Lindsay Pimentel Hand to Shoulder Rehab

New Patient Information

Patient Last Name:_____ First:_____ MI:____

Address:_____ City:_____ Zip:_____

Home Phone:_____ Work:_____ Ext:_____ Cell:_____

E-mail:_____ Birthdate_____ SS#_____ M/F

Current Employer:_____ Phone #_____

Emergency Contact Name:_____ Phone #_____

Referring Dr:_____ Phone #_____ Fax:_____

Primary Treating Dr:_____ Phone #_____ Fax:_____

Date of injury:_____ Date of Surgery:_____

Had therapy or chiropractic care before today? ❑ Yes ❑No

❑ Physical Therapy ❑ Occupational Therapy ❑ Speech Therapy ❑ Chiropractic

If "yes", when? _____ where? _____# of visits you had?_____

For what condition?_____

Are you receiving Home Health Services/or in a Skilled Nursing Facility? ❑ Yes ❑No

(IF YES, *YOU MAY NOT BE ABLE TO RECEIVE THERAPY HERE*)

Worker's Compensation

Claim #_____ Company:_____ Phone #_____

Adjuster:_____ Phone #_____

Nurse Case Manager:_____ Phone #_____

Employer at time of injury (*if not current*):_____ Phone #_____

Primary Health Insurance

Insured Name:_____ Date of Birth:_____

Insured SSN or Policy # _____ Relationship to Patient:_____

Ins. Company:_____ Phone #_____

Group #_____ ID#_____ Plan:_____

Secondary Health Insurance

Insured Name:_____ Date of Birth:_____

Insured SSN or Policy # _____ Relationship to Patient:_____

Ins. Company:_____ Phone #_____

Group #_____ ID#_____ Plan:_____

New Patient – Medical History

Name: _____ Age: _____ M F Next doctor appointment: _____

What is your Diagnosis? _____ Date of Injury: _____ Date of Surgery: _____

What is your Main Complaint? _____

List **all** current Medication and Dosage:			
List **any** Allergies: (cortisone, Latex, iodine, sulphar etc.)			
Please answer all the following questions. If you answer YES **to any, please explain.**			
Have you had **Xrays, MRI** or other imaging studies for current condition?	**YES**	**NO**	Date or last image:
Have you had therapy or chiropractic care this year?	**YES**	**NO**	Date: # of Visits:
Do you **have** or have you **had** a tumor/growth?	**YES**	**NO**	
Are you sensitive to heat?	**YES**	**NO**	
Are you sensitive to ice?	**YES**	**NO**	
Do you use Tobacco?	**YES**	**NO**	How Much?
How many standard size alcoholic drinks do you drink per week:			Per Occasion:

Check **all** the symptoms you are **CURRENTLY** experiencing:

Fever/Chills/Sweats	Diarrhea	Numbness or Tingling
Nausea/Vomiting	Unexplained weight loss	Poor Balance/Falls
Dizziness	Fatigue	Depression/Anxiety
Fainting Spells	Shortness of Breath	Pregnancy

Check **all PAST** and **PRESENT** conditions:

High Blood Pressure	Diabetes	Respiratory/Breathing Problem
Stroke	Circulation/Bleeding Problems	Lung Disease
Cholesterol	Blood Disorders (hepatitis or	Emotional/Psychological Px
Heart Conditions	other_____)	Insomnia/Nightmares
Pacemaker	Infectious Disease	Hearing Loss
Arthritis	Kidney Disease	Other serious medical
Osteoporosis	Liver Disease	condition we should know:
Cancer		_____

How do you rate your General Health? **Excellent** **Good** **Fair** **Poor**

What are **YOUR** goals for therapy?

Briefly describe your job. Please include how much you lift, carry, push, pull:

Medicare Patients *ONLY* -MEDICATION LIST

Medication Name: *(Includes prescribed, over-the-counter, herbal, and vitamin/mineral/ dietary supplements)*	**Dosage:**	**Frequency:**	**Route of Administration:** *(Ex: Oral, Injected, topical…)*

Lindsay Pimentel Hand to Shoulder Rehab

Patient Disclaimer (pg. 1 of 2)

We are committed to serving you in the best possible way. In order to achieve this goal, we ask that you please read the following terms for receiving care in our facility.

Supervising Children: The equipment we have here includes heavy weights and delicate electronic devices. Please carefully supervise your children while in the clinic. *They should not play with any equipment*; we have a toy box in the waiting room for their use. Hand to Shoulder Rehab, Inc. will assume no liability for any injuries to children or other visitors playing in the clinic.

We have several therapists: working here that have varying weekly shifts; it is probable that you will see more than one therapist during your course of treatment. Even so, it is our goal to give consistent care. For any special accommodation, please let us know and we will do our best to meet your request.

Worker's Comp Patients: Please extend the courtesy of calling us for any cancellations the day before your scheduled appointment. We are required to notify your insurance company and doctor of cancellations or missed appointments and note it in your chart. Frequent cancellations or "no shows" may jeopardize your claim.

Claims Filing: We file insurance claims as a courtesy to our patients. The patient is ultimately responsible, however, from the date the services are first rendered.

Co-Pays/Co-Insurance: Any co-pay required by your insurance plan will be due at the time that services are rendered. Monthly statements may also be sent for co-insurance amounts, or balances on account, regardless of insurance payment. If you need to set up payment arrangements please ask.

Private Pay Patients: Our fees are usual and customary. These rates will be discussed with you based upon the determined treatment plan. Payment of services is due at the time the services are rendered, unless other arrangements have been approved. We accept cash, checks and credit cards. Supplies such as splints, exercise equipment, etc., may be paid for on the date of service or billed to you each month in a statement. These charges will be due upon receipt.

Not all Insurance Companies Cover Supplies: Please note that your therapy may call for such items as splints and exercise equipment that may not be covered; ie United Health Care, some Santé secondary insurances, etc. If your insurance company does not cover items given, you will be billed for these supplies.

I agree to assign all medical payments for this clinic's services, including private insurance and any other health plans to Hand to Shoulder Rehab, Inc. I understand and agree that I am ultimately responsible for all charges for services & supplies rendered. I will notify you of any changes in insurance coverage.

There will be a $50.00 charge for "no shows", same day cancellations, *and returned checks*. Absolutely no exceptions.

Limited English Patients: Some Health insurance patients may access a free telephone interpreting service during therapy visits, provided by their insurance companies. Please ask regarding this program.

BY SIGNING THIS DOCUMET, I CERTIFY THAT I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE TERMS AND POLICIES WRITTEN HEREIN.

_____ _____

Patient's Name Printed Date

_____

Patient's Signature

7005 N. Maple Ave. Suite 104, Fresno, CA 93720
(559) 325-3503

Patient Disclaimer (pg. 2 of 2)

MediCare Patients Only

NOTE: are you a current or intermittent patient of Home Health or in a Skilled Nursing Facility? **If yes**, you may not be eligible to be seen in our facility. *Please see the receptionist immediately.*

Effective January 1, 2014, Medicare has implemented a fixed dollar amount for Occupational and Physical Therapy services in the amount of $1920 each, per year. This equals approximately 12-16 visits for each discipline per year. Our clinic offers both PT and OT services, *UNLESS you are exempt from this cap by your diagnosis. Certain diagnosis allow for more than this fixed dollar amount. In some cases, a final cap of $3700 will be applied.*

Once the benefits have been exhausted, you do have an option of receiving additional services at an outpatient hospital based clinic, if it is deemed medically necessary.

This clinic does its best to monitor the number of treatment visits you have to help you know when the $1920 cap is close to being reached, or has been reached. I understand, however, that it is my responsibility to check on my balance remaining, directly with Medicare.

I understand and agree that I am ultimately responsible to pay for any services I receive in excess of the $1920 cap.

Please inform us if you have signed up for a Medicare Prescription Drug Plan as services may not be covered at our clinic, if you are enrolled in ***Kaiser Medicare*** inform the receptionist immediately before any services are rendered.

_____ _____

Patient's Name Printed Date

_____

Patient's Signature

Notice of Privacy Practices

UNDERSTANDING YOUR HEALTH RECORD/ INFORMATION: Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examinations and test results, diagnoses, treatment and a plan for future care. This Protected Health Information (PHI) serves as a basis for planning your care and treatment and serves as a means of communication among the many health professionals who contribute to your care.

YOUR HEALTH INFORMATION RIGHTS: Unless otherwise required by law, your health record is the physical property of the healthcare practitioner or facility that compiled it, although the PHI actually belongs to you. You have several PHI rights:

- To inspect and obtain copies of your PHI
- To request corrections to your PHI
- To request that your PHI be restricted
- To request confidential communications
- To request a report of disclosures of your PHI
- To have a paper copy of this Notice

OUR RESPONSIBILITIES: This organization is required to maintain privacy of your PHI. In addition, to provide you with a notice as to our legal duties and privacy practices with respect to information we collect and maintain about you. This organization must abide by the terms of this notice; notify you if we are unable to agree to a requested restriction, accommodate reasonable requests you may have to communicate PHI by alternative means, or at alternative locations. We reserve the right to change our practices and to make the new provisions effective for all PHI we maintain. We will not use or disclose your PHI without your authorization, except for treatment, payment and healthcare operations.

FOR MORE INFORMATION OR TO REPORT A PROBLEM: If you have questions or would like additional information, you may contact our Compliance Officer, Brittany Feldmann at 325-3503 x20. If you believe your privacy rights have been violated, you can file a complaint with the Secretary of Health and Human Services. There will be no retaliation for filing a complaint.

EXAMPLES OF DISCLOSURES FOR TREATMENT, PAYMENT & HEALTH OPERATIONS:

We will use your PHI for treatment. For example: information obtained by a healthcare practitioner will be recorded in your chart and used to determine the course of treatment that should work best for you. By way of example, your physician will document in your record their expectations of the therapy to be provided. We will also provide your physician with copies of various reports that should assist them in treating you.

We will use your PHI for payment. For example: a bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your PHI for regular health operations. This information will be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business Associates: There may be some services provided to our organization through contracts with Business Associates. (For example: collection agencies, medical equipment suppliers, or a copy service.) When these services are contracted, we may disclose some or all of your PHI to them so that they can perform the job we've asked them to do. To protect your PHI, however, we require the Business Associate to appropriately safeguard your information.

Notification: We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relatives, close personal friends, or to any other person you identify, PHI relevant to that person's involvement in your care, or payment related to your care.

Food and Drug Administration (FDA): As required by law, we may disclose to the FDA your PHI relative to adverse events with products and product defects or post marketing surveillance information to enable product recalls, repairs, or replacement.

Public Health: We may disclose PHI to public health or legal authorities charged with tracking birth and deaths, as well as with preventing or controlling disease, injury, or disability.

Workers Compensation: We may disclose PHI to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other programs established by law.

Law enforcement: We may disclose PHI for law enforcement purposes as required by law or in response to a valid subpoena. Federal law allows for your PHI to be released to an appropriate health oversight agency, public health authority or attorney, in the event that someone believes, in good faith, that Hand to Shoulder Rehab, Inc. has engaged in unlawful conduct or has otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

❑ I acknowledge receiving a copy of this notice/or reviewing it and give my consent to release my PHI.

Patient Signature: _____ Effective Date: _____

Rental Agreement

If this is a Delivery Receipt for rental of equipment (as checked on the face side) the following terms apply:

The customer acknowledges receipt of the equipment described on the service dates indicated, and agrees that title to the equipment shall at times be and remain in Lessor ("Hand to Shoulder Rehab"): that this is a transaction of lease only: that the equipment is accepted in its "as is" condition (having been inspected by the undersigned upon delivery): and further, the Customer agrees: to protect the equipment from all loss and damage and remain responsible (to release the equipment for pick-up only to a duly authorized representative of Hand to Shoulder Rehab, to operate the equipment only in the manner for which it was intended, to refrain from making any repairs to the equipment (but the customer will notify company in the event repairs are necessary), and to promptly and faithfully pay the stated rental each month (without pro-rate) until the equipment has been returned (it being understood that Hand to Shoulder Rehab will credit the Customer's account for payment received by Hand to Shoulder Rehab under any medical insurance program or from any third party).

The company is not a manufacturer of the equipment, and is not responsible for the adequacy of the same nor any defects in the equipment or which may appear from use and maintenance there of; nor shall Hand to Shoulder Rehab be responsible for any delay or interruption in connection with the delivery or service of the equipment or for any damage whatsoever relating to the use of equipment. Hand to Shoulder Rehab has not prescribed the equipment and further makes no warranty whatsoever, expressed or implied, of merchantability of fitness for purpose. The Customer agrees to accept whatever warranties are offered by the manufacturer of the equipment in lieu of any warranties of seller. The customer irrevocably agrees to indemnify and save Company harmless from and against any claims whatsoever which may be brought to any person whomsoever arising from the rental, delivery and use of the said equipment.

Sales Agreement

If this is a Delivery Receipt for rental of equipment (as checked on the face side) the following terms apply:

The customer acknowledges receipt of the equipment described, on the service dates indicated, and agrees the equipment is accepted in its "as is" condition (having been inspected by the customer upon delivery). The customer agrees to pay the stated price for the equipment, it being understood that credit will be given to the Customer's account for payments received from any medical insurance program or from any third party.

The Company ("Seller") has not prescribed the equipment, and further makes no warranty whatsoever, expressed or implied, of merchantability of fitness for purpose. On the contrary the customer has been informed and agrees that he knows that Seller is not a manufacturer of equipment and is not responsible for the adequacy of the same, not for any defects in the equipment. In lieu of any warranties of Seller, Seller is not responsible for any damage whatsoever relating to the sale or use of the equipment.

Medicare DMEPOS Supplier Standards

1.A supplier must be in compliance with all applicable Federal and State licensure and regulatory requirements and cannot contract with an individual or entity to provide licensed services. 2. A supplier must provide complete and accurate information on the DMEPOS supplier application. Any changes to this information must be reported to the National Supplier Clearinghouse within 30 days. 3. An authorized individual (one whose signature is binding) must sign the application for billing privileges. 4. A supplier must fill orders from its own inventory, or must contract with other companies for the purchase of items necessary to fill the order. A supplier may not contract with any entity that is currently excluded from the Medicare program, any State health care programs, or from any other Federal procurement or non-procurement programs. 5. A supplier must advise beneficiaries that they may rent or purchase inexpensive or routinely purchased durable medical equipment, and of the purchase option for capped rental equipment. 6. A supplier must notify beneficiaries of warranty coverage and honor all warranties under applicable State law, and repair or replace free of charge Medicare covered items that are under warranty. 7. A supplier must maintain a physical facility on an appropriate site. This standard requires that the location is accessible to the public and staffed during posted hours of business. The location must be at least 200 square feet and contain space for storing records. 8. A supplier must permit CMS, or its agents to conduct on-site inspections to ascertain the supplier's compliance with these standards. The supplier location must be accessible to beneficiaries during reasonable business hours, and must maintain a visible sign and posted hours of operation. 9. A supplier must maintain a primary business telephone listed under the name of the business in a local directory or a toll free number available through directory assistance. The exclusive use of a beeper, answering machine, answering service or cell phone during posted business hours is prohibited. 10. A supplier must have comprehensive liability insurance in the amount of at least $300,000 that covers both the supplier's place of business and all customers and employees of the supplier. If the supplier manufactures its own items, this insurance must also cover product liability and completed operations. 11. A supplier must agree not to initiate telephone contract with beneficiaries, with few exceptions allowed. 12. A supplier is responsible for delivery and must instruct beneficiaries on use of Medicare covered items, and maintain proof of delivery. 13. A supplier must answer questions and respond to complaints of beneficiaries, and maintain documentation of such contracts. 14. A supplier must maintain and replace at no charge or repair directly, or through a service contract with another company, Medicare-covered items it has rented to beneficiaries. 15. A supplier must accept returns of substandard (less than full quality for the particular item) or unsuitable items (inappropriate for the beneficiary at the time it was fitted and rented or sold) from beneficiaries. 16. A supplier must disclose the supplier standards to each beneficiary to whom it supplies Medicare-covered item. 17. A supplier must disclose to the government any person having ownership, financial, or control interest in the supplier. 18. A supplier must not convey or reassign a supplier number; i.e., the supplier may not sell or allow another entity to use its Medicare billing number. 19. A supplier must have a complaint resolution protocol established to address beneficiary complaints that relate to these standards. A record of these complaints must be maintained at the physical facility. 20. Compliant records must include: the name, address, telephone number and health insurance claim number of the beneficiary, a summary of the complaint, and any actions taken to resolve it. 21. A supplier must agree to furnish CMS any information required by the Medicare statute and implementing regulations. 22. All suppliers must be accredited by a CMS-approved accreditation organization in order to receive and retain a supplier billing number. The accreditation must indicate the specific products and services, for which the supplier is accredited in order for the supplier to receive payment of those specific products and services (except for certain exempt pharmaceuticals). Implementation Date October 1, 2009. 23. All suppliers must notify their accreditation organization when a new DMEPOS location is opened. 24. All suppliers locations, whether owned or subcontracted, must meet the DMEPOS quality standards and be separately accredited in order to bill Medicare. 25. All suppliers must disclose upon enrollment all products and services, including addition of new product lines for which they are seeking accreditation. 26. Must meet the surety bond requirements specified in 42 C.F.R. 424.57©. Implementation date – May 4, 2009. 27. A supplier must obtain oxygen from a state-licensed oxygen supplier. 28. A supplier must maintain ordering and referring documentation consistent with provisions found in 42 C.F.R. 424.516(f). 29. DMEPOS suppliers are prohibited from sharing a practice location with certain other Medicare providers and suppliers. 30. DMEPOS suppliers must remain open to the public for a minimum of 30 hours per week with certain exceptions.

Patient Initials:_____ Date:_____