Hand & Orthopedic Physical Therapy Associates, P.C.

Patient Name: **Date of Birth:**

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

NOTE: If Medicare doesn't pay for items listed 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 items listed below.

	Reason Medicare May Not Pay:	**Estimated Cost:**
Out Patient Physical Therapy _____		

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 services/supplies 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.

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

❑ **OPTION 1.** I want the services/supplies 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 services/supplies 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 services/supplies listed above. I understand with this choice I am **not** responsible for payment**,** and **I cannot appeal to see if Medicare would pay.**

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.

Signature:	**Date:**

HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, P.C.

ATTENDANCE AND MISSED APPOINTMENT POLICY

We strive to provide our patients with the utmost professionalism and excellence of service. Our commitment to your well being and restoration of your physical abilities is something every one in our clinic takes quite seriously.

The purpose of your rehabilitation program is to expedite restoration of maximum functional status as quickly and as safely possible. Quality care cannot be accomplished without compliance with your program, including consistent attendance in therapy.

Please schedule your therapy appointments for 4 weeks in advance.

It is important to attend all scheduled appointments. If you are unable to keep an appointment, **please call the office where your appointment is scheduled to cancel:**

Pennsylvania Locations:
Levittown Phone: (215) 943-3300
Newtown Phone: (215) 579-4300
Langhorne Phone: (215) 702-8269

New Jersey Locations:
Mercerville Phone: (609) 581-8116
East Windsor Phone: (609) 443-5500

With the exception of serious emergencies it is expected that you keep all your appointments. If you must cancel or reschedule, call as soon as possible, **at least 24 hours in advance**. In an instance of a cancellation without 24 hours notice or no-show to a scheduled appointment, **we reserve the right to charge you a $25.00 fee, which will be payable by you at the time of your next visit.**

1. If your call is taken by our answering service, please call again during regular business hours to reschedule or reconfirm any changes.

2. If you fail to attend an appointment without notifying us in advance, you are considered a “NO SHOW”. If you are a “NO SHOW”, your referring Physician and other appropriate parties may be notified and you may be considered self-discharged from our care.

3. If you cancel more than once during your course of treatment, you may not be obtaining optimal benefit from your treatment. Your therapist may recommend discontinuing treatment and your physician and other appropriate parties will be notified.

Failure to attend therapy denies you, and also other waiting patients, the opportunity for treatment. Failure to attend therapy consistently decreases your benefits from therapy.

I have read and I understand my responsibilities.

Signature of Patient/Representative_____ Date_____

Relationship of Patient Representative to Patient_____

MTW 4/24/2012

Hand & Orthopedic Physical Therapy Associates, P.C.

Medicare Beneficiaries

Consent for Care - Assignment of Benefits - HIPAA Authorization

Patients Name _____ Medicare # _____

To ensure the best possible service, the following information is provided to help you better understand your right and responsibilities as our patient.

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, P.C., to provide Care and Treatment considered necessary and proper in evaluating and/or treating my physical condition. I further authorize Hand & Orthopedic Physical Therapy Associates to release to appropriate agencies, any information acquired in the course of my examination and treatment in accordance with HIPAA Standards.

Patient/Representative_____ Date _____

Assignment of Benefits

Covered Benefits: As a courtesy, we will verify and file your claim with Medicare however we cannot guarantee payment. You are responsible for payment of any deducible, co-payment/ co-insurance and any non-covered services as determined by your contract with your insurance carrier. If you or your physician elect to continue therapy past your allowed/approved visits, payment will be expected from you. Verification is only an explanation of benefits, not a guarantee of payment for services provided.

Co-payments: Co-payments must be paid at each therapy visit according to your insurance contract. We accept cash, checks or credit cards. You will be asked to remit your co-payment at the time of service.

I have read the above statements. I authorize Medicare and any other insurer to pay any benefits directly to Hand & Orthopedic Physical Therapy Associates P.C. I further agree to pay Hand & Orthopedic Physical Therapy Associates, P.C. any portion of charges that are my responsibility.

Patient/Representative_____ Date _____

CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Your protected health information will be used by this practice, known as Hand & Orthopedic Physical Therapy Associates, P.C. and may be disclosed to others for the purposes of treatment, obtaining payment or supporting the day-to-day health care operations of the practice. We are providing you with a copy of our Notice of Privacy Practices. We request that you review the notice prior to signing this consent.

I have reviewed this consent form and have reviewed the Notice of Privacy Practices. I give my permission to this practice to use and disclose my health information in accordance with it.

Signature of Patient/Representative_____ Date_____

Relationship of Patient Representative to Patient_____

MTW 4/24/2012

HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, P.C.
HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, A NEW JERSEY PROFESSIONAL CORPORATION

LITIGATION INTAKE FORM

PATIENT: _____ DOB: _____

_____ **NO, I do not have an attorney:** *Only sign and date form.*

_____ **YES, I do have an attorney:** *Complete, sign and date form.*

LITIGATION TYPE:

_____ AUTO

_____ PERSONAL INJURY

_____ WORKER'S COMPENSATION

_____ OTHER

ATTORNEY INFORMATION:

ATTORNEY NAME: _____

FIRM NAME: _____

STREET ADDRESS: _____

CITY, STATE & ZIP: _____

PHONE: _____ FAX: _____

I attest that the above information is true. If I do not presently have an attorney, but obtain an attorney in this matter, I will immediately notify this provider.

_____ _____

PATIENT /PATIENT REPRESENTATIVE SIGNATURE DATE

MTW 4/4/2012

HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, P.C.

MEDICATION MANAGEMENT

Current Medications/Supplements

Name _____ Date _____ Date of Birth mm/dd/yyyy / / ❑ Male ❑ Female Gender

Therapist _____ Therapist Signature _____

PRESCRIPTION MEDICINES:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

OVER-THE-COUNTER MEDICINES:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

VITAMIN/NUTRITIONAL SUPPLEMENTS:

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Name: _____ Dosage: _____ Frequency: _____

Patient Signature _____ Date _____

Authorized Representative Signature _____ Date _____

HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, P.C.

PAIN ASSESSMENT

Name _____ Date _____ Date of Birth mm/dd/yyyy / / ❑ Male ❑ Female Gender

Therapist _____ Therapist Signature _____

PAIN INTENSITY: VeAS (Verbal Analogue Scale) **Scale:** 0/10 = Pain 10/10 = Worst Pain Ever

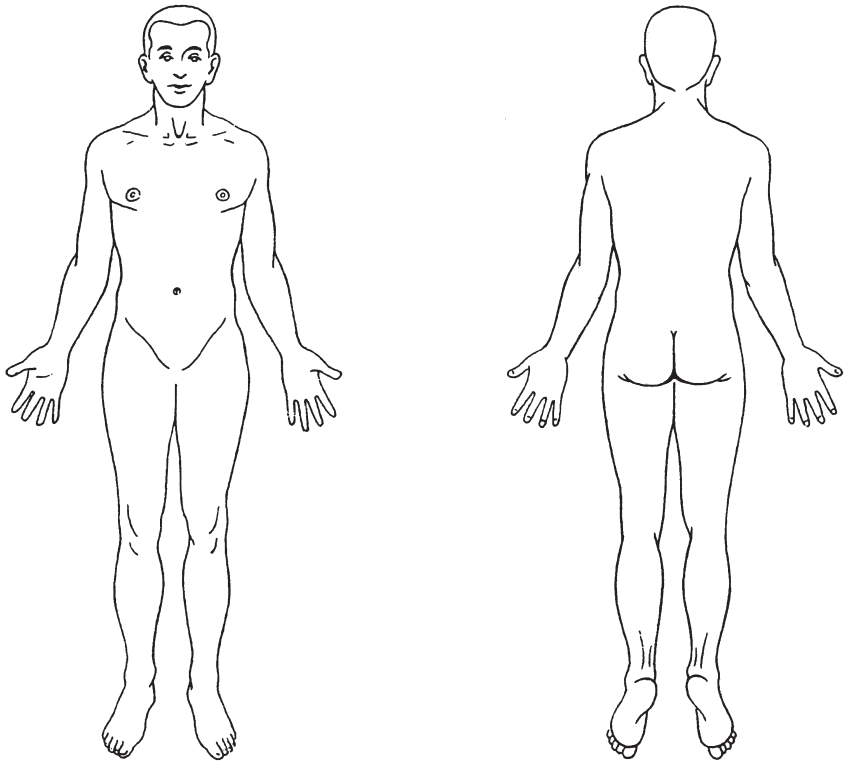
Score: Now _____ Best _____ Worst _____

VeAS (Verbal Analogue Scale) ***Place a mark on the line describing your present pain level.***

NO PAIN _____ SEVERE PAIN

Pain Qualifiers	Code	Pain Qualifiers	Code
❑ Aching	1	❑ Stiffness	7
❑ Burning	2	❑ Swelling	8
❑ Cramping	3	❑ Throbbing	9
❑ Heaviness/Fatigue	4	❑ Tingling/Pins & Needles	10
❑ Numbness	5	❑ Weakness	11
❑ Sharp/Stabbing	6	❑ Other _____	12

Location: Using the body diagram below, outline your pain/symptoms and qualify using code numbers.



Pain Assessment Follow-Up Plan	YES	NO	DATE
1. Reassessment of Pain	❑	❑	_____
2. Future Appointment	❑	❑	_____
3. Education	❑	❑	_____
4. Referral	❑	❑	_____
5. Notification Primary Care Provider	❑	❑	_____
6. Pain Management	❑	❑	_____

Patient Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

USES AND DISCLOSURES—PLEASE READ THIS IN ITS ENTIRETY AND CAREFULLY

TREATMENT: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of therapy evaluations and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

PAYMENT: Your health information may be used to seek payment from your health plan, from other sources or coverage such as payment for services to this practice, an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with full insurance coverage information, health, auto and workers compensation (if applicable), or discuss and provide an alternative method for providing

HEALTH CARE OPERATIONS: Your health information may be used as necessary to support the day-today activities and management of this practice, Hand & Orthopedic Physical Therapy Associates, P.C.
For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

LAW ENFORCEMENT: Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections to facilitate law enforcement investigations and to comply with government mandated reporting.

PUBLIC HEALTH REPORTING: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

OTHER USES AND DISCLOSURES REQUIRE YOUR AUTHORIZATION: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to evoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

ADDITIONAL USES OF INFORMATION
APPOINTMENT REMINDERS: Your health information may be used by our staff to call or send you appointment reminders.

INFORMATION ABOUT TREATMENTS: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health related goods and services that we believe may be of interest or benefit to you.

INDIVIDUAL RIGHTS: You have certain rights under the federal privacy standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections of your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

THE DUTIES OF THIS PHYSICAL THERAPY PRACTICE KNOWN AS *Hand & Orthopedic Physical Therapy Associates, P.C. and Hand & Orthopedic Physical Therapy Associates, A NJ P.C:* We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

REQUEST TO INSPECT INFORMATION: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access by asking our receptionist.

COMPLAINTS: If you believe that your privacy rights have been violated, you may submit a complaint to our practice or to the Secretary of Health and Human Services. To file a complaint with the practice, you may contact our Privacy Officer at our listed address. The practice will not retaliate against you for filing a complaint. The effective date of this notice: October 16, 2002.

HAND & ORTHOPEDIC PHYSICAL THERAPY ASSOCIATES, P.C.
PATIENT MEDICAL HISTORY

Patient: _____ Date of Birth: _____/____/_____

Referring Physician: _____ Family Physician: _____

Date of Onset/Injury: _____ Date(s) of Surgery: _____

Type of Surgery: _____

Medications and Supplements: SEE ATTACHED FORM FOR NAMES AND DOSAGES

Are you *ALLERGIC* to any medications/topicals? Yes__ No __

Name(s): _____

CURRENT PROBLEM: Any of these for the problem or injury *for which you are seeing us?*

	YES	NO		YES	NO
Chiropractor	_____	_____	Home Health Services	_____	_____
Emergency Room	_____	_____	Occupational Therapy	_____	_____
Family Physician	_____	_____	Physical Therapy	_____	_____
Hand	_____	_____	Speech Therapy	_____	_____
Neurologist	_____	_____	Bone Scan	_____	_____
Neurosurgeon	_____	_____	CT Scan	_____	_____
Orthopedic Surgeon	_____	_____	EMG/NCV	_____	_____
Physiatrist (Rehabilitation Doctor)	_____	_____	MRI	_____	_____
Plastic Surgeon	_____	_____	Myelogram	_____	_____
Rheumatologist	_____	_____	X Ray	_____	_____

Do you presently have, or have had in the Past?

	YES	NO		YES	NO
Angina, Chest Pain	_____	_____	Headaches	_____	_____
Asthma, Bronchitis, Emphysema	_____	_____	Hearing Loss	_____	_____
Arthritis	_____	_____	High Blood Pressure	_____	_____
Cancer	_____	_____	Infection	_____	_____
Congestive Heart Failure	_____	_____	Infectious Disease	_____	_____
Coronary Artery Disease	_____	_____	Osteoporosis	_____	_____
Diabetes	_____	_____	Psychological Problems	_____	_____
Dizziness/Fainting	_____	_____	Vision Problems	_____	_____
Gout	_____	_____	Any Home Health services	_____	_____

Are you, or could you be, Pregnant? Yes__ No __

Do you, or did you, use Tobacco? Yes__ No __

Have you had any (other) Surgeries? Yes__ No __

Explain: _____

_____

Do you understand your condition/injury and the expected outcomes as discussed with your physician? Yes__ No __ With this understanding, what are your goals for therapy?

GOALS: _____

Signature of Patient/Representative_____ Date_____

Reviewed By: _____ Date_____

MTW 4/4/201