Health Information

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

Occupation: _____ Referred to us by: _____

How did you hear about us? _____

Date last seen by physician: _____ What problem are you seeing Physical Therapy treatment for:

_____

_____

When did the problem begin? _____ Have you ever had this problem before? _____

If yes, what did you do for the problem: _____

Did it improve? Yes/No What makes the problem worse: _____

What are your goals for physical therapy? _____

Living Environment

Does your home have: Stairs, no railing_____ Stairs with railing ____ Ramps _____

Elevator_____ Uneven terrain _____ Obstacles_____

Do you live in a: Private Home_____ Assisted Living _____ Apartment _____

General Health Status

Height _____ Weight _____

Please rate your health: Good_____ Excellent _____ Fair _____ Poor _____

Smoking: Currently smoke tobacco? Yes ____ No ____ If yes, how many packs per day?_____

Smoked in past, but quit (how long ago) _____? I have never smoked: _____

Alcohol Use: Y/N How many servings per week? _____

Exercise: Do you exercise beyond your normal daily activities and chores? Yes_____ or No _____ If yes, how often per week do you exercise or do physical activity? _____. How many minutes on average? _____

Medical/Surgical History

Please check the box if you have ever had any of the following:

- ☐ Arthritis
- ☐ Fractured Bones
- ☐ Osteoporosis
- ☐ Blood Disorders
- ☐ Circulation/Vascular Problems
- ☐ Heart Problems
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes/High Blood Sugar
- ☐ Head Injury
- ☐ Multiple Sclerosis
- ☐ Muscular Dystrophy
- ☐ Parkinson's Disease
- ☐ Seizures/Epilepsy
- ☐ Growth Problems
- ☐ Kidney Problems
- ☐ Recurrent Infection
- ☐ Cancer
- ☐ TB
- ☐ Hepatitis
- ☐ Stomach Problems
- ☐ Skin Diseases
- ☐ Depression
- ☐ Headaches
- ☐ Vision Problems
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Allergies _____
- ☐ Previous surgeries: _____

_____

_____

_____

MEDICATION LIST

Name: _____ Date: _____

Please list all prescription and non-prescription medications you take

	Medication Name	Doseage	How Often?
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

PRO Therapy Financial Policy

TO OUR VALUED PATIENTS:
We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive you maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due on each visit for charges incurred through your last visit. All copayments are expected at time of service. We accept cash, checks, and all major credit cards. There is a service charge for insufficient funds.
Please read carefully:

1. Your insurance is a contract between you, your employer and your insurance company. We are not a party to that contract. We bill your insurance as a courtesy to you. We must emphasize that our relationship is with you, our patient, not your insurance company. It is the policy of PRO Therapy to comply with all terms and conditions of our insurance contracts.
2. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. These particular services, if any, are your responsibility. We will do everything on our part to verify benefits on your behalf, but ultimately, you are responsible for your own insurance benefit verification.
3. You are expected to pay your deductible and/or co-insurance applied by your insurance carrier. If payment from your insurance company is not received within 90 days from the date of service, you will be expected to pay the balance in full. Patients with an outstanding balance of 60 days overdue must make payment arrangements prior to scheduling future appointments.
4. Our fees are considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 80%) of usual, customary, and reasonable by most companies. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees, which bears no relationship to the current standard and cost of care in this area.
5. If this injury is work related, and a Workers Compensation claim has been initiated we require on your initial visit that you provide us with your medical insurance to ensure payment of the account if your case is not allowed. If you already have a claim number, please provide us with the number, billing address, and adjusters contact information on the registration form. Our office does not bill to third parties.
6. Our office requires a 24-hour notice for cancellation of appointments; you can call and leave a message on the answering machine if needed. We realize conflicts with work, other activities, or unexpected illness may require you to call and reschedule, however, there will be a $80.00 charge for a missed appointment.

Again, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. It is PRO Therapy's policy to have the right to adjust specific out of pocket expenses in order to provide our patients the care they need within their financial ability to pay. If such problems do arise, we encourage you to contact us promptly for assistance. A patient must indicate, in writing, a reason for inability to pay and then the terms of agreement can be negotiated. Each case will be valid only for the term of the physician script and will be re-evaluated on a case by case basis.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask us. We are here to help you! I have read the above policies and agree. I further agree to assign insurance benefits to be paid directly to PRO Therapy and that I am responsible for non-covered services

SIGNATURE: _____DATE: _____

To: All Medicare Patients

The purpose of this letter is to inform you of your Medicare Part B benefits for out-patient physical therapy services in 2022.

Beginning January 1, 2022, Medicare re-initiated the therapy cap (a maximum benefit amount) for out-patient physical therapy and occupational therapy services. This cap replaces prior year's Medicare benefits by limiting therapy services at private out-patient clinics to a yearly dollar value. Previously therapy benefits were based on medical necessity.

The 2022 Part B deductible is $233.00. The allowable limit is up to $3,000 per calendar year for physical therapy. Of that, Medicare will pay 80%. The remaining 20% balance due is from you as a co-insurance or from your secondary insurance. This Medicare imposed dollar limit provides you a total of approximately 24 visits +/- per calendar year for all out-patient physical therapy services you may need. This is not per injury or per condition, but per calendar year for all physical therapy services you may require. With this in effect, it is important that you understand your options.

If you decide to have physical therapy at PRO Therapy, Medicare will allow up to $3,000 dollars for treatment. After your benefits ($3,000) have been exhausted, you may elect to pay "out of your pocket" for your physical therapy care. If you decide to stay at PRO Therapy to continue your treatments, payment is expected at the time of your visit. You will not be charged more than what Medicare would allow for the same service. You will be required to sign an Advance Beneficiary Notice of Non-coverage (ABN) form, which will be provided for you.

Please sign below, acknowledging that you have read the letter and understand what your Medicare benefits are for out-patient physical therapy services.

Patient's Printed Name: _____

Signature: _____

Date: _____

PRO Therapy Patient Bill of Rights

As a patient, family member, or responsible guardian, you have the right to:

- Be fully informed verbally and in writing of your rights before treatment.
- Care regardless of race, color, creed, sex, or national origin.
- Be free of verbal, physical, and psychological abuse.
- Refuse treatment and be informed of the consequences of this action.
- Exercise any of these rights as a patient of this agency.
- Receive the highest quality of care.
- Be treated with respect and dignity to yourself and your property.
- Be referred to an alternative service if the agency is unable to provide necessary care or for any reason denies service to you.
- Voice grievances regarding treatment or care or lack of respect for property without discrimination or reprisal for voicing those grievances.
- Participate in planning your care and treatment or any changes in your care.
- Be informed in advance of any changes in the plan of care before being made.
- Receive appropriate instruction and education regarding your care plan.
- Be informed in the disciplines of physical therapy and the frequency of proposed visits.
- Confidentiality of your clinical records and be informed of the agency's policy regarding the disclosure of your clinical records for any purpose.
- Review your clinical records unless contraindicated by the physician.
- Be advised in advance the extent to which payment for services may be expected from you. Patient liability will be the balance of the bill remaining after filing insurance claims with Medicare and Secondary insurances.
- Be informed of any changes in the payment for services within 15 days.
- Be informed of charges or services not covered by Medicare or any federally funded
- programs or insurance.
- Have access to all bills for services.

- Have received and read PRO Therapy, Inc.'s Notice of Privacy Practices as posted, or upon request.

Patient Signature_____ Date_____

PRO Therapy, Inc.

INFORMED CONSENT FOR PHYSICAL THERAPY

Dear Patient:

Physical Therapy involves the use of many different types of physical evaluation and treatment. At PRO Therapy, we use a variety of procedures and modalities to help us to try and improve your function. As with all forms of medical treatment, there are benefits and risks involved with physical therapy. Since the physical response to a specific treatment can vary widely from person to person, it is not always possible to accurately predict your response to a certain therapy modality or procedure. We are not able to guarantee precisely what your reaction to a particular treatment might be, nor can we guarantee that our treatment will help the condition you are seeking treatment for. There is also a risk that your treatment may cause pain or injury, or may aggravate previously existing conditions.

You have the right to ask your physical therapist what type of treatment he or she is planning based on your history, diagnosis, symptoms and testing results. You may also discuss with your therapist what the potential risks and benefits of a specific treatment might be. You have the right to decline any portion of your treatment at any time before or during your treatment session.

Therapeutic exercises are an integral part of most physical therapy treatment plans. Exercise has inherent physical risks associated with it. If you have any questions regarding the type of exercise you are performing and any specific risks associated with your exercises, your therapist will be glad to answer them.

I acknowledge that my treatment program has been explained by PRO Therapy, and all of my questions have been answered to my satisfaction. I understand the risks associated with a program of Physical Therapy as outlined to me, and I wish to proceed.

_____ _____

Patient's Printed Name Signature

Date_____

Emergency Contact’s Name and Phone Number: _____