

**Name:** \_\_\_\_\_  
(First) (Middle) (Last)

**Local Address:** \_\_\_\_\_  
(Street) (Apt, Ste, Unit) (City) (State) (Zip)

**Northern Address:** \_\_\_\_\_  
(Street) (Apt, Ste, Unit) (City) (State) (Zip)

**Phone:** \_\_\_\_\_  
(Home) (Work or Northern Phone) (Cell Phone)

**Email Address:** \_\_\_\_\_

**Soc. Sec #:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Age:** \_\_\_\_\_ **Sex:** M F  
Month/Day/Year Circle One

**Marital Status (circle):** Single Married Divorced Widow

**Employment Status (circle):** Full Time Part Time Not Employed Retired

**Employer:** \_\_\_\_\_  
(Name) (Address)

**In case of an emergency, Notify:** \_\_\_\_\_  
(Name) (Phone #) (Relation)

**Is the illness/injury for which you are being seen the result of any of the following? Circle One:**

Auto Accident Work Injury Other Litigation None of these

**Is there an attorney involved in relation to your injury/illness? Circle One:** YES NO

**If yes:** \_\_\_\_\_  
(Name of Attorney) (Address) (Phone)

**Please provide us with your insurance information. You will need to supply our office with a copy of each of your insurance cards as well as a copy of your driver's license. If you are unable to supply us with a copy of ALL of your insurance cards and we are unable to verify that your insurance is current you must pay for your visit by cash. We accept checks, cash, Visa, or Mastercard.**

If you are not the insured person under your insurance policy please provide the INSURED's information.

**Insured's Name:** \_\_\_\_\_

**Insured's Date of Birth:** \_\_\_\_\_

**Consent To Treat & Authorization To Release Information**

Please read and initial the following:

\_\_\_\_\_ I consent to *evaluation & treatment* by Medical & Sports Rehabilitation Center, Inc and realize I have the right to refuse any procedure after having the risks & benefits explained to me.

\_\_\_\_\_ I authorize the **release of information** acquired in the course of my treatment, including, but not limited to medical records, electronic media, and oral communications, to my insurance company representatives, employer, primary care physician, referring physician, and/or third party payer.

\_\_\_\_\_ I authorize *phone messages* regarding my treatment & appointments to be left with persons or machines at the phone numbers I have provided.

\_\_\_\_\_ A copy of this facility's *Statement of Privacy Notice* has been provided to me.

**FOR MEDICARE PATIENTS ONLY:** Please answer the following 5 questions YES or NO

1. Do you or your spouse work full or part-time? \_\_\_\_\_
2. Do you or your spouse still have Primary Health Insurance coverage through an employer? \_\_\_\_\_
3. Was your injury/condition caused by an automobile, work, service-related, or any other accident for which someone else will be responsible for your medical expenses? \_\_\_\_\_
4. Do you receive MEDICARE due to kidney disease? \_\_\_\_\_
5. Have you received any form of therapy (physical, occupational, or speech) prior to attending therapy at our facility? \_\_\_\_\_

*If you answered YES to any of the above questions please advise the front office. It may be possible that Medicare is not your primary insurance.*

**Please Sign Below**

Patient's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_

Date: \_\_\_\_\_

(If different from patient)

Relation To Patient: \_\_\_\_\_

Your therapist will discuss your responses with you during the evaluation. Thank you for completing this information.

**PERSONAL INFORMATION**

Interests/hobbies/exercise: \_\_\_\_\_

Is there anyone who can assist you with doing home exercises or activities if needed?  Yes  No

Will you have any problems attending therapy sessions?  No  Yes If yes, please describe:

\_\_\_\_\_

Next scheduled Dr Appointment: Date \_\_\_\_\_ Physician \_\_\_\_\_

**KEY QUESTIONS ABOUT YOUR CONDITION**

What is your **MAIN** complaint?

\_\_\_\_\_  
\_\_\_\_\_

**Darken** the areas on the body where you are having problems

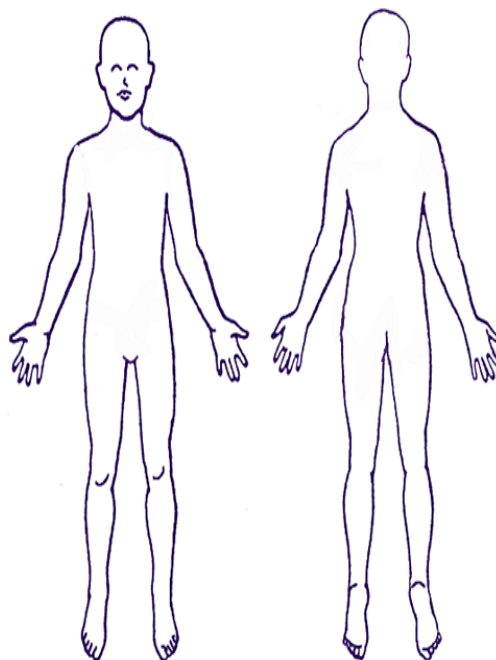
Please mark your level of pain with a **X** along the following lines:

What is your pain at rest?

\_\_\_\_\_  
No Pain Worst Pain  
Imaginable

What is your pain with activity?

\_\_\_\_\_  
No Pain Worst Pain  
Imaginable



**GENERAL HEALTH**

Are you having trouble sleeping? \_\_\_\_\_YES \_\_\_\_\_NO

Normal hours of sleep \_\_\_\_\_ hours Current hours of sleep \_\_\_\_\_ hours

Medical conditions you have or have had. Check all that apply.

- Fever, Chills, or Sweats       Arthritis       Stroke       Visual Problems
- Bowel Dysfunction       Cancer       Stomach Disorders       Hearing Problems
- Numbness       Diabetes       Anxiety       Neurological Disorders
- Weakness       Heart Disease       Depression       Osteoporosis
- Night Pain       High Blood Pressure       Panic Attacks       Fibromyalgia
- Weight Change       Lung Disease       Pacemaker       Epilepsy
- Fatigue       Nausea/Vomiting       Shortness of Breath       Parkinson's Disease
- HIV Positive       AIDS       Vascular Disorder       Hemophilia
- Other: \_\_\_\_\_

Are you taking any medications (prescription, over the counter, herbal preparations)? YES NO

If yes, please list or provide us with a list. \_\_\_\_\_


Do you have any allergies (adhesives, latex, cortisone, medications)? YES NO

If yes, please list with any reaction/treatments:

	Reaction/Treat _____
	Reaction/Treat _____
	Reaction/Treat _____

**PERSONAL GOALS FOR THERAPY**

What do **YOU** want to achieve from having therapy? Check all that apply.

- Improve home activities       Improve mobility       Improve range of motion
- Improve leisure/sports activities       Decrease pain/discomfort       Improve endurance
- Improve self care activities       Return to work       Improve balance/walking

Please include any additional information you feel would help us to provide your care. (What you think would help any apprehensions about treatment, special communication, language, spiritual or cultural needs). \_\_\_\_\_

\_\_\_\_\_

**To the best of my knowledge the above information is complete and factual.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

Medical and Sports Rehabilitation Center, INC.  
661 Goodlette Rd North, Suite 101, Naples, FL 34102  
12840 Tamiami Trail North, Suite 200, Naples, FL 34110

### **Private Insurance, Medicare, Liability and Cash Fee Statement**

Medical and Sports Rehab is very concerned about the cost of health care. Great care has been taken in setting fees for our services. Our charges accurately reflect the complexity of care rendered and the skill and expertise required for care. **One of the sections below will apply to your therapy coverage. Please read the applicable section & sign the back of this form.**

**PRIVATE PAY (CASH):** If you **DO NOT** have insurance coverage or **DO NOT** wish us to bill an insurance company, payment will be required at the time of each service. We accept cash, personal check, Visa, and Mastercard.

**WALK-INS:** Our office calls to verify benefits prior to any appointment. It is possible that your insurance company has certain restrictions that may limit payment if you chose to be seen as a walk-in. Pre-certification requirements may apply and treatment will not be covered unless our office obtains authorization prior to treating you. If you choose to be seen without our office calling on benefits prior to treating you, you may be responsible for today's treatment.

**INSURANCE COMPANY:** We bill your insurance company as a **COURTESY** to you, on the condition that you have provided us with the correct billing information including name, address, phone number, and claim/policy number(s). If your claim is denied or delayed you will be billed so you can submit the claim to your insurance company for prompt payment. **It is your RESPONSIBILITY to know what your plan covers and if there are any "special conditions" that your insurance company requires for payment. We will call your insurance company to verify benefits as a COURTESY to you, but frequently the information provided is not accurate. We will not know if the information is truly correct until we receive your first explanation of benefits, which is 30 days after your initial visit. Verification of benefits is not a guarantee of payment or your assigned patient responsibility. We recommend you contact your insurance provider to verify benefits for outpatient therapy services.**

**You must also be aware that:**

1. **You are responsible for what your insurance does not pay, including applicable deductibles, co-payments and/or the percentage not covered by your plan. Payment is due AT THE TIME OF EACH VISIT.**
2. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your deductible has NOT BEEN MET for the plan year, you will be REQUIRED TO PAY for services as they are rendered. We will submit your claims to the insurance company as a courtesy to you so that they will be applied toward your deductible.

### **MEDICARE**

Effective January 1, 2007 a cap will be in effect for outpatient physical, occupational, and speech therapy. The allowances will be as follows. The updated cap amounts as of January 1, 2008 are:

\$1,810.00 allowed for Physical & Speech Therapy Combined

\*Medicare Pays 80% of \$1,810.00, which would be \$1,448.00

\*The remaining \$362.00 would be billed to your supplemental insurance.

\$1,810.00 allowed for Occupational Therapy

\*Medicare Pays 80% of \$1,810.00, which would be \$1,448.00

\*The remaining \$362.00 would be billed to your supplemental insurance.

**PLEASE TURN OVER & SIGN THE BACK OF THIS PAGE**

(Medicare Section Cont)

You are responsible for keeping track of your medical expenses so that you do not exceed the cap. Medical & Sports Rehabilitation Center, Inc. will be happy to provide you with updates upon request. Medicare will cover 80% of physical and occupational therapy services. You will be responsible for the remaining 20% after Medicare. If you have a secondary insurance we will bill them **as a courtesy to you**, provided we have the correct name, address, and phone number for the insurance company. **Again, you will be responsible for what your co-insurance does not pay of the 20% and any deductibles.** If your secondary/supplemental insurance pays you for the 20%, then we require you to pay us the 20% or any deductible at the time of service. We will confirm this when we call to verify your benefits. Please remember that a quote of benefits from your insurance is not a guarantee of payment.

Under Medicare you must attend therapy at least **TWO** days per week in order for Medicare to cover. Attending therapy less than two days is considered maintenance treatment and may be denied by Medicare, leaving you responsible for the charges. If at any time you are advised that Medicare may not cover for treatment and you choose to continue therapy, you will be responsible for any charges not covered by Medicare and your supplemental insurance.

**ATTORNEY/LIABILITY:** In cases that involve an attorney, we require if possible, to file claims to an insurance company. We are not responsible for claims not received within their timely filing limits. We will no longer send these claims certified mail. If you wish to do so we will provide you with a copy of your bill. If there is NO such insurance to cover therapy claims, we will bill the attorney directly on the condition that our “Letter of Protection” (LOP) is signed. We will hold a file until the balance reaches \$1500.00 **with a signed LOP**, if you choose to continue therapy after this balance has been reached then it will be an out of pocket expense. **The patient is to FULLY UNDERSTAND that in case of NO SETTLEMENT, the patient is FULLY RESPONSIBLE for the TOTAL BALANCE on his/her account.** If payment IS NOT made, the account will be turned over to a collection agency.

**LATE FEES:** Medical & Sports Rehab Center has a 20-day billing cycle. You have 20 days from the date on the statement to make your payment. If payment is not received within the 20-day limit, a **\$10.00 late fee will be assessed each time** we must re-bill you for services rendered. If you are not able to make your payment within our time limits you must call us and advise us immediately.

We must emphasize as a care provider, our relationship is with you, not your insurance company. You are ultimately responsible for payment for services rendered, regardless of insurance, regardless of outcome. We accept cash, personal checks, Visa, and MasterCard. If you have any questions, please do not hesitate to contact our Billing Department at (239) 261-0291.

I have read, understand, and agree to the above listed policy.

\_\_\_\_\_  
Printed Name of Patient/Responsible Party

\_\_\_\_\_  
Signature of Patient/Responsible Party

\_\_\_\_\_  
Date

Medical & Sports Rehabilitation Center, Inc.  
Insurance Verification of Benefits Disclaimer

Dear Patient:

It is important for you to understand that Medical & Sports Rehabilitation Center will verify your benefits as a **COURTESY**. The information provided to us by your insurance company is often incorrect, which results in a discrepancy for patient responsibility. Verification of benefits is not a guarantee of payment or patient responsibility. We can only provide you with the information given to us by YOUR insurance company. We will not know if the information is truly correct until we receive your first explanation of benefits, which is 30 days after your initial visit. **You will be responsible for any changes in co-pays or co-insurance amounts as assigned to you by your insurance company. We highly recommend you contact your insurance provider to verify benefits for outpatient physical or occupational therapy.**