Continuum Wellness
Physical Therapy & Sports Rehab

PATIENT NAME_____ **DATE** _____
Last First

Social Security #_____-_____-_____ **Date of Birth**_____/_____/_____ **SEX: M F**

Address _____
City State/Zip

Secondary Adress _____
City State/Zip

Primary Phone # (_____)_____ **Secondary Phone #** (_____)_____
Please circle: Cell or Home **Please circle**: Cell or Home

Email Address _____

Employer _____
Name Address /City/State/Zip Phone

Emergency Contact _____ **Relationship to Patient**_____ **Phone**_____

Referring Physician_____ **Phone**_____

Person Responsible for Payment_____/_____
Name Relationship to Patient

Address _____ **Phone**_____
Street City State/Zip

INSURANCE INFORMATION:

PRIMARY INSURANCE: _____

Policy/ID Number:_____ **Group Number:**_____

POLICY HOLDER: _____ **Policy Holder Date of Birth**_____/_____/_____

Relationship to Patient: Self Spouse Parent Guardian Other_____ Phone:_____

Policy Holder Address:_____
Street City State/Zip

SECONDARY INSURANCE: _____

Policy/ID Number:_____ **Group Number:**_____

POLICY HOLDER: _____ **Policy Holder Date of Birth**_____/_____/_____

Relationship to Patient: Self Spouse Parent Guardian Other_____ Phone:_____

Policy Holder Address:_____
Street City State/Zip

SIGNATURE_____ **DATE**_____

HOW DID YOU HEAR ABOUT US: REFERRING DOCTOR FAMILY / FRIEND INTERNET LOCATION OTHER

INITIAL PATIENT QUESTIONNAIRE

This questionnaire is designed to help us obtain necessary information about your health problems and activity level. Completing the form as completely as possible will help us to develop the most effective treatment program to meet your needs. If you have difficulties answering or understanding these questions, please ask for assistance.

NAME: _____ **Date:** _____

DOB/Age: _____ **Sex: M F** **Height** _____ **Weight** _____

What is your injury? _____

_____

Date of injury/onset of symptoms? _____

What is the mechanism/cause of injury? _____

Have you had previous treatment for this condition? Y N

If yes, what type of treatment? _____

Was there surgery? Y N **If so, what type of surgery?** _____

Date of surgery: _____

Where is your pain located? _____

Please indicate all symptoms:

	___ Ache/Dull pain	___ Burning	___ Numbness
___ Other: please explain:	___ Spasm/Cramp	___ Pins & Needles	___ Stabbing/Sharp Pain
_____	___ Stiffness	___ Shooting Pain	___ No pain

Please circle the numbers that indicate your pain level in the following categories. **Zero** indicates **no pain** and **ten** indicates the **worst** your symptoms have been.

WORST:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
CURRENT:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
BEST:	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

What increases your pain? _____

What activities, movements or treatments relieve your pain? _____

_____

PAST MEDICAL HISTORY

Please check if you experience any of the following:

___ Asthma ___ Diabetes ___ Lung Disease ___ Psoriasis

___ Allergies ___ Heart Disease ___ Gout ___ Rheumatoid Arthritis/Disease

___ Alcoholism ___ High Blood Pressure ___ Cancer ___ Seizure Disorder

___ Faintness ___ Difficulty Controlling ___ Osteoarthritis/ ___ Lupus Erythematosis

___ Bowel or bladder ___ Joint disease

___ Muscle Weakness/Where? _____ ___ Numbness/Where? _____

___ Joint Pain/Where? _____ ___ Swelling/Where? _____

___Other _____

Current Medications Prescription/over the counter:

_____

_____

_____

Have you undergone any special testing recently Y N

If so, which ones: XRAY MRI CAT SCAN BONE SCAN Dates: _____

EMG EKG STRESS TEST INJECTION _____

Please list all surgeries in the last 5 years? _____

_____

WORK HISTORY

Current Work Status: ___Full-time ___Part-time ___ Light Duty ___ Not Working ___Unemployed

Where do you work? _____

What is your vocation/profession? _____

Briefly describe your tasks at work? _____

_____

Are you currently off work? Y N

When did you stop working? _____ **When do you return to work?** _____

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INSURANCE VERIFICATION ACKNOWLEDGEMENT

Date:_____

I_____ understand that Continuum Wellness has
Patient/Guardian

contacted my insurance company, _____, in
Insurance Company

A good faith effort to obtain my benefit information including co pay, co-insurance and deductible portions that may be my obligation should insurance deem me responsible. However, Continuum has explained to Me and I am fully aware that this information obtained from the insurance company is by no means a guarantee of payment by my insurance and therefore agree to pay any unpaid portion that my insurance deems my responsibility.

_____ _____
CONTINUUM WELLNESS REPRESENATIVE PATIENT/GUARDIAN

A. Notifier:

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

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

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy	***Benefits Exhausted** ***Deductible Not Met** ***Currently Having Home Health Or Not Discharged Yet**	**105.00 – 135.00 Per Visit**

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.** _____ 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.** _____ 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 a Medicare 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 co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** _____ 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.** _____ 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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Authorization for Release of Protected Health Information

Patient Name: _____ Med Rec / Account #_____
Date of Birth: _____

I hereby authorize Provider to release information from my medical records to the following entity or persons:
Name: _____
Address: _____
Fax: _____ Email: _____

Please check type of information to be released:
- ☐ Entire Medical Record ☐ Registration Forms ☐ Billing / Financial Records
- ☐ Other (Specify) _____

Drug and/or Alcohol Abuse, and/or Mental Health, and/or HIV/AIDS Information Release
Please answer YES or NO to each of the following questions to indicate your permission for us to release the following information (if it is contained in your medical record):

Alcohol & Drug Abuse ☐**YES** ☐**NO**
Genetic Test Results ☐**YES** ☐**NO**
Domestic Violence Counseling ☐**YES** ☐**NO**
HIV/AIDS Test Results ☐**YES** ☐**NO**
Mental Health Diagnosis/Treatment ☐**YES** ☐**NO**
Sexual Assault Counseling ☐**YES** ☐**NO**

I understand that:
- I may withdraw my authorization at any time by submitting a written request to the Privacy Officer. My authorization may be withdrawn except for the following:
  - To the extent that action has been taken in reliance on this authorization.
  - If the authorization is obtained as a condition of obtaining insurance coverage, other laws provide the insurer with the right to contest a claim under the policy.
- I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility benefits will not be affected.
- Information released on this authorization, if re-disclosed by the recipient, is no longer protected by Provider.
- This authorization expires: **___ 1 year from date below ___ One time disclosure only ___ Other:_____**

I have carefully read and understand the above, have had any questions explained to my satisfaction, and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons or agencies listed above.

Patient's Signature: _____ Date: _____
Print Name: _____ **(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: ☐ Parent ☐ Medical Power of Attorney (attach documentation)
☐ Other _____ (Explain and Attach Documentation)

Signature must be verified by Provider staff OR must be notarized. When completed, please place in patient record.

_____ _____ _____
Signature of staff member **Print Name** **Date**

SUBSCRIBED AND SWORN before me this _____day of _____, 20_____.
My commission expires:

_____
Notary Public Signature

For Internal Use Only

Information Released/Reviewed By: _____ Date: _____
Clinic/Office: _____

Rev 12/2014

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Date :_____

Patient Name: _____Med Rec # / Account#_____

I hereby acknowledge that I have received Notice of Privacy Practices of Provider.

Patient's Signature: _____ Date: _____
Print Name:_____**(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)_____
_____

(FOR OFFICE USE ONLY IF PATIENT DOES NOT SIGN ABOVE)
DOCUMENTATION OF GOOD FAITH EFFORTS TO OBTAIN ACKNOWLEDGEMENT

Patient Name:_____

Date:_____
The Patient presented for service on the date set forth above and was provided with a copy of the Notice of Privacy Practices ("Notice"). A good faith effort was made to obtain the Patient's written acknowledgement of receipt of the Notice. However, an acknowledgment was not obtained for the following reason(s):

□ **Patient refused to sign acknowledgement.**

□ **Patient was unable to sign the acknowledgement because:**
_____
_____

□ **Other reason (describe below):**
_____
_____
_____

Name of Employee Completing Form: _____

Signature:_____

Date: _____

Continuum Wellness
Physical Therapy & Sports Rehab

Medicare Secondary Payer Form

Date :_____

Patient Name: _____Med Rec # / Account#_____

Dear Medicare Patient:

As a direct result of mandated Medicare Secondary Payer (MSP) regulations, we are required to gather the following information to determine if Medicare is your primary insurance.

1. Is the illness/injury due to an automobile accident, liability accident or Workman's Compensation?	□**Yes**	□**No**
2. Is illness covered by the Black Lung Program or Veterans Administration program?	□**Yes**	□**No**
3. If under 65, are you a renal dialysis patient in your first 30 months of Medicare entitlement?	□**Yes**	□**No**
4a. **If under age 65**, is your Medicare coverage due to disability?	□**Yes**	□**No**
4b. If patient has Group Health Plan coverage based on their own or their spouse's employer, does that employer have **20 or more employees**?	□**Yes**	□**No**
5. **If 65 and over**, and patient have Group Health Plan coverage based on their own or their spouse's employer, does that employer have **100 or more employees**?	□**Yes**	□**No**

Registrar Notes:

A. If patient responds "no" to questions 1-5, Medicare is primary.
B. If patient responds "yes" to any questions, Medicare is secondary and primary insurance information must be obtained.

Name of Insurance Company _____
Address of Insurance Company _____
Name of Policy Holder _____
Policy Number _____
Policy Holder's Employer Name _____
Policy Holder's Employer Address _____
Date of Accident (if applicable) _____

Home Health Section – REQUIRED

******Have you received Physical, Occupational or Speech Therapy from the following?**

Skilled Nursing Facility □ Yes □No **Home Health Agency** □ Yes □No **Date Discharged:** _____
Do you have a copy of your discharge letter? □ Yes □No

Home Health Agency Name / Phone #: _____

Protocol for Resolving Medicare Complaints From Medicare Beneficiaries

The patient has the right to freely voice grievances and recommend changes in care or services without fear of reprisal or unreasonable interruption of services. All complaints will be handled in a professional manner. All logged complaints will be responded to in writing or by telephone by a front office manager and investigated by the Medicare Compliancy Officer within five (5) business days after the receipt of the complaint. If there is no satisfactory resolution of the complaint, the next level of management will be notified progressively and up to an owner of the company.

_____ _____
Patient/Guardian/Responsible Party signature Date

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Date :_____

Patient Name: _____Med Rec # / Account#_____

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to the use and disclosure of my health information for treatment provided to me by **Provider**, payment for services provided by the Provider or other health care providers and the operations of the Provider and others under certain circumstances. I understand that a more detailed explanation of the ways the Provider may use and disclose my health information is contained in the Notice of Privacy Practices of the Provider, a copy of which has been provided to me.

Authorization to Release Information

My signature below constitutes my permission for Provider to discuss my protected health information with following individuals:

Name of Authorized Individual	Relationship	Phone#
Name of Authorized Individual	Relationship	Phone#

CONSENT FOR TREATMENT:
Knowing that I have a condition requiring treatment by Provider, I do hereby voluntarily consent to such treatment as deemed necessary in the judgment of the physician and therapist.

FINANCIAL RECORDS CONSENT AND INSURANCE ASSIGNMENT OF BENEFITS:
I certify the information given to me in applying for payment under Title XVIII of the Social Security Act or other financial carriers is correct. I assign payment directly to provider for unpaid charges. I agree to pay provider for these services and supplies according to its regular rates and charges at the time these services and supplies are rendered. I understand that I am responsible for any health insurance deductibles, co-insurance and any amounts not paid by my insurance carrier. If this account is delinquent, I agree to pay all expenses including, but not limited to collection fees, court costs and actual attorney fees incurred by provider in collecting this account.

CONSENT FOR DISCLOSURE FOR DURABLE MEDICAL EQUIPMENT:
I consent to allow provider to release my outpatient treatment records to durable medical equipment suppliers to simplify ordering my durable medical equipment. Specific information disclosed will be a patient information face sheet, physician orders and selected information to process my durable medical equipment order.

CANCELLATION AND NO SHOW POLICY:
Patients are encouraged to keep all scheduled appointments to maximize the benefits of their treatment plan. If a patient is unable to make a scheduled appointment, the patient is expected to give 24 hours advance notice. Two (2) consecutive appointment no-shows may result in discontinuation of the current appointment schedule for the therapy involved. A pattern of frequent absences (cancellation and/or no-shows) will be considered problematic and result in discontinuation of services.

Planned absences from scheduled therapy will not be considered cancellations or no-shows. If a patient provides notice of a planned absence, their on-going schedule may be placed on "hold" for up to two (2) weeks. A renewed prescription and appointment schedule may need to be arranged depending on the length of time which has passed.

TELEPHONE CONSUMER PROTECTION ACT NOTICE:
In order to service your account or to collect any amounts I may owe, you may contact me by telephone at any telephone number associated with my account, including wireless telephone numbers, which could result in a charge to me. You may also contact me by sending text messages or e-mails, using an e-mail address I provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

My signature below indicates that I understand the terms of treatment by Provider.

Patient's Signature: _____ Date: _____
Print Name: _____ **(when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____ Date: _____
Print Name of Legal Representative: _____
Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)
□ Other _____ (Explain and Attach Documentation)