ROZINA & SMITH
PHYSICAL THERAPY

846 W Foothill Blvd #C
Upland, CA 91786
T: (909) 985 8686
F: (909) 985-5706
rozinaandsmithpt.com

INSTRUCTIONS

1. Accurately type your information in the “patient information” form. You can press “Tab” to go forward from box to box or “Shift + Tab” to move back a box.
2. When you are finished entering all of your information, please save the document to your computer.
3. Print out and sign and initial where the lines are highlighted.
4. Bring the printed document to the clinic for your first appointment.

WHAT YOU WILL NEED FOR YOUR APPOINTMENT:

1. Appropriate clothing allowing access to the area to be treated - for example shorts, loose fitting sweat pants, t-shirt or tank top (you may be doing exercise, especially after your initial evaluation).
2. The attached paperwork.
3. Current prescription from your doctor.
4. Insurance card.
5. Medication list.

Please be sure to get a copy **of all** your appointments when you come in. If you have any questions or concerns please feel free to call our office (909) 985-8686.

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PATIENT DEMOGRAPHICS

Last Name:_____ First Name: _____ MI: _____

Social Security:_____ Gender: _____ Date of Birth: _____ Age: _____

Marital Status:_____ Height: _____ ft _____ in. Weight: _____ lbs

Address:_____ City:_____ State: _____ Zip: _____

Email Address:_____

Home Phone:_____ Primary: ☐ Y ☐ N Work Phone: _____ Primary: ☐ Y ☐ N

Cell Phone:_____ Primary: ☐ Y ☐ N Student/Employment Status: _____

Spouse Name:_____ Phone Number:_____

Emergency Contact:_____ Relationship:_____ Phone:_____

Responsible Party:_____ Phone:_____

Drivers License Number:_____ State Issued:_____

Employer Name:_____ Occupation:_____

Address:_____ City:_____ State: Zip:_____

Employer Phone:

How did you hear about us? _____

Date / Onset of Injury / Condition: _____

Have you received IN/OUT Patient Physical Therapy or any other Therapy services this calendar year?: ☐ Y ☐ N

If yes, describe services? _____

Have you received any Chiropractic Care this calendar year?: ☐ Y ☐ N If yes, number of visits: _____

Medicare Patients *Have you received Home Health Care this calendar year?*: ☐ Y ☐ N

If yes, what is the Discharge date? _____ *(Please supply copy of discharge report)*

INSURANCE INFORMATION

Primary Insurance:_____ Policy Holder Name: _____

Relationship to Policy Holder:_____ Policy Holder DOB: _____

Secondary Insurance:_____ Policy Holder Name: _____

Relationship to Policy Holder:_____ Policy Holder DOB: _____

MEDICAL HISTORY

Allergies	☐YES ☐NO	Dizzy Spells	☐YES ☐NO	MRSA	☐YES ☐NO
Anemia	☐YES ☐NO	Emphysema/Bronchitis	☐YES ☐NO	Multiple Sclerosis	☐YES ☐NO
Anxiety	☐YES ☐NO	Fibromyalgia	☐YES ☐NO	Muscular Disease	☐YES ☐NO
Arthritis	☐YES ☐NO	Fractures	☐YES ☐NO	Osteoporosis	☐YES ☐NO
Asthma	☐YES ☐NO	Gallbladder Problems	☐YES ☐NO	Parkinsons	☐YES ☐NO
Autoimmune Disorder	☐YES ☐NO	Headaches	☐YES ☐NO	Rheumatoid Arthritis	☐YES ☐NO
Cancer	☐YES ☐NO	Hearing Impairment	☐YES ☐NO	Seizures	☐YES ☐NO
Cardiac Conditions	☐YES ☐NO	Hepatitis	☐YES ☐NO	Smoking	☐YES ☐NO
Cardiac Pacemaker	☐YES ☐NO	High/Low Blood Pressure	☐YES ☐NO	Speech Problems	☐YES ☐NO
Chemical Dependency	☐YES ☐NO	High Cholesterol	☐YES ☐NO	Strokes	☐YES ☐NO
Circulation Problems	☐YES ☐NO	HIV/AIDS	☐YES ☐NO	Thyroid Disease	☐YES ☐NO
Currently Pregnant	☐YES ☐NO	Incontinence	☐YES ☐NO	Tuberculosis	☐YES ☐NO
Depression	☐YES ☐NO	Kidney Problems	☐YES ☐NO	Vision Problems	☐YES ☐NO
Diabetes	☐YES ☐NO	Metal Implants	☐YES ☐NO		

Describe any other conditions or precautions: _____

_____

FALL HISTORY

Is this injury a result of a fall in the past year? ☐Y ☐N Date of fall: _____

Have you had two or more falls in the last year? ☐Y ☐N Date of falls: _____

SURGICAL HISTORY

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

Body Region: _____ Surgery Type: _____ Date of Surgery: _____

CURRENT MEDICATIONS

Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

Drug: _____ Dosage: _____ Reason for taking: _____

CURRENT SYMPTOMS

Currently, I am experiencing (check all that apply):		☐ Fever/chills/sweats	☐ Poor balance (falls)
☐ Unexplained Weight Loss	☐ Numbness or Tingling	☐ Change in appetite	☐ Difficulty swallowing
☐ Depression	☐ Shortness of Breath	☐ Dizziness	☐ Headaches
☐ Changes in bowel or bladder function		☐ Nausea/vomiting	☐ Increased pain at night

☐ Y ☐ N	During the past month, have you often been bothered by feeling down, depressed or hopeless?
☐ Y ☐ N	During the past month, have you often been bothered by little interest or pleasure in doing things?

Is this something with which you would like help?

☐ Yes - today ☐ Yes - but not today ☐ No - I do not want help

The above information is correct to the best of my knowledge.

Patient Signature: _____ Witness: _____ Date: _____

Parent/Guardian (If patient is a minor): _____ Date: _____

PT Initials: _____

Office Use Only

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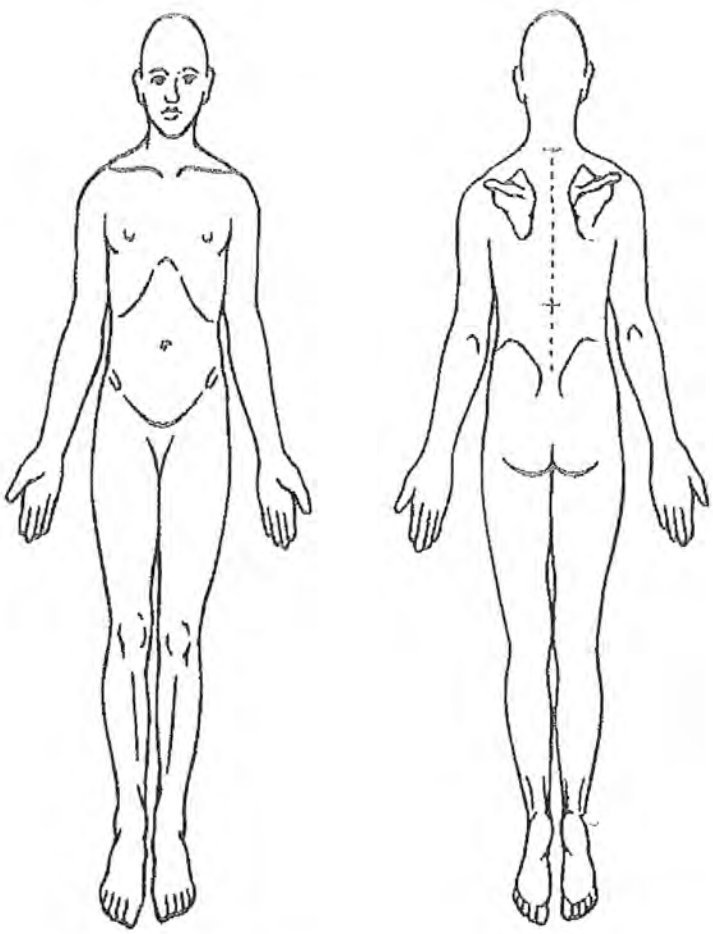
PAIN INTENSITY SCALE

- ☐ 10 Pain as bad as it could be
- ☐ 9 Excruciating
- ☐ 8
- ☐ 7 Severe
- ☐ 6
- ☐ 5 Moderate
- ☐ 4
- ☐ 3 Mild
- ☐ 2 Slight
- ☐ 1
- ☐ 0 No Pain

PAIN LOCATION BODY CHART



1. Please check the number on the pain intensity scale that best describes your pain at the present time.
2. Draw the location of your pain on the body charts above
3. If you have any other symptoms, such as tingling or numbness, draw these as a dotted line.

Please describe the details of your injury, including the date of injury and any treatment of the injury:

NAME: _____ **DATE:** _____

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OUR FINANCIAL POLICY

Please initial following each statement to authorize.

Insurance is a contract between the patient or guarantor and the insurance company and Rozina and Smith Physical Therapy only bills insurance as a courtesy to the patient. I am financially responsible to Rozina and Smith Physical Therapy for services rendered. _____

I fully understand that Rozina and Smith Physical Therapy may not accept my insurance fees as payment in full. This would lead to my receiving a bill for deductibles, co-payments, co-insurance and non-covered items. I agree to pay for any such balance. _____

I understand that it is my responsibility to obtain all necessary referrals from my doctor or Primary Care Physician as required by my insurance company. Prescriptions must be kept current from month to month. In the event that services are rendered and later denied by my insurance company(s) for lack of referral/pre-authorization, I understand it will be my responsibility to pay Rozina and Smith Physical Therapy for services rendered. _____

Unless appointments are canceled at least 24 hours in advance, our policy is to charge $25.00 for missed appointments. This charge is not covered by insurance and is your responsibility to pay. _____

ASSIGNMENT OF BENEFITS

I have read the Financial Policy. I understand and agree to this policy. I hereby authorize my insurance company to pay all benefits directly to:

Rozina and Smith Physical Therapy
846 West Foothill Blvd., Suite C
Upland, CA 91786

Patient Signature: _____ Date: _____

Parent or Guardian, if patient is a minor: _____

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PATIENT CONSENT TO TREAT

I authorize Rozina and Smith Physical Therapy Center to render appropriate treatment to me. I understand appropriate personnel will provide this treatment and that I have the right to refuse.

I authorize Rozina and Smith Physical Therapy Center to obtain or provide emergency care if conditions warrant it during a treatment session and I am unable to give consent (CPR or emergency care).

A PATIENT HAS THE RIGHT TO:

1. Be informed of the nature of their condition, the proposed treatment and alternatives, and the expected results/risks of the proposed treatment to the best of their knowledge.
2. Be fully informed about the care and treatment to be furnished and participate in the planning and changing of care and treatment. This includes refusal of all or part of the proposed treatment after being informed of expected consequences of an activity.
3. Voice grievances regarding care and treatment that is or is not furnished.
4. Be informed of any experimental treatment and not receive such treatment.

ROZINA AND SMITH PHYSICAL THERAPY HAS THE RIGHT TO EXPECT THE PATIENT TO:

1. Provide complete and accurate medical history and other necessary information in a timely fashion. This includes necessary billing information.
2. Read and ask questions about all forms and documents that are requested to be signed.
3. Participate in the development and review of the plan of treatment.
4. Adhere to the treatment plan developed by the physical therapist including home exercises.
5. Take an active role in identifying specific activities necessary for care.
6. Be present and on time for scheduled appointments.
7. Report undue stress and discomfort that may be elicited during a treatment in a timely fashion.

PATIENT INFORMATION ACKNOWLEDGEMENT

I have read and fully understand Rozina and Smith Physical Therapy's Notice of Information Practices. I understand that Rozina and Smith Physical Therapy may use my personal information for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to payment or treatment. I have been given an opportunity to obtain a copy of Rozina and Smith Physical Therapy's Notice of Privacy Practices should I ask for it.

Patient Signature: _____ Date: _____

Parent or Guardian, if patient is a minor: _____

Patient Name: _____ Case# _____

Medicare Financial Responsibility Disclosure

Effective January 1, 2017, you are responsible for an annual $183.00 Deductible. (Medicare will only pay for services after expenses exceed $183.00.)

Medicare will pay 80% of the allowable charges. You are responsible for the remaining 20%. If you have secondary insurance coverage and provide us with that information, we will bill your secondary insurance as a courtesy for you. If you do not have secondary coverage or your secondary coverage fails to pay for your services, you are responsible for the payment of the 20%.

If Medicare denies charges because you have other insurance that is considered your primary insurance, you will be responsible for all incurred charges. It is your responsibility to inform us of any other insurance coverage that you may have.

On January 1, 2017, Medicare capped payment for combined services of physical, occupational and speech/language therapy at $1,980.00.

These caps will only apply to therapy services you receive in the following places:

- **A doctor's private practice**
- **An outpatient rehabilitation facility or rehabilitation agency.**
- **A comprehensive outpatient rehabilitation facility (CORF)**
  A skilled nursing facility IF you are an outpatient.
- **A skilled nursing facility IF you are a resident but Medicare is NOT paying for your stay.**
- **At your home if therapy services are provided by a home health agency and Medicare is NOT paying for your home health care.**

You should check your Medicare summary Notices, which will tell you how much of the cap you have used. If you have any concerns that your therapy benefits will end while you still need services, please contact our office. We will be happy to help you!

Supplies:

Medicare also does not pay for certain clinical supplies used in physical therapy such as electrical stimulation pads. If electrical stimulation is indicated for your treatment, you are responsible for the purchase price of the electrical stimulation pads ($15.00). It is customary to pay for any supplies once you have received them. This is a one-time charge as the pads are reusable. For sanitary reasons, these pads are only used by you. We store them in our files under your name and dispose of them when you are discharged. Other less commonly used supplies that Medicare **does not reimburse for include Iontophoresis Pads, Electrical Stimulation Pads and tape.** If your therapist or physician feels these items are necessary, we will explain the purpose and the cost of each item before the procedure is done. You will have the option of paying for and receiving the supplies or deciding not to use the supplies.

If you have any additional questions, ask one our staff members or contact your Medicare carrier (that number is listed on the front of your Medicare Summary Notice) or call toll free: 1-800-MEDICARE

Medicare Part C (Medicare Advantage or Medicare+ Choice)
Please notify one of our office staff if your Medicare coverage is Medicare Part C coverage. Medicare Part C coverage is also known as Medicare+ Choice and is purchased and administered through a private insurance company and includes HMO, PPO, PFFS, PSO and MSA products. Medicare Part C beneficiaries pay premiums

that typically provide them with more coverage than the "traditional Medicare programs" (Medicare Part A and B) at a lower cost. Failure to provide us with this information may result in non-payment of your health claims.

- ☐ I am covered under a Medicare Advantage or Medicare+ Choice program.
- ☐ I am NOT covered under a Medicare Advantage or Medicare+ Choice program.

Medicare Home Health Services
Medicare has required that patients receiving certain Home Health Services must have outpatient therapy services consolidated with the Home Health Agency. Failure to provide us with this information may result in non-payment of your health claims by Medicare.

- ☐ I am receiving Home Health Services.
- ☐ I am NOT receiving Home Health Services

Previous Physical Therapy Services
Have you had any Physical Therapy services this year?

- ☐ Yes
- ☐ No

If yes, please provide the following:
Name of clinic: _____
Therapist: _____
Number of visits:_____

I have read and understand the preceding information regarding the Medicare financial responsibilities disclosure, Medicare rehabilitation services cap and reimbursement regarding clinical supplies. Please submit my claim to Medicare. I understand that you may bill me for items or services not covered by Medicare and that I may have to pay the bill while Medicare is making its decision.

Date:_____ _____
Signature of patient or person acting on patient's behalf

Patient Name: _____ Case# _____

Rozina & Smith Physical Therapy, Inc.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name: _____ Case# _____

Part I

1. Are you receiving Black Lung (BL) Benefits. ☐**No /**☐**Yes** : Date benefits began _____
2. Has the Department of Veterans Affairs (DVA) authorized and agreed to pay for care at this office?

   ☐**No /**☐**Yes:** DVA is primary for these services.
3. Was the illness due to a work related accident/condition? ☐**No /**☐**Yes**: Date of Injury _____

   WC Claim#_____

   WC Claims Adjuster Name/Tel#_____

   WC Carrier Name/Address_____

Part II

1. Is the illness/injury due to a non-work related accident? ☐**No /**☐**Yes**: Date of Accident _____
2. Did an automobile accident cause the illness/injury? ☐**No /**☐**Yes**
3. Is there another person responsible, auto, no-fault, or liability insurance covering these services? ☐**No /**☐**Yes**

Part III

1. Are you entitled to Medicare based on:

   ☐ Age – **Go to Part IV**

   ☐ Disability – **Go to Part V**

   ☐ End Stage Renal Disease (ESRD) – **Go to Part VI**

Part IV

1. Are you currently employed? ☐**No – Date of Retirement**: _____

   ☐**Yes – Employer Name & Address**: _____

   _____
2. Is your spouse currently employed? ☐**No – Date of Retirement**: _____

   ☐**Yes – Employer Name & Address**: _____

   _____

If you have answered "No" to all of these questions, STOP - Medicare is Primary. Otherwise, continue:

3. Do you have Group Health Plan (GHP) coverage based on your own, or your spouse's, current employment?

   ☐**Yes** - My employer employs more than 20 employees: ☐ No / ☐ Yes

   My spouse's employer employs more than 20 employees: ☐ No / ☐ Yes

   ☐**No** – STOP: Medicare is Primary.

Part V - Disability

1. Are you currently employed? ☐**No – Date Retired** _____

   ☐**Yes**: Employer Name/Address _____

   _____

Rozina & Smith Physical Therapy, Inc.

MEDICARE SECONDARY PAYER QUESTIONNAIRE

2. Is your spouse/legal sponsor currently employed? ☐**No – Date Retired** _____

   ☐**Yes**: Employer Name/Address _____

   _____

If you answered No to Part V (1 & 2), Medicare is Primary.

1. Do you have GHP coverage based on your own, or legal sponsor's, current employment?

   ☐**Yes** /☐**No** – STOP: Medicare is Primary.

2. Does the employer that sponsors your GHP employ 100 or more employees?

   ☐**No** – STOP: Medicare is Primary.

   ☐**Yes** – STOP: GHP is Primary

PART VI – ESRD

1. Do you have GHP coverage? ☐**Yes /**☐**No** – STOP: Medicare is Primary.
2. Have you received a kidney transplant? ☐**No /**☐**Yes**: Date _____
3. Have you received maintenance dialysis treatment? ☐**No /**☐**Yes**: Date Dialysis began: _____
4. Are you within the 30-month coordination period? ☐**Yes /**☐**No** – STOP: Medicare is Primary.
5. Are you entitled to Medicare on the basis of either ESRD and age or ESRD and Disability?

   ☐**Yes /**☐**No** – STOP: GHP is Primary during the 30 month coordination period.

6. Was your initial entitlement to Medicare (including simultaneous entitlement) based on ESRD?

   ☐**Yes** – STOP: GHP continues to pay primary during the 30 month coordination period.

   ☐**No** – Initial entitlement based on age or disability.

7. Does the working aged or disability MSP provision apply? (GHP primary based on age or disability entitlement)

   ☐**Yes** – GHP continues to pay primary during the 30 month coordination period

   ☐**No** – Medicare continues to pay primary

I certify that all of the information provided is true and correct.

(If someone other than the patient has filled this out, please print your name and relationship to the patient here:

_____)

_____ _____

Patient/Representative Signature Date