ORANGE LAKE PHYSICAL THERAPY, PLLC

211 South Plank Rd. #3, Newburgh, NY 12550 • (845) 566-4303 Fax: (845) 566-4255

MEDICARE PATIENT INFORMATION

FIRST NAME_____LAST NAME_____
ADDRESS_____CITY_____STATE___ZIP_____
HOME PHONE#_____WORK PHONE#_____CELL PHONE#_____
DATE OF BIRTH_____S.S. #_____LICENSE #_____
M____F____ MARITAL STATUS: M____S____D____W____
INJURED AREA_____

HOW DID YOU HEAR ABOUT US?_____

PATIENT'S EMPLOYER INFORMATION:

ARE YOU CURRENTLY WORKING? Y_____N_____ RETIRED? Y_____N_____
EMPLOYER NAME_____
ADDRESS_____CITY_____STATE___ZIP_____
EMPLOYER PHONE #_____OCCUPATION_____

NAME OF PRIMARY PHYSICIAN_____
NAME OF REFERRING PHYSICIAN_____
DATE OF RETURN VISIT TO REFERRING PHYSICIAN_____

IF INSURED IS OTHER THAN PATIENT PLEASE GIVE FOLLOWING INFORMATION (IF SAME AS PATIENT SKIP THIS SECTION):

NAME_____ DATE OF BIRTH_____

EMPLOYER NAME_____ MEDICARE ID#_____

SECONDARY INSURANCE CARRIER_____ ID#_____

RELATIONSHIP TO INSURED_____

TO ALL MEDICARE PATIENTS:

Please read and sign the following statement. I request that payment of authorized Medicare benefits be made on my behalf to Orange Lake Physical Therapy for services furnished to me by the providers of the physical therapy group. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits as payable for related services.

PATIENTS SIGNATURE_____ DATE_____

Name:_____ Date:_____

Do you now or have you had any of the following: (Please answer Yes or No)

	YES	NO
Breathing Problems	_____	_____
Cancer	_____	_____
Diabetes	_____	_____
High Blood Pressure	_____	_____
Blood Vessel Disease	_____	_____
Heart Attack	_____	_____
Pacemaker	_____	_____
Headaches	_____	_____
Joint Replacements	_____	_____
Metal Implants/Fragments	_____	_____
Arthritis	_____	_____
Nervous System Disorder	_____	_____
Known Allergies	_____	_____
Previous Surgery	_____	_____
Dizziness	_____	_____
Pregnant Now	_____	_____
Infectious Disease	_____	_____
Fractures	_____	_____

If you checked yes to any of the above, please explain and give dates:

_____

_____

List all current medications and state condition that they are used for:

_____

_____

_____

Emergency contact person:

Name:_____

Relaltionship:_____Phone#:_____

The above is correct to the best of my knowledge.

_____ _____

Patient's or Guardian's Signature Date

APPOINTMENT POLICY AGREEMENT

I understand that my doctor has prescribed physical therapy for me and that physical therapy is an ongoing process which requires regular attendance to be optimally effective. Consequently, I am aware that not attending scheduled sessions may be jeopardizing my progress and also may adversely affect my disability status (no-fault and workers compensation).

PLEASE BE ON TIME FOR YOUR APPOINTMENTS SO THAT YOU MAY RECEIVE THE FULL BENEFIT OF YOUR SCHEDULED TREATMENT. LATE ARRIVAL OF 15 MINUTES OR MORE MAY RESULT IN A SHORTENED OR CANCELLED TREATMENT. We require 24 hours notice for cancellations. Multiple late arrivals, cancellations and/or "no-shows" will result in scheduling you on a call-in basis. Please schedule appointments at the end of the initial evaluation. We will schedule all of your appointments at once for your convenience. If you do not schedule all appointments at once, please do not assume that you automatically have the same appointments each week.

Signature:_____ Date:_____

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ASSIGNMENT OF BENEFITS/FINANCIAL POLICY

I hereby authorize the release of any medical information to my insurance company which may be necessary to process my insurance claim. I assign the payment of any medical benefits payable to Orange Lake Physical Therapy. I understand that I am financially responsible for all charges not paid for by insurance, including any and all co-payments, deductibles, collection costs or attorney fees. I understand that it is my responsibility to inform Orange Lake Physical Therapy of any changes in insurance coverage.

Co-payment amount:_____

If a check is returned for insufficient funds, you will be charged the bank fee in addition to the amount of your check which will then be due in cash. If you have any balance due on your account and it has not been paid within 90 days (unless other financial arrangements have been made), the account will be turned over to collections. Collection agency's charge 33% of the unpaid balance due. Should these additional costs be incurred, you will be responsible for the unpaid balance due plus the 33 %.

I understand and agree to comply with the Financial Policy explained above.

_____

Signature of Patient or Guardian (if minor)

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have reviewed the Notice of Privacy Practices:

Patient Name (Print):_____

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

_____

For Office Use Only

Documentation of Good Faith Efforts

Patient Name:_____ Date:_____

The patient presented for his/her procedure on this date and has reviewed a copy of the Orange Lake Physical Therapy, PLLC Notice of Privacy Practices. A good faith effort was made to obtain a written acknowledgement of review of the Notice. However, an acknowledgement was not obtained because:

_____Patient refused to sign

_____Patient was unable to sign because of medical reasons or emergency (will attempt to obtain acknowledgement at the next available opportunity).

_____Other reason _____

Signature of employee:_____ _____

ORANGE LAKE PHYSICAL THERAPY, PLLC

Dear Medicare Patient,

Medicare has implemented a cap of $1870.00 for outpatient physical therapy services for 2011. What this means is we can bill Medicare up to $1870.00 for physical therapy services. After this cap is reached, you will be done with physical therapy for the year unless your diagnosis can be found on the Medicare cap exempt list. The cap exempt list is a list of diagnosis codes where Medicare will allow long term treatment for the patient. If your diagnosis code is not on the cap exempt list, you will still receive treatment up to the cap of $1870.00. Some of you have secondary insurance that will pay what Medicare does not. Others follow Medicare guidelines 100% and will not pay once Medicare stops paying. You are also responsible for the annual Medicare deductible of $162.00. Please sign below acknowledging that you understand the above information regarding the Medicare cap and deductible.

ALSO, IT IS VERY IMPORTANT THAT YOU LET US KNOW IF YOU HAVE RECEIVED PHYSICAL THERAPY AT ANOTHER FACILITY THIS YEAR OR IF YOU ARE RECEIVING HOME CARE PHYSICAL THERAPY AT THIS TIME. OUTPATIENT PHYSICAL THERAPY WILL NOT BE COVERED AND YOU WILL BE RESPONSIBLE FOR THE CHARGES IN THEIR ENTIRETY. BE SURE THAT YOU ARE DISCHARGED FROM HOME CARE PRIOR TO STARTING OUTPATIENT PHYSICAL THERAPY.

If you have any questions or concerns, please see Susan Etri our office manager.

Orange Lake Physical Therapy

_____I acknowledge that I am responsible for the 2011 Medicare deductible of $162.00

I have_____have not_____received physical therapy elsewhere during 2011

If yes, was the physical therapy through a home care agency? _____ Yes _____No

If yes, what agency and when were you discharged_____

Print Name:_____Patient Signature:_____

Date: _____