LESTER PHYSICAL THERAPY

Dr. Clint Lester

Patient Information

Patient Name: ____ Date: ____________ Email: _____________________________
Home phone: ______________________ Cell Phone: ______________________ Date of Birth: _________________________
Address: ____ City: _______________________ State: _______ Zip: ___________
Social Security Number: _______________________________________ Driver's License Number: ______________________
□ Male □ Female Check appropriate box: □ Minor □ Single □ Married □ Divorced □Widowed
Employer Name: ____________________________ Spouse/Legal Representative's Name: ______________________________
Spouse/Legal Representative's Employer: ____________________________
Name of your referral source: ______________________________ Emergency Contact: _________________________________
Phone: _____________________ Physician: ___________________________

Are you receiving any Home Health (HH) Services? YES NO If so, which Agency__________________________________

Date of Discharge from HH?________________________

Have you given us ALL Health Insurance coverage that you have? YES NO

Have you received any PT, OT, Speech or Chiropractic services this year? YES NO

Are we treating you for a condition as a result of an accident: YES NO Date of accident _____________

If yes, what kind of accident? __Auto Accident __Workmans Comp __Other

Briefly describe accident: ____
____

How did you hear about Lester Physical Therapy?

___Referring Provider ___Friend ___Hospital ___Former Patient ___Home Health Agency ___Internet ___Other

Name of referring entity____

Communication Preferences

May we call, email, or text you with appointment confirmations/reminders and other health-related messages? YES| NO

May we leave a message on your answering machine at the home and cell phone numbers you provide? YES | NO

May we discuss your medical condition with a member of your family? YES | NO

If YES, please name the family member(s) allowed: ____

Emergency Contact Information:

Name____ Phone________________________________

Address____ Relationship______________________________

Responsible Party

Name of Person Responsible for Account: ____

Past Medical History

Current/Past Medical Conditions:

Arthritis YES NO Cancer YES NO Communicable Diseases YES NO Numbness YES NO Seizures YES NO

Diabetes YES NO Fracture YES NO High Blood Pressure YES NO Dizziness YES NO Tingling YES NO

Metal Implants YES NO Heart Issues YES NO Joint Swelling YES NO Other______________________________

Current Medications: (include non-prescription)

____
____
____

Allergies/MedicationAllergies:

____
____

Previous Hospitalizations/ Surgeries/ Serious Illnesses: When? Hospital, City, State?

____
____
____
____

Patient Social History

Use of Alcohol: □ Never □ Rarely □ Moderate □ Daily

Use of Tobacco: □ Never □ Rarely □ Moderate □ Daily

Use of Drugs: □ Never | □ Type/Frequency: _____________________________________

Signature

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor's office of any changes in my medical status. I also authorize the healthcare staff to perform the necessary services I may need.

Signature of the Patient, Parent, or Legal Representative Date

____ ___________________

ASSIGNMENT OF HEALTH BENEFITS AND RIGHTS AND APPOINTMENT AS PERSONAL REPRESENTATIVE AND BENEFICIARY

I understand and agree that, regardless of whatever health insurance or medical benefits I have, I am ultimately responsible to pay Lester Physical Therapy, as well as all employees, employers, representatives, and agents thereof (hereinafter collectively referred to as "Healthcare Provider"), the balance due on my account for any professional services rendered and for any supplies, tests, or medications provided. I hereby authorize payment of, and assign my rights to, any health insurance or medical plan benefits directly to Healthcare Provider for any and all medical/healthcare services, supplies, tests, treatments, and/or medications that have been or will be rendered or provided. I hereby assign directly to Healthcare Provider all rights to payment, benefits, and all other legal rights under, or pursuant to, any health plan (including but not limited to any plan or insurance contract governed by the Employee Retirement Income Security Act of 1974 (ERISA) or Patient Protection and Affordable Care Act (PPACA)) that I (or my child, spouse, or dependent) may have under my/our applicable health plan(s) or health insurance policy(ies).

I also designate and appoint a Healthcare Provider as my beneficiary under all health insurance or medical plans which I may have benefits under, including but not limited to any plan or insurance contract governed by ERISA or PPACA. I also hereby appoint and designate Healthcare Provider to act on my/our behalf, as my/our Personal Representative, ERISA Authorized Representative, and PPACA Authorized Representative as to any claim determination; to request a relevant claim or plan information from the applicable health plan or insurer; to file and pursue appeals and/or legal action (including in my name and on my behalf) to obtain and/or protect benefits and/or payments that are due (or have been previously paid) to either Healthcare Provider, myself, and/or my family members as a result of services rendered by Healthcare Provider; and to pursue any and all remedies to which I/we may be entitled, including the use of legal action against the health plan, the insurer, or any administrator. I hereby also declare that Healthcare Providers can pursue any and all rights that I/we may have under state and/or federal law regarding my/our health plan.

I hereby authorize the release, in compliance with the Health Insurance Portability and Accountability Act of 1996, of any health status, conditions, symptoms, or treatment information contained in my/our Lester Physical Therapy records that is needed to file and process any insurance or medical plan claim; to pursue appeals on any denied or partially paid claims; to legally pursue any unpaid or partially paid claims; or to pursue any other remedies necessary in connection with the same.

This assignment, appointment, and designation will remain in effect unless revoked by me in writing. *It is my intent that the effective date of this document shall relate back to include all services, supplies, tests, treatments, or medications that have been previously provided by Healthcare Provider.* A photocopy or scan of this document is to be considered as valid and as enforceable as the original.

____

Patient Name

____ _______________

Patient, Parent, or Legal Representative Signature Date

PATIENT AGREEMENT

It has been our experience that those who understand and agree to the following guidelines can benefit the most from the care they receive at our office.

Visits: Our recommendations for your care are customized to your health goals and your body's needs. Please consider the following guidelines:

• Attend all appointments and arrange your other activities and responsibilities to accommodate these appointments.

• Call us as soon as possible if you have an emergency or unavoidable conflict so that we can reschedule your appointment.

New Symptoms: If you experience any new symptoms or other significant changes in your health, please let us know immediately.

Payment of Bills: We expect you to honor the financial agreement you make with our office. If you find that you cannot fulfill this financial obligation, tell our front office staff as soon as possible so that we can discuss available options. Your insurance company will be billed for services rendered if you have such insurance coverage. If you receive a check from your insurance company to pay for our services, it is your responsibility to bring it into our office within 3 days of receiving it, along with the "Explanation of Benefits" attached to the check. If you fail to bring in the insurance check and/or the "Explanation of Benefits," we reserve the right to bill you directly for those services. Available methods of payment include Visa, Mastercard, Discover, American Express, cash, or check.

Questions or Concerns: If you ever have any questions or concerns concerning your care in our office, please talk to a staff member immediately so we can help answer your questions and find you any assistance you may need.

I, the undersigned, fully understand, accept, and agree to adhere to these policies.

____
Patient Name

____ ________________
Patient, Parent, or Legal Representative Signature Date

PROVIDER STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
  Patients have the right to have their treatment and other patient information kept private. Only by law may records be released without patient permission.
- Patients have the right to access care easily and in a timely fashion.
- Patients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
- Patients have the right to the delivery of services in a culturally competent manner.
- Patients have the right to information about the organization, its providers, services, and role in the treatment process.
- Patients have the right to information about provider work history and training.
- Patients have the right to information about clinical guidelines used in providing and managing their care.
- Patients have the right to know about advocacy and community groups and prevention services.
- Patients have the right to freely file a complaint, grievance, or appeal, and to learn how to do so.
- Patients have the right to know about laws that relate to their rights and responsibilities.
- Patients have the right to know of their rights and responsibilities in the treatment process and to
- make recommendations regarding the organization's rights and responsibilities policy.
- Patients have the right to understand and help develop plans and goals to improve their health.

Patient Responsibilities

- Patients have the responsibility to treat those giving them care with dignity and respect.
- Patients have the responsibility to give providers the information they need in order to provide the best possible care.
- Patients have the responsibility to ask their providers questions about their care.
- Patients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
- Patients have the responsibility to let their provider know when the treatment plan no longer works for them.
- Patients have the responsibility to tell their provider about medication changes, including medications given to them by others.
- Patients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
- Patients have the responsibility to let their provider know about their insurance coverage and any changes to it.
- Patients have the responsibility to let their provider know about any problems paying fees.
- Patients have the responsibility not to take actions that could harm others.
- Patients have the responsibility to report fraud and abuse.
- Patients have the responsibility to openly report concerns about quality of care.
- Patients have the responsibility to let their provider know about any changes to their contact information (name, address, phone number, etc.).
- Patients have the responsibility to understand and help develop plans and goals to improve their health.

____
Patient Name

____ _______________
Patient, Parent, or Legal Representative Signature Date

Advance Beneficiary Notice of Non-Coverage (ABN)

FOR MEDICARE PATIENTS ONLY

NOTE: If Medicare doesn't pay for **D. Daily Therapy Services** below, you may have to pay. Medicare does not pay for everything, even some care that you or your healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D. Daily Therapy Services** below.

D. Daily Therapy Services	E. Reason Medicare May Not Pay:	F. Estimated Cost
◻ I. Laser Therapy ◻ II. TDN (Needle Insertion(s) without injection(s)): 20560 (1 or 2 muscles) OR 20561 (3 or more muscles) ◻ III. Iontophoresis - 97033 ◻ IV. 97014 E-stim ◻ V. 97124 Massage Therapy ◻ VI. 97110 Ther Ex ◻ VII. X-Rays ◻ VIII. 97810 Acupuncture		◻ I. $65 ◻ II. $40 ◻ III. $50 ◻ IV. $25 ◻ V. $25 ◻ VI. $25 ◻ VII. $25 ◻ VIII. $40

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 **D. Daily Therapy Services** 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.

G. OPTIONS: Check only one box. We cannot choose a box for you.
☐ **OPTION 1.** I want the **D. Daily Therapy Services** 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 aMedicare 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 copays or deductibles. ☐ **OPTION 2.** I want the **D. Daily Therapy Services** 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 **D. Daily Therapy Services** listed above. I understand with this choice I am **not** responsible for payment, and I cannot appeal to see if Medicare would pay.

H. 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.

I. Signature:	J. Date:

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