TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

Patient Registration Form

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		☐ M ☐ F	**DOB:**
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Address *(Street)*			**Social Security:** - -
(City, State, Zip)			**Referring Physician:**
Home Phone:	**Cell Phone:**		**Primary Care Physician:**
Employer:	**Occupation:**		**Work Phone:**
In case of emergency notify:	**Relation:**		**Phone:**

INSURANCE INFORMATION

Primary Insurance:			
Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	Insured's Name:	Policy ID:	
	Insured's DOB:	Group #:	
	Insured's Employer:		
Secondary Insurance:			
Relationship to Patient: ☐ **Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	Insured's Name:	Policy ID:	
	Insured's DOB:	Group #:	
	Insured's Employer:		

Do you have any other health insurance: ☐ Y ☐ N If so, please ist_____

FINANCIAL RESPONSIBILITY

Name:	**Phone:**	**Relationship to Patient:**
Address *(Street)*		**Social Security:** - -
(City, State, Zip)		**DOB:**

OUR POLICY ON BILLING AND INSURANCE FEES

Our fees are based on the "customary and reasonable charge" established by Medicare in our area. Our services are covered by health insurance plans, auto insurance, worker's compensation, most managed care networks, and Medicare. We will attempt to clarify specifics of physical therapy coverage in your insurance plan before beginning your treatment. As therapy progresses we will submit your bill to your insurance company, including worker's compensation and auto insurance. However, plans vary widely with deductibles and co-insurance. It is possible that some portions of our total bill will not be fully covered by your health insurance carrier.

If your insurance does not cover physical therapy, we will make special consideration or a "fee for service" agreement. If a financial hardship exists do not hesitate to bring it to the attention of our insurance billing administrator. We will work out arrangements so that your needed treatment can be provided.

We appreciate payment of insurance co-payment and any unmet deductible amounts at the time of service.

☐ I Have /☐ Have Not had *Home Health* services recently

☐ I Have / ☐ Have Not had any *Physical* or *Speech* therapy this year

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Toepperwein Physical Therapy & Spine Rehab, P.C. I understand that I am financially responsible for any balance. I also authorize Toepperwein Physical Therapy to release any information required to process my claims.

Patient or Guardian Signature _____ Date _____

TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

NOTICE OF PRIVACY PRACTICES

I understand that under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been given the opportunity to review the **Toepperwein Physical Therapy Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I understand that Toepperwein Physical Therapy has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this office at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**. *NOTE: Uses and disclosures for treating physicians' office may be permitted without prior consent in an emergency.*

☐ No Restrictions
☐ I request the following restriction to the use or disclosure of my health information:

I understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time. If I do revoke my authorization it will become effective the following date of received written revocation, or withdrawal. I have read & fully understand the above general consent form. Any questions I have had have also been answered to my satisfaction. 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 or not to receive my health information.

Patient Name: (Please Print)_____

_____ _____
SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE **DATE**

YES NO

☐ ☐ Permission to leave Information with a family member or on an answering machine.
☐ ☐ Permission to discuss treatment options with spouse, parent or legal guardian.

Name(s) of third party/parties you have approved our office to discuss your health information with:

CONSENT TO THERAPY

Please initial each line to verify you have read, understand, and agree to the following policies:

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 is not an exact science, so no guarantees or warranties can be made to me regarding the 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 understand that if I do not see my physical therapist for two weeks or miss three consecutive appointments, the physical therapist may discharge my case. Once I have been discharged, I understand that I will need a new physician's order/referral for any further therapy and will be receiving a new evaluation. This is in compliance with the Texas State Law. _____
4. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. _____
5. I am responsible for any services not covered by my insurance. I have read and fully understand our Policy on Billing and Insurance Fees. _____
6. Worker's Compensation - I hereby authorize my rehab consultant to receive my records related to my work injury. _____
7. We may from time to time take photo graphs of patients during their course of care with us. We insure all photos protect your modesty and only show you at your best! Do you consent to having your photograph taken? ☐ Yes ☐ No
8. I understand that Toepperwein Physical Therapy & Spine Rehab, P.C. is not responsible for valuable and personal property brought to the facility. _____

TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

MEDICARE FINANCIAL LIMITATION NOTIFICATION FORM

Effective January 1, 2017 the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling $**1,980.00** for Medicare Part B outpatient services for Physical 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 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 $1,980.00 financial limitation (Cap) for both therapies combined.
- Occupational Therapy services will have separate $1,980.00 financial limitation.
- These financial limitations will be effective until December 31, 2017 unless otherwise changed or suspended by CMS.

These limits are based on the Medicare fee schedule allowed amount after your $183.00 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 $1,980.00 financial limitation for Physical 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 $1,980.00 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 $1,980.00 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 office of any physical or speech therapy services you have received between January 1, 2017 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 2017 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*

This notice was adapted from CMS's "Notice of Exclusion from Medicare Benefits" form and is not an all-inclusive list of excluded Medicare benefits. This notice pertains to Medicare's financial limitation and excluded benefits beyond $1,980.00.

TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

PROVIDER-PATIENT EMAIL / TEXT COMMUNICATION CONSENT FORM

PROVIDER INFORMATION:
NAME: TOEPPERWEIN PHYSICAL THERAPY
ADDRESS: 11481 TOEPPERWEIN ROAD SUITE 1201
EMAIL: TOEPPERWEINPT@HOTMAIL.COM

PLEASE PICK ONE OF THE FOLLOWING AS YOUR PREFERRED METHOD OF COMMUNICATION:

- ☐ PHONE
- ☐ TEXT
- ☐ EMAIL

PATIENT ACKNOWLEDGMENT AND AGREEMENT
I ACKNOWLEDGE THAT I HAVE READ AND FULLY UNDERSTAND THIS CONSENT FORM. I UNDERSTAND THE RISKS ASSOCIATED WITH THE COMMUNICATION OF EMAIL BETWEEN THE PROVIDER AND ME, AND CONSENT TO THE CONDITIONS OUTLINED HEREIN, AS WELL AS ANY OTHER INSTRUCTIONS THAT THE PROVIDER MAY IMPOSE TO COMMUNICATE WITH PATIENTS BY EMAIL/TEXT. I ACKNOWLEDGE THE PROVIDER'S RIGHT TO, UPON THE PROVISION OF WRITTEN NOTICE,WITHDRAW THE OPTION OF COMMUNICATING THROUGH EMAIL. ANY QUESTIONS I MAY HAVE HAD WERE ANSWERED.

PATIENT NAME: _____

PATIENT ADDRESS: _____

PATIENT EMAIL: _____

PATIENT PHONE: _____

PATIENT SIGNATURE _____

DATE _____

TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

INITIAL EVALUATION

Salutation:	☐ Mr. ☐ Mrs. ☐ Miss ☐ Ms. ☐ Dr.		**DOB:**	**Age:**
	Name *(Last, First, M.I.):*	☐ M ☐ F	**Height:**_____	**Weight:**_____
Referring Physician	Doctor which referred you to our clinic:			
	When is your next doctor's appointment for follow-up of this condition?			
Current Symptom Onset	How recent did the symptoms start or become worse? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago			
	How did the symptoms appear? ☐ Suddenly ☐ Gradually ☐ Insidiously ☐ Injury			
	How long have the symptoms persisted for? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years			
	What was the cause of the symptoms? (i.e. car accident, fall, surgery, other)			
	Have the symptoms ☐ Worsened ☐ Improved ☐ Remained the same			
Problem	First Symptom ☐ Pain ☐ Swelling ☐ Numbness ☐ Stiffness ☐ Other _____			
	First area affected by symptoms:	☐ Neck	☐ Wrist	☐ R ☐ L
		☐ Back ☐ upper ☐ mid ☐ low	☐ Hip	☐ R ☐ L
		☐ Shoulder ☐ R ☐ L	☐ Knee	☐ R ☐ L
		☐ Elbow ☐ R ☐ L	☐ Ankle	☐ R ☐ L
	What is the intensity of the pain? ☐ Mild ☐ Moderate ☐ Severe ☐ Unbearable			
	Do the symptoms radiate to another area? (please list)			
	Do the symptoms change after resting? ☐ Increase ☐ Decrease ☐ Remain the same			
	Do the symptoms change after activity? ☐ Increase ☐ Decrease ☐ Remain the same			

Medications	Medication Name:	How Much (dose):	How Often:

Current Pain	What would you rate your pain level NOW?	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
	What is your pain rated in the morning?	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
	What is your pain rated in the afternoon	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain
	What is your pain rated in the evening?	☐ No Pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ Worst Pain

Activities	List activities that AGGRAVATE symptoms:	List activities which EASE/DECREASE SYMPTOMS:
	1.	1.
	2.	2.
	3.	3.

TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

Work Activities	List any strenuous activities performed at work (lifting, bending, twisting, sitting/standing for long periods, repetitive motion activity)
	How often is this activity performed ☐ Frequently ☐ Regularly ☐ Occasionally ☐ Hourly ☐ Daily ☐ Constantly
	Are your symptoms aggravated by this activity? ☐ Yes ☐ No
Sitting/ Standing	How long can you remain sitting before having to change position? _____/_____ (Minutes / Hours)
	In what position(s) do you usually sit? ☐ Guarded ☐ Even weight distribution ☐ Uneven weight distribution
	How long can you remain standing before having to change position? _____/_____ (Minutes / Hours)
	Do you experience discomfort while using stairs? ☐ Yes ☐ No If yes, is the discomfort ☐ Minimum ☐ Moderate ☐ Severe
	Do you use any assistive device(s) for movement? (walker, cane, wheelchair)

Please skip questions of Prior Symptoms if it does not apply to you.

Prior Symptoms	Prior Treatment, provider type, and name: (Dr., PT, DO, Chiropractor, RMT)
	Prior Treatment Types: ☐ Moist Heat ☐ Cold Pack ☐ Ultrasound ☐ Massage ☐ Interferential current ☐ Traction ☐ Other
	How long ago was the treatment received? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago
	How would you rate your recovery? ☐ Poor ☐ Satisfactory ☐ Good ☐ Very Good ☐ Excellent
	How long ago was the treatment received? _____ ☐ Days ☐ Weeks ☐ Months ☐ Years ago

Please list surgeries which may relate to the condition we will be treating.

Related Surgeries	Most Recent Surgery:	Date of surgery: _____/_____/_____
	Location of incision:	Incision has: ☐ Healed ☐ Not healed
	Physician:	Recovery was: ☐ Poor ☐ Satisfactory ☐ Full
	Other Surgery:	Date of surgery: _____/_____/_____
	Location of incision:	Incision has: ☐ Healed ☐ Not healed
	Other Surgery:	Date of surgery: _____/_____/_____
	Location of incision:	Incision has: ☐ Healed ☐ Not healed
Precautions	Have you been given any precautions or limitations by your doctor? ☐ Yes ☐ No	
	If yes, please explain:	

Please skip questions of Accident Information if it does not apply to you.

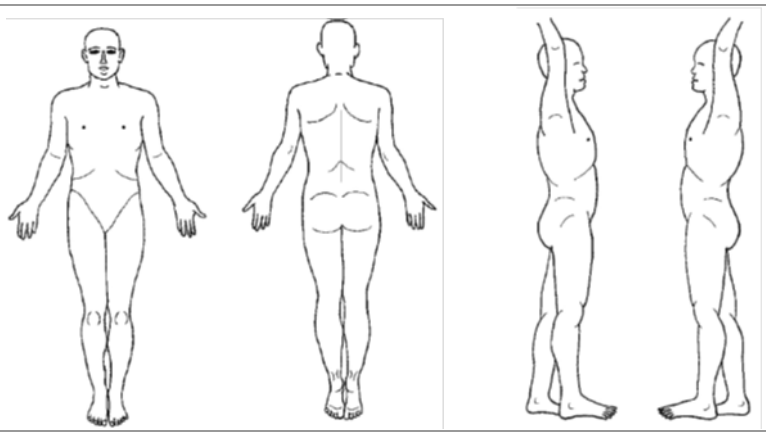
Accident	Date of your injury : _____/_____/_____	☐ Auto ☐ Work ☐ Other _____
	Describe how and what happened in your accident:	
	Did you receive treatment after your injury / accident? ☐ Yes ☐ No	Were you able to continue working? : ☐ Yes ☐ No
	What treatment(s) did you receive? (ER, X-Rays, Medication(s))	
	Did the treatment you received help your condition? : ☐ Yes ☐ No ☐ Somewhat	
	If not able to continue working, when are you to be re-evaluated by your physician for returning to work? _____/_____/_____	

TOEPPERWEIN PHYSICAL THERAPY™ & Spine Rehab

HEALTH HISTORY

Check if you or a family member have, or have had, any of the following symptoms:	
Cancer	☐ You ☐ Family Member
Diabetes	☐ You ☐ Family Member
High Blood Pressure	☐ You ☐ Family Member
Heart Disease	☐ You ☐ Family Member
Angina / Chest Pain	☐ You ☐ Family Member
Stroke	☐ You ☐ Family Member
Osteoporosis	☐ You ☐ Family Member
Osteoarthritis	☐ You ☐ Family Member
Rheumatoid Arthritis	☐ You ☐ Family Member

Please indicate each area(s) of your current pain or other symptoms



Check if You have, or have had, any of the following symptoms:		Check if You have, have had, or experienced in the past 3 months:	
Allergies / Asthma	☐ Yes ☐ No	A change in your health	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Loss of strength or energy	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Nausea / Vomiting	☐ Yes ☐ No
Kidney Disease	☐ Yes ☐ No	Fevers / Chills / Sweats	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Menstrual irregularities	☐ Yes ☐ No
Ulcers	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Hearing Impairment	☐ Yes ☐ No	Dizziness	☐ Yes ☐ No
Vision Impairment	☐ Yes ☐ No	Upper Respiratory infection	☐ Yes ☐ No
Speech Impairment	☐ Yes ☐ No	Urinary tract infection	☐ Yes ☐ No
Sexually Transmitted Disease	☐ Yes ☐ No	Been bothered by feeling down, depressed, or hopeless	☐ Yes ☐ No
Positive Tuberculosis Testing	☐ Yes ☐ No	Have you often been bothered by little interest or pleasure in doing things?	☐ Yes ☐ No
Living with someone who has Tuberculosis	☐ Yes ☐ No	Change in bowel / bladder function	☐ Yes ☐ No

OTHER PROBLEMS

I Have Difficulty with:		Answer the following questions:	
Driving	☐ Yes ☐ No	Are your symptoms? ☐ Getting worse ☐ The Same ☐ Improving	
Lifting	☐ Yes ☐ No	How are you able to sleep at night? ☐ Fine ☐ Moderately difficulty ☐ Only with medication	
Walking	☐ Yes ☐ No	Are you Currently? ☐ Pregnant ☐ Under Stress	
Bending at the waist	☐ Yes ☐ No	Have you had any medical Tests performed recently? If yes state where the test(s) were performed	Date:
Running	☐ Yes ☐ No	X-Ray ☐ Yes ☐ No	
Playing Sports	☐ Yes ☐ No	EMG ☐ Yes ☐ No	
Standing	☐ Yes ☐ No	MRI ☐ Yes ☐ No	
Getting up from a chair	☐ Yes ☐ No	Cat Scan ☐ Yes ☐ No	
Regular exercise	☐ Yes ☐ No	Ultrasound ☐ Yes ☐ No	