NEW PATIENT PAPERWORK – MEDICARE

PATIENT INFORMATION		
Name:		Preferred:
Address:		
City:	State:	Zip:
DOB:		Social security #:
Email Address:		

Home Phone:	Appointment Reminder Method
Cell Phone:	Home Phone ☐ Cell Phone ☐ Text ☐
Work Phone:	

Please keep in mind that communication via email over the Internet is not a secure form of communication. By providing your above contact information and signing below, you agree to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information.

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Partner's Name:
Financial Responsibility: ☐ Self ☐ Other
Emergency Contact:
Emergency contact phone: Relation:

Have you had Physical Therapy treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Chiropractic treatment since January of this year? ☐ Yes ☐ No # of visits:
Have you had Home Healthcare in the last 30 days? ☐ Yes ☐ No If yes, Home Healthcare Provider:

CONSENT TO TREATMENT
I hereby authorize and consent to treatment/services for myself, or on the behalf of the above-named patient, performed by the staff at Physical Therapy Central (PTC) or Redbud Physical Therapy and/or as directed by my referring provider. I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including risk or alternatives to the treatment plan that has been recommended. Signature Patient/Guardian and relationship to patient: Date:

INSURANCE INFORMATION Please Note: A copy of your insurance card(s) will be kept on file. The patient is responsible to provide their most current insurance information.	
Primary Insurance:	Secondary Insurance:
Policy #:	Policy #:
Group #:	Group #:

PHYSICAL THERAPY CENTRAL | REDBUD PHYSICAL THERAPY

MEMBERS OF THE CONFLUENT HEALTH FAMILY

MEDICARE SECONDARY PAYER (MSP) FORM

Name:

Part I

1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-relatedaccident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	☐ Yes ☐ Yes	☐ No ☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: Attorney's Name: _____ Address: _____ Phone Number: _____ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No

Part II

1. Are you entitled to Medicare based on? *Check the box that applies*
   - ☐ Age (65 & older) – go to question #2
   - ☐ Disability – go to question #2
   - ☐ End Stage – Go to **Part III**

2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:	☐ Yes	☐ No
☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u>	☐ Yes	☐ No
☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes	☐ No

Part III

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

1. Do you have group health plan coverage?	☐ Yes	☐ No
2. Are you within the 30-month coordination period?	☐ Yes	☐ No
If yes to BOTH questions, GHP is primary during the 30-month coordination period		

Please provide a copy of your group health insurance if determined to be primary.

Signature of Patient/Representative:	Date:
Relationship to Patient:	

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PAYMENT FOR SERVICES AND INSURANCE
I assign payment for these services directly to PTMS 3.0, LLC. I authorize the filing of claims to my insurance plan and authorize PTMS 3.0, LLC to release necessary health information related to these services to process the claims. I certify that the information I have provided is accurate and complete. In signing this form, I will promptly pay any required co-pay, coinsurance and/or deductible amounts. I accept that insurance plans may deny payments for what I believed were covered services, resulting in my responsibility for paying for these services. I acknowledge that I am responsible for deductibles, copays, coinsurance, and non-covered services not paid by the insurance plan and understand that I am fully responsible for any balance due for services rendered. Patient/Guardian Signature: Date:
NOTICE OF PRIVACY PRACTICE
I acknowledge that I have received the Notice of Privacy Practices, which describes the ways the practice may use or disclose my healthcare information. I understand that my healthcare information may be used for treatment, payment, healthcare operations and other described and permitted uses or disclosures. I understand that I may contact the Confluent Health Compliance Officer listed on the notice if I have a question or complaint. Patient/Guardian Signature:_____ Date: _____ For questions, please contact the Compliance Department (Toll free) at 888-937-4479.

PATIENT HEALTH QUESTIONNAIRE
Occupation: Height: Weight: Sex: ☐ Male ☐ Female
Leisure Activities/Hobbies:
Are you? ☐ Right-handed ☐ Left-handed
Where do you live? ☐ Private home ☐ Apartment/rented room ☐ Assisted living/group home ☐ Hospice ☐ Other
With whom do you live? ☐ Alone ☐ Spouse only ☐ Spouse and others ☐ Child ☐ Other
Does your home have? ☐ Stairs, no railing ☐ Stairs, railing ☐ Ramps ☐ Uneven terrain Please explain:
How many times have you fallen in the past 12 months? Did it result in an injury? ☐ Yes ☐ No
During the past month have you been feeling down, depressed, or hopeless or bothered by having little interest or pleasure in doing things? ☐ Yes ☐ No
General Health Status, please rate your health. ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any known allergies (including medications, latex, etc.) below:

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Please list current medications (including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.						
Name	Dosage	Frequency	Please indicate route			
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other
			Oral	Patch	Topical	Other

Surgery / Hospitalization, please include date and reason.	

Are you currently experiencing any of the following?			
Nausea or Vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Unexplained weight changes	☐ Yes ☐ No

Have you been diagnosed with any of the following?			
Allergies	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV	☐ Yes ☐ No
Anxiety or Panic Disorders	☐ Yes ☐ No	Kidney Disease/Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No
Auto Immune Disease If yes, Type:	☐ Yes ☐ No	Metal Implants	☐ Yes ☐ No
Blood Clots	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No
Bowel or Bladder Disorder	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No
Cancer If yes, Site:	☐ Yes ☐ No	Osteoarthritis	☐ Yes ☐ No
Cardiac Conditions	☐ Yes ☐ No	Parkinson's	☐ Yes ☐ No
Cardiac Pacemaker	☐ Yes ☐ No	Peripheral Vascular Disease	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Rheumatoid Arthritis	☐ Yes ☐ No
Currently Pregnant	☐ Yes ☐ No	Seizures	☐ Yes ☐ No
Depression	☐ Yes ☐ No	Speech Problems	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Spinal Cord Stimulator	☐ Yes ☐ No

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Emphysema/Bronchitis	☐ Yes ☐ No	Stomach Ulcers	☐ Yes ☐ No
Fractures	☐ Yes ☐ No	Stroke/TIA	☐ Yes ☐ No
Gall Bladder Problems	☐ Yes ☐ No	Thyroid	☐ Yes ☐ No
Gastrointestinal Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Hearing Loss	☐ Yes ☐ No	Vision Problems	☐ Yes ☐ No
Hepatitis If yes, Type:	☐ Yes ☐ No	Heart Attack	☐ Yes ☐ No

Social History / Wellness	
Do you drink alcoholic beverages?	☐ Yes ☐ No / Comments:
Do you use tobacco?	☐ Yes ☐ No / Comments:
How often have you completed at least 20 minutes of exercise, such as jogging, cycling, or brisk walking, prior to the onset of your condition? ☐ At least 3 times per week ☐ 1-2 times per week ☐ Seldom or Never	

Current Condition
When did this problem(s) first begin?
Describe the problem(s).
Explain how problem(s) occurred.
Have you ever had this problem before? ☐ Yes ☐ No If yes, how many times?
Are your symptoms worse in the: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Same all day
How are you taking care of the problem(s) now?
My pain/problem is slowing getting: ☐ Worse ☐ Better ☐ Staying the same
My symptoms bother me: ☐ Constantly (100%) ☐ Most of the time (75%) ☐ Occasionally (50%) ☐ Once in a while (25%)
Do you have any numbness, tingling, or burning? ☐ Yes ☐ No If yes, please check one: ☐ Constantly ☐ Intermittently
What functions could you perform before, that you now are unable to do?
Please explain any specific treatment you have received for this problem, such as previous physical or occupational therapy, chiropractic visits, pain medications, etc.
Please list the dates and results of any:
X-Rays:
MRI:
Bone Density Test:

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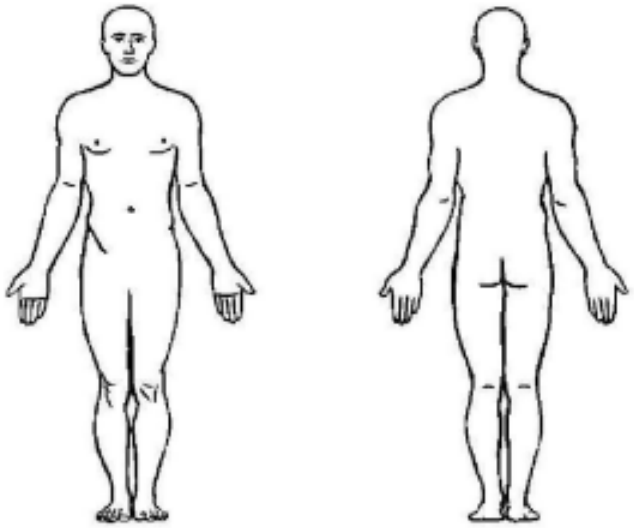
Nerve Conduction Test:
Other:
Are you aware of any physical reason why you should not receive treatment? ☐ Yes ☐ No If yes, please tell us what it is:
What are your goals for therapy?

Symptom Rating

Mark location of symptom(s)

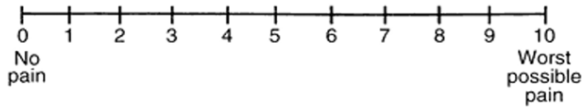
O for pain

X for numbness/tingling/burning

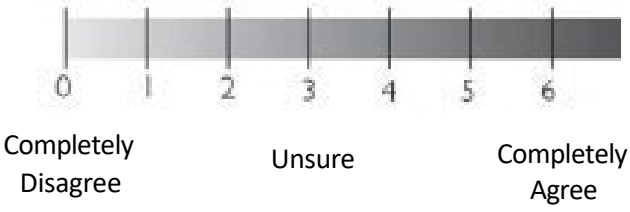


Please rate your pain - on a scale from 0 – 10
(0 = No Pain; 10 = Worst pain imaginable)

Current: / 10	Best: / 10	Worst: / 10



"I should not do physical activity which (might) make my pain worse."
Please rate your level of agreement on the scale below:



Patient/Guardian Signature: Date: