Demographics

Name ____ DOB _______________ Age _____

Address ____

STREET CITY STATE ZIP CODE

Best phone to contact you ____

Permission to receive texts from your physical therapist? (please circle) Yes No

E-mail Address ____

Do you wish to communicate with our office via e-mail? (please circle) Yes No

Emergency Contact

Name ____

Phone # ____ Relationship ______________________________________

Referring Physician

Name ____ Date of Injury/Surgery ______________________________

Diagnosis ____

If you were not referred by a physician – how did you hear of us? ____

Primary Physician, if different from referring physician:

Name ____ Phone Number _____________________________________

Primary Insurance Company ____

(This is for reference only, as we are out-of-network and don't participate with any insurance providers. You can submit to your insurance based on your personal out-of-network physical therapy benefits)

Employment Status

Occupation ____ Employer ___________________________________

Work Status (Circle one):

Full Time Part Time Self Not Working Retired

Common physical positions you go through at work or throughout your normal day (please circle all that apply) :

Sit Stand Walk Sit at Computer Lifting

Other work positions or requirements that affect your physical position:__________________________________

MEDICAL HISTORY

Current Medications: ________________________ Taking for: ____________________________
________________________ Taking for: ____________________________

Past Surgeries/ Significant Health History

Past Surgeries/ Significant Health History	Year	Procedure	Successful?

Past Muskulo-Skeletal Injuries/ Significant Health Events

Past Muskulo-Skeletal Injuries/ Significant Health Events	Treatment	Successful?

Sports/ Recreation/ Activity History - please describe:

During youth: ____
During college/education: ____
Competitive: ____
Current: ____

Healing Arts Treatment - massage, acupuncture, personal training, etc...

Past Treatment: ____ Successful?_________
____ Successful?_________

Current Tx: ____ Successful?_________
____ Successful?_________

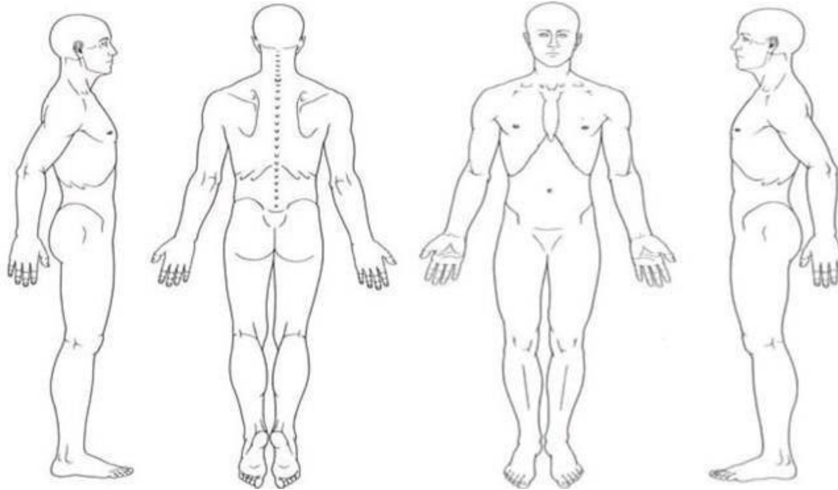
Does your pain vary and change with position changes? YES NO

If yes, describe: ____

What has been most helpful in treating your pain or condition so far?

Symptom and Activity Report

1. Primary Concern for attending Physical Therapy today: ______________
2. Regular exercise engaged in this week: ________
3. Indicate anywhere on your body with symptoms that would be helpful for your therapist to know about today (ex: aching, numbness, tingling, sharp pain, burning, etc)____ _______



4. Level of pain/other symptom (0-10 scale with 10 being the worst): ____

Physical Goals

1. What do you hope to accomplish through Physical Therapy?
   ____
2. Do you have a physical event or a travel date that you are preparing for?
3. Please list anything else you feel the physical therapist should know regarding your injury:

Consent for Treatment

I, the undersigned, do hereby authorize Jennifer Cooper, PT OCS (Licensed Physical Therapist and Certified Orthopedic Specialist) to administer treatment as necessary. I acknowledge that no guarantee or assurance has been, nor can be, made as to the results of the prescribed treatment. Furthermore, I understand that I am ultimately responsible for payment of all services rendered, unless otherwise provided by law. Physical therapy involves massage, mobilization, exercise and other modalities to facilitate healing. This involves physical contact with my body, which I consent to. I understand that if I have questions regarding treatment, my home program, or anything in relation to my treatment, I will ask for clarification. Initials: _______

Cancellation Policy

By signing below, I understand that cancellations MUST be made **at least 48 hours, but preferably 72 hours** prior to the scheduled appointment time. I am aware that I will be responsible for a fee that amounts to 100% of the scheduled session cost for no shows or late cancellations within 48 hours of the scheduled appointment time. This payment is due at the time of the originally scheduled appointment. We are a small therapy and wellness practice, and late cancellations do not allow us enough time to schedule another patient. Please be respectful of this policy and do not request for a waiver.

We understand that extenuating cancellation circumstances may occur (such as acute illness), and will be considered on a case-by-case basis. Though our scheduling program is automated to send a reminder email, there can sometimes be a glitch in the system. It is the patient’s responsibility to know when the appointment is, to check with reception if confirmation is needed, and to arrive on time. Repeated cancellations and/or no shows may result in discharge from our facility. Initials: _______

Notice of Patient Information Practices – HIPAA Compliance

Your personal health information is protected by law and may only be used for personal purposes, auditing purposes, and emergencies. If you provide a written authorization to release your information for any reason, you may later revoke that authorization at any time. You have the right to review or obtain a copy of your health information at any time or request a correction of any inaccurate or incomplete information. If you feel as though your rights to privacy have been violated, you may file a complaint to the US Department of Health and Human Services. Please sign below to indicate that you have read the above information and are aware that your personal health information is protected. Initials: _______

Consent for TeleCommunication during TeleMedicine

I, the undersigned, hereby consent to engaging in telemedicine with Jennifer Cooper, PT OCS RYT as part of my treatment. I understand that “telemedicine” includes the practice of healthcare diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. I understand that there are inherent privacy risks from telemedicine, including, but not limited to, the possibility, despite reasonable efforts on the part of my provider, that: the transmissions of my medical information could be disrupted or distorted by technical failures; or that the transmission of my medical information could be interrupted by unauthorized persons, out of control of the provider.

Initials: _______

Payment and Billing policy

Thank you for choosing Flow Physical Therapy. We kindly ask for payment at the time of services, unless other arrangements have been made. We accept cash, check or credit card. We can arrange for billing to your accountant or personal assistant if requested. At this time we are **not contracted** with any medical insurance companies. This means that your services **may or may not** be covered under the non-provider policy with your insurance company. It is **your responsibility** to know your policy and your benefits. We will provide records of any service with us, and then you will be able to self-submit according to your plan policy. Self-submission information is usually available online, through the 800 number on your card, or through a human resource department, if available. Initials: _______

Signature: ____Date: ________________

Important Information If You Are Covered by Medicare - MUST READ

If you wish Medicare to pay for your services please choose another provider. **Medicare will not allow for out of network submission**. You will not be able to change your mind later and submit. *This is Medicare's policy and by signing below you are electing for services outside of the Medicare system*.
If, based on your or your partner's current employment (and the employer has 20 or more employees, and you're over 65) then your group health plan may be considered as your primary. Only in this case will you be eligible for primary insurance submittal for these services, still never to Medicare. If you have Medicare and more than one other type of insurance, check your policy or coverage as it may include these rules about who pays first (your primary). Please keep in mind you will be asked to provide evidence that Medicare is not your primary care provider in order to receive an itemized receipt with all of the information you will need to submit to your primary care provider, not Medicare.

I, the Medicare beneficiary, or my legal representative, understand that Medicare limits do not apply to what Jennifer Cooper, PT OCS RYT, may charge for services, and agree not to submit a claim to Medicare, or to ask Jennifer Cooper to submit a claim to Medicare:

Signature: ____Date: ________________

You will now be asked to sign the ABN, which is a requirement of Medicare as proof that you understand our services will not be reimbursed at all.

Advanced Beneficiary Notice (ABN)

A signed Advanced Beneficiary Notice (ABN) Medicare form serves as proof that you, the undersigned, know prior to accepting such therapy services that you will have to pay out of pocket for said services. You must complete and sign the form on the next page before services can begin.

A. Notifier: Flow PT
B. Patient Name:
C. Identification Number:

Advance Beneficiary Notice of Non-coverage (ABN)

NOTE: If Medicare doesn't pay for **D.** Physical Therapy below, you may have to pay.
Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**__________ below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy	out of network	$300

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**__________ listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**__________ listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but I can appeal to Medicare by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☒ **OPTION 2.** I want the **D.** PT listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. I cannot appeal if Medicare is not billed.

☐ **OPTION 3.** I don't want the **D.**__________ listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048).
Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

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Form CMS-R-131 (Exp. 06/30/2023) Form Approved OMB No. 0938-0566