If your insurance company has not paid the balance of charges within 60 days of your visit, HPT will require the balance from you. I understand I am responsible for contacting my insurance carrier if payment is not made.

Claims rejected by Worker's Compensation will be your responsibility. The balance due will be your responsibility. You must provide us with the correct claim number and date of injury for proper billing.

Budget Agreements can be arranged. A minimum monthly payment of \$100 is expected within 10 days of the billing date on your monthly statement. If payments in the amount specified are not received on time the balance will be delinquent and due, payable immediately. I agree to pay all costs and expenses of collection, including reasonable attorney fees and court costs.

If unusual circumstances make you unable to meet our credit terms, call to discuss this matter with our billing department. We want you to keep your account in good standing. I give HPT the right to obtain a credit check. If my account becomes past due at any time for any reason, I agree to pay, for each month that it is past due, an additional \$10 per month.

I AGREE THAT I AM RESPONSIBLE FOR PAYMENT OF THE TOTAL BILL INCURRED AS A RESULT OF SERVICES RECEIVED. I, the undersigned, have read and understand the entire Consent to Treat form. I hereby agree to the terms therein.

Patient/Guardian Signature

Date

Witness/HPT Staff Member

Date

NOTICE OF EXCLUSIONS FROM MEDICARE BENEFITS (NEMB)

There are items and services for which Medicare will not pay.

- Medicare does **not** pay for all of your health care costs. Medicare only pays for covered benefits. **Some items and services are not Medicare benefits and Medicare will not pay for them.**
- When you receive an item or service that is **not** a Medicare benefit, **you are responsible to pay for it**, personally or through any other insurance that you may have.

The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you will have to pay for them yourself.

Before you make a decision, you should read this entire notice carefully.

Ask us to explain, if you don't understand why Medicare won't pay.

Ask us how much these items or services will cost you (**Estimated Cost: \$**_____).

Medicare will not pay for: Personal Comfort Items/Supplies: 99070B; L0500; A9300; E0943; 99071; Compression Garments, Gloves, Stockings; Exercise Equipment; Hot/Cold Packs; Lumbar Support Roll; Cervical Support Roll; Shoulder Pulley; Self-Treatment Books; Etc.

1. Because it does not meet the definition of any Medicare benefit.

2. Because of the following exclusion * from Medicare benefits:

- Personal comfort items.
- Routine physicals and most tests for screening.
- Most shots (vaccinations).
- Routine eye care, eyeglasses and examinations.
- Hearing aids and hearing examinations.
- Cosmetic surgery.
- Most outpatient prescription drugs.
- Dental care and dentures (in most cases).
- Orthopedic shoes and foot supports (orthotics).
- Routine foot care and flat foot care.
- Health care received outside of the USA.
- Services by immediate relatives.
- Services required as a result of war.
- Services under a physician's private contract.
- Services paid for by a governmental entity that is not Medicare.
- Services for which the patient has no legal obligation to pay.
- Home health services furnished under a plan of care, if the agency does not submit the claim.
- Items and services excluded under the Assisted Suicide Funding Restriction Act of 1997.
- Items or services furnished in a competitive acquisition area by any entity that does not have a contract with the Department of Health and Human Services (except in a case of urgent need).
- Physicians' services performed by a physician assistant, midwife, psychologist, or nurse anesthetist, when furnished to an inpatient, unless they are furnished under arrangements by the hospital.
- Items and services furnished to an individual who is a resident of a skilled nursing facility (a SNF) or of a part of a facility that includes a SNF, unless they are furnished under arrangements by the SNF.
- Services of an assistant at surgery without prior approval from the peer review organization.
- Outpatient occupational and physical therapy services furnished incident to a physician's services.

*** This is only a general summary of exclusions from Medicare benefits. It is not a legal document. The official Medicare program provisions are contained in relevant laws, regulations, and rulings.**

Signature _____

Date _____

RE: Home Health Services for Medicare Recipients

Are you currently receiving Home Health Services, or have you received Home Health Services in the past three months, including but not limited to:

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Nursing
- Medication Distribution
- Housekeeping/Laundry
- Meal Preparation

_____ YES (Discharge Date: _____) _____NO

Signature: _____ Date: _____



Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can access this information. Please review carefully.

Our promise to you, our patients...your information is confidential.

Your information is important and confidential. Our ethics and policies require that your information be held in strict confidence.

Introduction

HPT maintains policies and procedures to ensure the security and confidentiality of your personal information. We have physical security in our building, passwords to protect databases, compliance audits and virus protection software. Within HPT, access to your information is limited to those who need it to perform their jobs.

At HPT, we are committed to treating and using protected health information (PHI) about you responsibly. This Notice of Privacy Practices describes the personal information we collect and how and when we use or disclose that information. It also describes your rights as they relate to your PHI. This notice is effective April 14, 2003 and applies to all PHI as defined by federal regulation.

Understanding Your Health Record

Each time you visit HPT, a record of your visit is made. Typically, this record contains your symptoms, examination, test results, diagnosis, treatment and plan for future care. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment.
- Means of communicating among health professionals who contribute to your care.
- Legal document describing the care you received.
- Means by which you or a third-party payer can verify that services billed were actually provided.
- Tool in educating health professionals.
- Source of data for medical records.
- Source of data for planning and marketing.
- Tool by which we can assess and continually work to improve the care we render and outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to ensure it's accuracy and to better understand who, what, when and why others may access your health information and make more informed choices when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of HPT, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of privacy policies upon request.
- Inspect and copy your health record as provided by 45 CFR 164.524.
- Amend your health record as provided by 45 CFR 164.526.
- Obtain an accounting disclosure of your health information as provided by 45 CFR 164.528.
- Request confidential communication of your health information provided by 45 CFR 164.522.
- Request a restriction on certain uses and disclosures of your health information as provided by 45 CFR 164.522. (HPT, however, is not required by law to agree to a requested restriction.)

Our Responsibilities

All healthcare providers are required to:

- Maintain the privacy of your healthcare information.
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate your health information.

We reserve the right to change our practices and to make provisions effective for all PHI we maintain. We will keep a posted copy of the most current notice in our facility containing the effective date in the top right hand corner. In addition, each time you visit our facility for treatment you may obtain a copy of the current notice upon your request.

We will not use or disclose your health information in a manner other than described in the section regarding Examples of Disclosure for Treatment, Payment and Health Operations without your written authorization, which you may revoke as provided by 45 CFR 164.508(b)(5) except to the extent that action has already been taken.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact HPT at 304-525-4445. If you believe your privacy rights have been violated, you can either file a complain with HPT's Privacy Officer, or with the Office for Civil Rights, US Department of Health and Human Services (OCR). There will be no retaliation for filing a complaint with either our Privacy Officer or the OCR. The address for the OCR is as follows:

Offices for Civil Rights
US Department of Health and Human Services
200 Independence Avenue SW
Room 509F HHH Building
Washington, DC 20201

Examples of Disclosure for Treatment, Payment and Health Operations

We will use your Health Information for treatment.

Information obtained by a therapist or other member of our staff will be recorded in your record and used to determine the course of treatment that should work best for you. Your therapist will document in your record his or her expectations of your treatment and possible outcomes. With proper authorization your health care record will be released to other physicians or subsequent health care providers and/or attorneys when applicable. Once information is disclosed to a third party, that party may in turn disclose said information to another party.

We will use your Health Information for payment.

A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures and supplies used.

HPT Physical Therapy Specialists

2240 5th Avenue
Huntington WV 25703
304/525-4445
800/225-9672
304/529-7449 fax

Acknowledgement of Receipt of Notice of Privacy Practices (NOPP)

This is to serve as acknowledgement that I received a copy of the Notice of Privacy Practices from HPT Physical Therapy Specialists.

Patient's Name: _____

Patient's personal representative & relationship (if applicable):

Signature & Date: _____