Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

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INSURANCE REGISTRATION INFORMATION

For proper reimbursement we need all the boxes that apply to you to be filled in detail. We also require:

1. A valid script &/or referral for PT from your physician dated back **3 months or less**
2. Copies of Health Insurance Card/s or C4/MG2 forms for ALL workers' comp cases
3. A valid ID: Driver's License/ Passport/ State ID

Are You the Patient: ☐**Yes** ☐**No** **Are You the Insured:** ☐ **Yes** ☐ **No** Have You Had PT This Year? ☐**Yes** ☐ **No** **Emergency Contact Name/Tel. #**	
Patient's Last Name, First Name:	
Patient's Date Of Birth**:** **SSN:** **Email:**	
Patient's Address: **Street:**	
City: **State, Zip:**	
Patient's Telephone Number**: Cell:** **Home:**	
Patient's Relationship to Insured: ☐**Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	
Patient's Marital Status**:** ☐**Single** ☐ **Married** ☐ **Other** Employed: ☐ **Yes** ☐ **No** **Student:** ☐ **Yes** ☐ **No**	
Method of Reimbursement: ☐Through Insurance **(proceed to the appropriate sections below)** ☐ Self-Pay **(proceed to next page)**	
Name of referring MD/PCP **:** **Tel #:** **NPI:**	
PRIMARY PLAN NAME: **ID:**	
Insured's Last Name, First Name:	
Insured's Date of Birth: Insured's SSN**:**	
Insured's Address**: Street:**	
City: **State, Zip:** Tel #:	
SECONDARY PLAN NAME: **ID:**	
Insured's Last Name, First Name:	
Insured's Date of Birth**:** Insured's SSN:	
Insured's Address**: Street:**	
City: **State, Zip:** Tel #:	
TERTIARY PLAN NAME: **ID:**	
Insured's Last Name, First Name:	
Insured's Date of Birth**:** Insured's SSN:	
Insured's Address**: Street:**	
City: **State, Zip:** Tel #:	
Is your condition related to an injury☐Yes/ No☐ **Accident Date:** **SSN(Mandatory):** If Yes, fill all the following boxes, in complete detail ➔	
Indicate cause of accident ➔	☐ **Auto Accident (No Fault)** ☐ **Employment (Workers' Comp)**
Claim # ➔	
Policy # ➔	
Carrier Case # ➔	
Name of Employer	**Tel. #**
Employer's Mailing Address:	**Street:** **City:** **State, Zip:**
Name of Case Worker	**Tel#** Fax #
Name of Attorney (If applicable)	**Tel#** **Fax #**
Claim Mailing Address:	**Street:** **City:** **State, Zip:**

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PATIENT INTAKE FORM

Age: ____years. Male/Female: ☐ ☐ (R)/(L)Handed ☐ ☐ Height: ___Ft. __inches Weight:_____lbs BMI:_____

BMI Calculator: http://www.acefitness.org/acefit/healthy_living_tools_content.aspx?id=1

Diagnosis: _____

Describe your current problem: _____

_____

Is it constant 76-100% of the day:_____☐ Intermittent: 1-75% of the day:☐____

How did it start: _____

Date it started:_____Ocurred before: Yes/ No: If yes, when:_____ ☐ ☐

Is it ☐ A new Injury ☐ Aggravation of an old problem ☐ Chronic

Is your condition getting better or worse: _____

How do you feel today: ***Enter number:*** _____

1 2 3 4 5 6 7 8 9 10

No symptoms Unbearable symptoms

Are you using any assistive devices: ***Check*** all that apply:

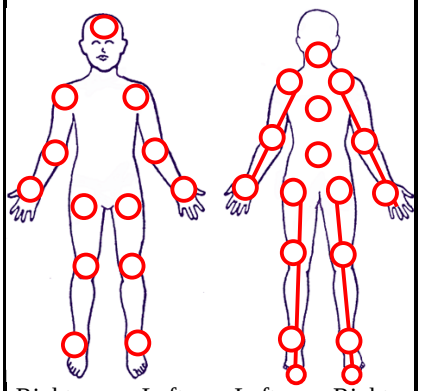
Orthotics/Splints/Corset/Crutches/Cane/Walker/Wheelchair /Other: _____

☐ ☐ ☐ ☐ ☐ ☐ ☐

Describe briefly any treatment & # of visits (chiropractic, physical therapy etc.) you had:_____

_____

_____which did (or did not) benefit. ☐ ☐



Indicate on the diagram where you have pain or other symptoms

Checkmark your area of pain inside the red circles. Type details if needed:

Past Surgical History: Date of Surgery: _____

Shoulder, Hip, Knee, Ankle joint replacement, Arthroscopy, Fractures, Spine, any other _____

Is there any crepitus, clicking or locking present during movement? ( ) Yes ( ) No _____

Is there any twitching or involuntary movement of muscle or joint? ( ) Yes ( ) No _____

Smoker: ( ) Yes ( ) No Alcohol Consumption: ( ) Yes ( )No_____

Difficulty in speech: ( ) Yes ( ) No Difficulty in writing: ( ) Yes ( ) No_____

Have you had: X-rays, MRI, CAT: Spine, R/L hip/knee/ankle Tests: EMG-NCV on upper extremity or lower extremity Yes/ No_____

Medical History/Precautions: Check all that apply on the list below with approximate year of onset:

Condition		Medications Taken	
Do you suffer from:	**Check box**	**Name of Medication**	**Dosage & Frequency**
Obesity			
Hypertension			
Diabetes			
Rheumatoid and Osteoarthritis			
Osteoporosis/osteopenia			
Migraine			
Dizziness			
Anxiety			
High/Low Thyroid	☐ High ☐ Low		
Asthma			
Gangrene			
Peripheral Vascular disease/Varicose veins	☐ PVD ☐ Varicose veins		
Congestive Heart failure /COPD			
Dementia/Cognitive deficits			
Other Medications or Supplements taken (attach list)			

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SELF-ASSESSMENT

1. Are you currently on work restrictions: ( ) Yes ( ) No Since when:_____
2. Live ( ) alone ( ) with family

Function That May Be Affected By Pain Etc.	Not Applicable	No Difficulty	Little Difficulty	Moderate Difficulty	Much Difficulty	Unable To Perform
Dressing: • Pullover • Shirt • Buttoning • Shoes						
Transfers: • Bed • Chair • Tub • Toilet • Car						
Activities of Daily Living: (ADL) • Bathing • Grooming • Lifting • Carrying • Pushing • Pulling • Bending • Stooping • Squatting						
Overhead Tasks: • Reaching for objects on high shelf • Painting ceiling etc.						
Work Tasks • Writing • Driving • Housework includes cleaning & cooking						
Static Activity: Ability to perform with no pain for 10-15 mins in: • Lying down • Sitting • Standing • Walking						
Dynamic Activity i.e. Moving to/from: • Lying to sitting • Sitting to standing • Stand to walk						
Loss of Balance						
Difficulty in using arm						
Any other difficulty						

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ASSIGNMENT AND RELEASE

PRIVATE INSURANCE AUTHORIZATION

I, the undersigned, have insurance coverage with _____ (name of your insurance company) and assign directly to Caroline Konnoth Physical Therapy, P.C. all medical benefits, if any, otherwise payable to me for services rendered.

I understand that I am financially responsible for all charges, viz: copays, co-insurance, deductibles or for those claims that were denied payment by my insurance company and my insurance company states that I am financially responsible for the same. Any failure in payment for services may require a recovery process and any cost incurred for that recovery process will be my responsibility.

I hereby authorize the provider to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I give consent to Caroline Konnoth Physical Therapy, P.C. to carry out all procedures required for the evaluation, treatment and future treatment planning for my condition.

_____ _____

(Signature of Insured/Guardian) (Date)

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made on my behalf to Caroline Konnoth Physical Therapy, P.C. for any services furnished to me by the therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature below requests that payment be made and authorizes release of medical information necessary to pay claim.

If another health insurance is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

(Signature of Beneficiary) (Date)

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

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HIPAA PRIVACY RULE SUMMARY

Below is a summary of the HIPAA Act. For complete details and disclosures visit:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

Protected Health Information: The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)." "Individually identifiable health information" is information, including demographic data (e.g., name, address, birth date, Social Security Number), that relates to:

1. an individual's past, present or future physical or mental health or condition,
2. the provision of health care to an individual, or
3. past, present, or future payment for the provision of health care to an individual.

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

De-Identified Health Information: There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either:

1) a formal determination by a qualified statistician; or
2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

General Principle for Uses and Disclosures

Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either:
(1) as the Privacy Rule permits or requires; or
(2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

Signature: _____

Name:_____ Date: _____

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

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IMPORTANT COMPANY POLICIES

We strive to provide you with the best personal care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial at every policy and indicate your agreement by signing at the bottom.

_____**A Referring Physician Script** is necessary for proper reimbursement. *The absence of a script and the possible non-reimbursement by the Insurance Company will make me (your name)*_____*responsible* for the charge.

_____**24-Hour Advance Notice Fee**: A minimum 24-hour advance notice is required in order to change/cancel an appointment. Anything less than that will result in a full service fee charged to your account.

_____**No shows:** If you fail to show for your appointment without prior notice, all further appointments will be removed and a full service fee will be assessed to your account. You may reschedule appointments again on a "first-come, first serve basis".

_____ **ALL payments are due in advance of your treatment session.**

_____ **Cell phones must be SILENT.** We realize that emergencies may arise and therefore allow you to carry your cell-phone during your session, but please turn it to "silent" mode, to give yourself the full benefit of an undisturbed session.

_____**TCPA Regulations:** In keeping with the Telephone Consumer and Protection Act compliance regulations, you must agree to receive automated appointment reminders from our office before we start sending you these reminders.

_____**Updating Information**: Any changes in your demographics, telephone # or insurance plans must be promptly shared with our office. This will ensure accurate generation of all insurance claims. *Failure to do so may result in your claims being denied by your insurance company for timeliness.* Consequently as per the "assignment and release" signed by you, you will be responsible for all remaining dues.

I agree to all the policies on this form.

Signature:_____

Name:_____ Date: _____

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

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WAIVER OF LIABILITY

Caroline Konnoth, P.T. has advised me that the procedures of "craniosacral therapy," "visceral manipulation" or "running bars" are not reimbursed by any insurance company. Being that this clinical procedure has no CPT code, it is not considered medically necessary by all insurance companies and therefore not payable as a physical therapy service. Although this is so, I have instructed the therapist to proceed with the service and I will assume full responsibility for payment for all treatment sessions I will receive.

PAYMENT SCHEDULE :

Payment is always made in advance. **Sessions are 45 minutes long. Light food intake is recommended.**

1. For CRANIOSACRAL THERAPY AND VISCERAL MANIPULATION, there are 2 options for payment. The charge is per session.:

a. **OUT-OF-NETWORK**: Herein you will be responsible for
❑a charge of $200 for the initial session, and
❑subsequent payments of $160 for every following session
These out -of-network payments are reimbursable via HCFA forms that the therapist provides for all other payable physical therapy procedures also incorporated in each session

b. **IN-NETWORK**: Herein you will be responsible for:
❑a charge of $200 for the initial session, and
❑an additional charge of $75 if you carry Medicare, or
❑an additional charge of $120 if you carry any other insurance that allows unlimited PT visits without the need to pre-authorize them. The balance per session is paid for by your insurance company for all other payable physical therapy procedures also incorporated in each session.

2. **Discount Packages are available for craniosacral therapy and visceral manipulation as follows. These payments are non-refundable.:**
❑Purchase 5 sessions each session discounted as $150/session (out of network=$750) or $115/session (in-network=$575). **All treatment sessions must be completed within 3 months.**
❑Purchase 10 sessions, pay for 9 sessions & get 1 bonus session (out of network @ $160/session=$1,440) or (in-network @$120/session=$1080) **All treatment sessions must be completed within 6 months.**

3. ❑For ACCESS BARS the cost is $160 per session.
4. **Clinician Travel Charges: Home visits by this clinician are only undertaken as an emergency. These cost an additional❑ $70 fee per visit in Queens and Long Island and an additional ❑$90 fee per visit in Manhattan additional to the cost of the treatment session.**

THE ABOVE PAYMENT SCHEDULE HAS BEEN READ AND UNDERSTOOD BY ME.

Patient Signature: _____

Patient Name: _____Date_____

THIS PAGE IS TO BE FILLED IN ONLY BY PATIENTS OPTING FOR BODYWORK SUCH AS CRANIOSACRAL THERAPY, VISCERAL MANIPULATION OR ACCESS BARS

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

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ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

A. Notifier: CAROLINE KONNOTH PHYSICAL THERAPY, P.C.

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

NOTE: ***If Medicare doesn't pay for D. Physical Therapy 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. Physical Therapy below.(The following descriptors may be used in the header of Blank (D): • Item • Service• Laboratory test• Test • Procedure • Care• Equipment)

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy Session	• Medicare does not pay for physical therapy as often as this (denied as too frequent) • Medicare does not deem that this service is medically necessary	$100 per session

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 G below about whether to receive the D. Physical Therapy *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. Physical Therapy *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. Physical Therapy *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. Physical Therapy *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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Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

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