MEDICARE PATIENT & PAYOR INFORMATION FORM

***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

(2) Patient Sex: M F

Name: Last First Initial Sr. Jr.

Birthdate: ____/____/____

S.S # _____/_____/_____

Legal ID # _____

Address: Street Apt# City State Zip Code

____ **Married** ____ **Single**
____ **Other**
____ **Retired**
____ **Unemployed**
____ **Employed**

Phone: (____) ____-_____ (____) ____-_____ (___) ____-_____ / _____
Home Mobile Emergency E-Mail Address

(3) Condition to be treated in Physical Therapy: _____

Did this condition appear/occur suddenly? No Yes If Yes, Date of Onset ____/____/____

Did this condition appear gradually? No Yes If Yes, Date MD Contacted ____/____/____

Did this condition result from Surgery? No Yes If Yes, Date of Surgery ____/____/____

Did this condition result from an Accident? No Yes If Yes, Date of Accident ____/____/____

Have you had PT for this condition before? No Yes If Yes, Where? _____

When? _____ How Long? _____

Are you currently receiving Home Health? No Yes If Yes, From Who? _____

Do you live in a nursing home? No Yes If Yes, What Is Its Name? _____

Are you covered by Black Lung Disease? No Yes

Are you covered by End Stage Renal Disease? No Yes

Are you covered by Group Insurance? No Yes If Yes Name/GP # _____

(4) Patient's Doctor: *Is this the Primary Care Physician (PCP)? Y N*

*If not, please also complete the **PCP** section below*

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (____) ____-_____

Address: Street Apt/Suite# City State Zip Code **Office Fax:** (____) ____-_____

PCP- **Primary Dr's Name:** Last First Initial MD, DO, DDS, Other **Office Phone:** (____) ____-_____

Address: Street Apt/Suite# City State Zip Code **Office Fax:** (____) ____-_____

All Patients or Patients' Legal Representative Please Sign Section 6 on Page 2

MEDICARE PATIENT & PAYOR INFORMATION FORM

(5) Payment Authorization: *(Initials required for all 3 statements)*

_____ **Assignment of Insurance Benefits**

Initials — **I authorize that the payment of my insurance benefits be made directly to Mangan Physical Physical for any services that are reimbursable by Medicare or my any other insurance company, if I have one.**

_____ **Guarantee of Payment**

Initials — **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Certification of Information**

Initials — **I certify that the information I have provided Mangan Physical Therapy for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(6) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

Acknowledgment Of Receipt Of Notice Of Privacy Practices And Treatment Consent

My signature below indicates that I have been given the Notice Of Privacy Practices And Treatment Consent for Mangan Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain health care operations or as permitted or required by law I must give my written authorization to Mangan Physical Therapy to release any of my protected health care information.

I acknowledge giving consent to treatment at Mangan Physical Therapy.

_____

Patient or Authorized Representative's Signature & Date

24 Hour Appointment Cancellation Policy

Mangan Physical Therapy has a 24 hour cancellation / rescheduling policy.

If you miss your appointment, cancel or change your appointment with less than 24 hours notice, you may be charged $30.

This policy is in place out of respect for our therapists and our clients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all, you prevent someone else from being able to schedule into that time slot.

By signing below, you acknowledge that you have read and understand the Mangan Physical Therapy policy as described above.

Thank you for your understanding and cooperation.

_____

Printed Name

_____

Signature and Date

ADVANCED BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services

Advance Beneficiary Notice

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for:**

____ Any additional physical therapy because of the 'maintenance' nature of your care (no significant or measurable improvement noted or expected and/or not requiring complex and skilled procedures)

____ Any additional physical therapy because the duration of your care has exceeded or will exceed what Medicare considers 'reasonable' for your diagnosis and that the delivery of additional services is not essential to your recovery

____ Any additional physical therapy because the frequency of your care has exceeded what Medicare considers 'reasonable' for your diagnosis and that the delivery of additional services is not essential to your recovery

____ Modality _____ Procedure _____ because this treatment is not considered medically necessary for your condition

____ Supply _____ Medicare does not pay for this item

Please Choose ONE Option. Check ONE Box. Sign & Date Your Choice

☐ **Yes. I want to receive these items or services**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and full responsible for payment. That is, I will pay personally, either out of my pocket or through any other insurance that I have. I understand that I can appeal Medicare's decision.

☐ **No. I do not want to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

_____ _____

Date Signature of Patient or Patient's Representative

MEDICAL HISTORY HAVE YOU EVER HAD ANY OF THE FOLLOWING? PLEASE CIRCLE YES OR NO

HIGH BLOOD PRESSURE	YES NO	CANCER	YES NO
CARDIAC CONDITIONS	YES NO	VISION PROBLEMS	YES NO
HEART ATTACK	YES NO	METAL IMPLANTS	YES NO
CIRCULATION PROBLEMS	YES NO	PACEMAKER	YES NO
SEIZURES	YES NO	DIZZY SPELLS	YES NO
STROKE	YES NO	DIABETES	YES NO
FRACTURES	YES NO	ARTHRITIS	YES NO
SENSITIVITY HEAT	YES NO	SENSITIVITY COLD	YES NO
ARE YOU PREGNANT	YES NO		

HAVE YOU HAD SURGERY?

_____

_____

_____

LIST ALL MEDICATIONS YOU ARE TAKING

_____

_____

_____

PLEASE DESCRIBE ONSET OF SYMPTOMS AND CURRENT PRESENTATION_____

_____

_____

_____

_____

_____

PATIENT NAME_____DATE_____

PAIN GRAPH

PLEASE INDICATE ON THE BODY GRAPH WHERE YOU HAVE PAIN AND HOW MUCH ON A 0-10 SCALE.

10 WORST PAIN POSSIBLE

9 EXCRUCIATING

8

7 SEVERE

6

5 MODERATE

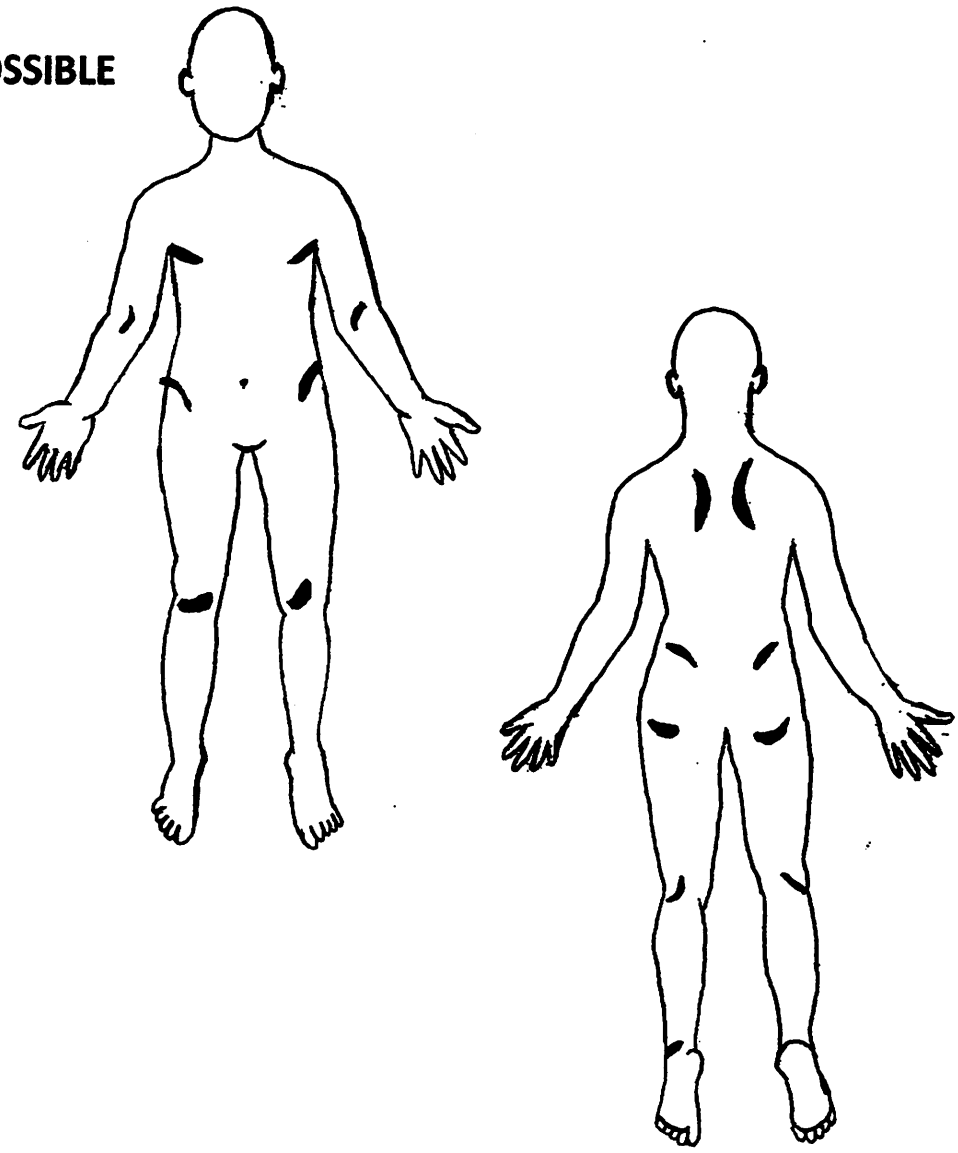
4

3 MILD

2

1 SLIGHT

0 NO PAIN



HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information.
Please Review This Document Carefully.

1. About Protected Health Information (PHI).

In this Notice, "we", "our" or "us" means this FACILITY and our workforce of employees, contractors and volunteers. "you" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

2. Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information

We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

Cont. 2. Uses and Disclosures

- Treatment

We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optical care is rendered.

- Payment

After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payor may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

- Health Care Operations

We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of real patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

- Special Uses

We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:

i. Remind you of appointments
ii. Carry out follow ups on home programs that you have been taught
iii. Advise you of new or updated services or home supplies

Cont 2. Uses and Disclosures

- Uses & Disclosures Required or Permitted by Law

Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

Permitted:

i. If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
ii. We may use your PHI in an emergency if you are not able to express yourself
iii. If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research

Required:

i. When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
ii. For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
iii. To report neglect, abuse or domestic violence
iv. To the government regulators or its agents to determine whether we comply with applicable rules and regulations
v. In judicial or administrative proceedings such as a response to a valid subpoena
vi. When properly requested by law enforcement officials or other legal requirements such as reporting gun shot wounds
vii. To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
viii. Deemed necessary by appropriate military command authorities if you are in the Armed Forces
ix. In connection with certain types of organ donor programs

- Stricter Requirement That We Follow

We will follow any and all State regulations should they be stricter than these federal privacy regulations

3. Your Authorization May Be Required

In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

4. Your Privacy Rights and How to Exercise Them

You have specific rights under our federally required privacy program. Each of them is summarized below:

- Your Right to Request Limited Use or Disclosure
  You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right
- Your Right to Confidential Communication

You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing

- Your Right to Inspect and Copy
  You have the right to inspect and copy your PHI. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.
- Your Right to Revoke Your Authorization
  If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope
- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that write. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the
  amendment we must notify you and make effort to notify others who have the original record

Cont. 4 Your Privacy Rights and How To Exercise Them

- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years; however you may not ask for disclosures that occurred prior to April 14, 2003. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually, we have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.
- Your Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us or to the Secretary of Health and Human Services. We will not retaliate against you if you file a complaint about us. To file a complaint with us please contact the person identified below in this Notice. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

5. Some of Our Privacy Obligations and How We Perform Them

   We are required to comply with the federal health information privacy regulations. Those rules require us to protect your PHI. Those rules also require us to give you Notice of our Privacy Practices. This document is our Notice. If you did not get a paper copy of this Notice, you may request one. We will abide by the privacy practices set forth in this Notice. However, we reserve the right to change this Notice and our Privacy Practices when permitted or required by law.

   If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

6. Contact Information

   If you have questions about this Notice, or if you have a complaint or concern, please contact:

   Privacy Office Hotline/ Office of HIPAA Compliance (OHC)

   Phone: (916) 445-4646

   Toll-free Number: (866) 866-0602

   E-mail: privacyofficer@dhcs.ca.gov

7. Effective Date: This notice takes effect on April 14, 2003