

ADVANCE BENEFICIARY NOTICE (ABN)

Name _____ Date _____ Medicare Number _____

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

As of September 1, 2003, Medicare instated a \$1590.00 cap for outpatient physical therapy benefits. 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 the following items or services because: Medicare believes there is not enough substantial evidence to prove these items or services advantageous to the patients recovery process.

1. Iontophoresis
2. Dexamethazone
3. Massage Therapy

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make any decisions about your options, you should:

1. Read this entire notice carefully.
2. Ask us to explain, if you do not understand why Medicare probably will not pay.
3. Ask us how much these items or services will cost you (Estimated Cost \$_____), in case you have to pay for them yourself or through other insurance.

Please choose one option. Check one box. Sign and date your choice.

Option 1: 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 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 fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

Option 2: NO, I have decided not 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 will not pay.

Signature of Patient or Person acting on Patient's Behalf

Date

Note: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.



Authorization to Release Information

I hereby authorize *Kate Grace Physical Therapy* to release any information acquired in the course of my evaluation or treatment for billing purposes.

Signed by the subscriber

I hereby authorize *Kate Grace Physical Therapy* to release any information regarding my medical condition to the attending or referring medical practitioner.

Signed by the subscriber

Authorization to Pay Benefits

I direct that payments be made directly to *Kate Grace Physical Therapy*. I understand that I am financially responsible for all charges not paid by my insurance. I also understand that all payments made directly to me are to be forwarded to this office.

Signed by subscriber

Please Print Name _____



CLINIC POLICIES

Name: _____

Date: _____

Welcome to KATE GRACE PHYSICAL THERAPY. We look forward to serving all of your physical therapy needs. As a new patient with our office, we would like you to be familiar with our office policies concerning your scheduling and account while you are with us. Please feel free to ask any questions regarding the following.

1. You will meet your therapist at your first appointment. Please be ready to begin your appointment at your scheduled time. To be fair to all patients, we will not run over the allotted time period.
2. All appointments are scheduled at the front desk. Any questions regarding your schedule please call 858-457-3545.
3. We require a 24 hour notice to change or cancel a scheduled appointment. If you fail to show or cancel your appointment without a 24 hour notice you will be charged \$60.00. Payment is due before your next appointment. These charges are the patient's responsibility and cannot be billed to your insurance company or work comp carrier.
4. Our office is happy to courtesy bill your insurance. We do not accept liens or third party payors. We will also courtesy call your insurance to verify your PT benefits. There is no guarantee of payment by your insurance, until the claim is received and processed. The patient's personal portion will be due after every visit and is collected at the front desk. Please be advised we are estimating what your portion will be based on the information received when benefits are quoted. An additional amount may be due after your insurance pays on the claim. Any overpayment will be refunded to the patient when the account is settled with your insurance. Any questions regarding your account please contact our business office at 619-260-0999.
5. The patient's personal portion of their insurance policy will be due after every visit and is collected at the end of the week. Patient may pay by MasterCard/Visa, personal check, or cash.
6. In the event any action is taken to enforce collection of this account, the presiding party will be entitled to recovery of all legal fees incurred.

The undersigned certifies that he/she has been informed and has read the foregoing and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

Signature _____ Date _____

Witness _____ Date _____

COMPLIMENTARY 30 MINUTE THERAPUTIC MASSAGE

Do you have friends, family members, or co-workers who have aches and pains?
Do you know someone who would like to increase their athletic performance?
Do you know someone who would like to start a fitness program?
We want to HELP!

Refer them to Kate **Grace Physical Therapy**.
To express our appreciation for your referral, you will receive a

Complimentary 30 Minute Massage
from one of our highly trained Massage Therapists.
Please contact us at 858-457-3545 to arrange a time for your massage
or simply stop at the Front Desk during one of your visits to our clinic.

Please complete the following information for our records:

Your Name: _____	Phone: _____
Patient Referred: _____	Phone: _____



Dear Patient,

Your insurance may pay your total bill for services rendered at ***Kate Grace Physical Therapy***. However, it is likely that your insurance will pay some portion of the charge(s). The unpaid portion of the bill is your responsibility. Please contact your insurance carrier directly if you feel your insurance company has underpaid its portion. Please remember that you are responsible for your deductible and co-payment. You will receive a monthly statement indicating the status of your account with ***Kate Grace Physical Therapy***.

Cash Pay Patients: Even though you may have health insurance benefits that would pay all or some portion of your physical therapy charges, you may choose to pay cash for services rendered at Kate Grace Physical Therapy.

If at any time during the period you are a patient at Kate Grace Physical Therapy you decide to stop paying cash and start using your insurance benefits you have one of two options:

Option 1: Your insurance will be billed from the date of service you decide to start using your insurance moving forward. Any prior visits paid for using cash **will not** be billed retroactively.

Option 2: If you want your insurance to be billed retroactive to your first date of service, you will pay \$10 for each date of service in the past to cover the administrative costs of retroactive billing.

We believe that you are entitled to the benefits of your insurance plan and we believe the services provided to you by Kate Grace Physical Therapy are within these benefits. You, as a plan member, are always more successful at dealing with your insurance company directly. Please make an effort to defend your rights as a member in your plan. You deserve the best care possible and you certainly have the right to demand excellent care.

If there is anything we can do to assist you, please do not hesitate to ask for help. Thank you for your cooperation in this matter.

Warm regards,

Kate Grace Physical Therapy



Waiver in Connection with use by Members and Guests of Kate Grace Physical Therapy

The execution of this form is a condition to use by member and guests of Kate Grace Physical Therapy. This form is intended to affect your right to maintain certain claims and legal actions against Kate Grace Physical Therapy weight/exercise room in the event of illness or injury and should be read carefully.

As a condition to my use of the Kate Grace Physical Therapy weight/exercise room, I agree to indicate in the space provided below any health problems or physical impairments which would affect my ability to participate in exercise programs or otherwise engage in exercises at Kate Grace Physical Therapy.

I hereby release Kate Grace Physical Therapy (the owners of the facility), its agents, directors and employees and its and their successors and assigns from any and all claims and demands of whatever nature for any and all losses, expenses, damages and costs suffered or incurred by an account of, or in any way growing out of illness or injuries which I may suffer or sustain by virtue of my use of the Kate Grace Physical Therapy weight/exercise room except for illness or injury suffered or sustained by me as a direct result of the gross negligence or willful misconduct of Kate Grace Physical Therapy or its owners, guests, directors and employees. No employee nor agent of Kate Grace Physical Therapy has the authority to alter in any way the provisions stated herein.

I have read the foregoing and understand it and any questions I may have asked regarding the use of the Kate Grace Physical Therapy weight/exercise room have been answered to my satisfaction.

Name Printed

Member/Guest Signature

Date

Statement of Member/Guest as to physical impairment(s)

Does the member/guest have any physical impairment(s) or illness which could affect his/her participation in an exercise program(s) at Kate Grace Physical Therapy?

Yes _____ No _____

If yes, please
explain _____



NOTICE OF PATIENT INFORMATION PRACTICES

****THIS NOTICE DESCRIBES HOW YOUR PERSONAL MEDICAL INFORMATION MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCESS TO THE INFORMATION. PLEASE REVIEW CAREFULLY.****

KATE GRACE PHYSICAL THERAPY'S LEGAL DUTY

Kate Grace Physical Therapy is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Kate Grace Physical Therapy uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, **Kate Grace Physical Therapy** may use your personal health information to contact you to provide appointment reminders, information about treatment alternatives, or other health related benefits that could be of interest to you.

Kate Grace Physical Therapy may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies, or for emergencies. We also provide information when required by law.

In any other situation, **Kate Grace Physical Therapy's** policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Kate Grace Physical Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in the waiting room and patient exam areas and will be provided to you on your next visit. You may also request a copy of our Notice Of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes.

You may also request in writing that we are not to use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. **Kate Grace Physical Therapy** will consider all such requests on a case by case basis, but the practice is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that **Kate Grace Physical Therapy** may have violated your privacy right or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our practice manager at the address listed above. You may also send a written complaint to the US Department of Health and Human Services.



PATIENT HISTORY

Patient Name: _____ Clinical Record #: _____

Mark an "X" next to any of the following which you currently have or have had in the past:

- | | | |
|----------------------------|---------------------------|---------------------------|
| _____ Circulatory Disorder | _____ Heart Disease | _____ Heart Attack |
| _____ Surgery | _____ Sensitivity to Heat | _____ Sensitivity to cold |
| _____ High blood pressure | _____ Hernia | _____ Allergies |

If you marked an "X" next to any of the above, please explain and give appropriate dates:

Are you presently taking and medication on a regular basis? _____ Yes _____ No

If yes, please list them and explain for what reason: _____

Mark an "X" next to any of the following with which you need assistance:

- | | | |
|------------------------|---------------------|-----------------------|
| _____ Transportation | _____ Meals | _____ Domestic Chores |
| _____ Shopping/Errands | _____ Personal Care | _____ Other |

Mark an "X" next to any of the following which your illness/disability has caused:

- _____ Financial Problems _____ Family Problems _____ Emotional Problems _____ Other

Please explain _____

What form of treatment have you previously received? _____

Are you prevented from doing anything you use do? _____

What are your goals for treatment? _____

Date _____ Patient Signature _____



Patient Intake Questionnaire

Date: _____

Patient's Name: _____

Age: _____ Sex: _____

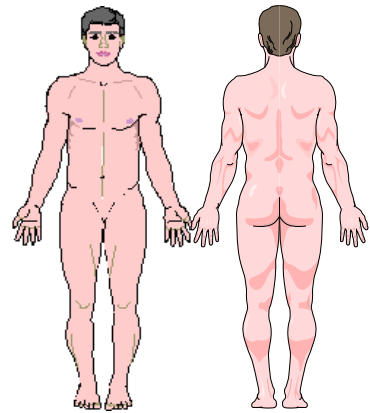
Kate Grace Physical Therapy
8929 University Center Lane
Suite 200
San Diego, CA 92122
858-457-3545
www.kgpt.com

About your current complaint:

1. What is the complaint that brought you here? _____
2. When did this complaint begin, or recently become worse? Approximate Date: _____
3. What caused this complaint? _____
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness: Yes No
 If "Yes", what activities? _____

5. What makes this complaint better? _____
6. Does this complaint affect your comfort, mood, or ability to sleep? Yes No

7. What symptoms are you experiencing with this complaint?
 Swelling Loss of balance or coordination
 Loss of motion Numbness Pain: Draw pain areas on body diagrams ->
 Weakness Tingling Other (Specify) _____



8. How frequent are the symptoms experienced? Constant Intermittent
9. How much pain are you experiencing?
 None Very Mild Mild Moderate Severe Very Severe

10. What tests have you had for this complaint?
 X-ray CT Scan MRI Myelogram Bone Scan
11. What treatment have you had for this complaint? Physical Therapy Occupational Therapy
 Athletic Training Chiropractic Alternative Medicine-(Specify): _____
12. Is this complaint work related? Yes No

If "Yes", your employer's name: _____ Your Occupation: _____
 Work Status: Full Time Part Time Working Medical Restrictions Medical Leave Last Date Worked: _____

13. Is this complaint auto related? Yes No

About your general health:

14. Please check all medical conditions that you have, or have had.
 Arthritis Heart Disease Stomach Disorder Headaches Pace Maker
 Cancer High Blood Pressure Anxiety Dizziness Other: _____
 Diabetes Lung Disease Depression Metal Implants
 Stroke/Seizure Thyroid Problems Panic Attacks Morning Stiffness

15. Please check all of the following items that currently apply to you.
 Hearing Problem Visual Problems Learning Problems
 Pregnant Bowel or bladder control Smoker Recent weight loss

16. Please list surgeries: _____

17. Please list allergies: _____

18. Please list medications you are currently taking: _____

19. What goals do you want to achieve through your treatment at Kate Grace Physical Therapy? _____

PATIENT RIGHTS

The following is our policy regarding the rights of the patients receiving service from **Kate Grace Physical Therapy**. Each patient has the right to:

- A. Be fully informed of his/her rights as well as all rules and regulations of **Kate Grace Physical Therapy** governing patient expectations.
- B. Be fully informed at the time of admission of services available and related charges not covered under Title XVIII of the Social Security Act.
- C. Be fully informed by a physician of his/her medical condition unless medically contraindicated, and to be afforded the opportunity to participate in the planning of his/her medical treatment.
- D. Refuse treatment to the extent permitted by law and to be informed of the medical consequences of such refusal.
- E. Be assured confidential treatment of clinical records and to approve or refuse their release to any individuals, except in the case of transfer to another health care facility, or as required by law or third party payment contracts.
- F. Be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and care of personal needs.
- G. Be informed by **Kate Grace Physical Therapy** of the provision of the law regarding complaints and of procedures for registering complaints confidentially including, but not limited to the address and telephone number of the complaint receiving unit of the California Department of Health Services.
- H. Be assured that personnel who provide care are qualified through education and experience to carry out the services for which they are responsible.
- I. Be informed that these rights may be denied for good cause only by the attending Physical Therapist. Denial of such rights shall be documented by the attending Physical Therapist in the patient's clinical record.

Any complaints regarding denial of patients rights not satisfied after a discussion with **Kate Grace Physical Therapy** may be registered in confidence with the California Department of Health Services. Upon request, the staff of **Kate Grace Physical Therapy** will assist the patient to contact the appropriate office of the state agency.

