Agape
Physical Therapy & Sports Rehabilitation

Agape Physical Therapy and Sports Rehabilitation

INSURANCE INFORMATION

As a courtesy to our patients, we will verify and file your insurance claim, HOWEVER, we cannot guarantee payment by your insurance company. We strongly suggest that you read your policy manual as it pertains to physical therapy coverage. Many insurance companies have stipulations, such as usual and customary rates (UCR), written referral requirements, limitation to number of therapy visits, limitations to reimbursable amounts per session, deductibles, coinsurance portions, copayments, limits on supplies, etc. Such stipulations should be indicated in your policy manual, if not, we recommend that you contact your insurance company directly.

YOU ARE RESPONSIBLE FOR AMOUNTS NOT COVERED BY YOUR INSURANCE. We have an agreement with YOU, not your insurance company, for receipt of payment. Please be aware of this and plan to make payments accordingly. Benefits will be verified for Workers' Compensation and Automobile Accident Claims, however, this does not guarantee payment. In the event of denial or exhaustion of benefits, this account becomes YOUR RESPONSIBILITY.

CONSENT TO TREATMENT

I understand that I have been referred for rehabilitative treatment and care to Agape Physical Therapy and Sports Rehabilitation. The evaluating therapist will describe for me, my plan of treatment and I understand that I have the right to ask and have any questions answered prior to receiving any treatment, including any risks or alternative treatment plans that have been prescribed by my physician and or recommended by my therapists. By signing this agreement, I consent to have Agape Physical Therapy and Sports Rehabilitation provide treatment and care as prescribed by my physician and/or recommended by my therapist.

ASSIGNMENT OF PAYMENT

I fully understand the payment and billing procedures outlined above. I hereby authorize Agape Physical Therapy and Sports Rehabilitation, their employees, servants and/or agents to furnish my insurance company(s), attorney, or legal representative all information that said parties may request concerning my present illness or injury. **I hereby assign Agape Physical Therapy and Sports Rehabilitation, all money to which I am entitled for medical expenses related to the services reported here, but not to exceed my indebtedness to Agape Physical Therapy and Sports Rehabilitation**. It is understood that any money received from the above named parties over and above my indebtedness will be refunded to me when my bill is paid in full.

PAYMENT POLICY AND PROCEDURES

1. If applicable, you will receive a monthly statement that will show you the status of your account.
2. *Payments should be mailed to the address on your statement or to:*
   Agape Physical Therapy PO Box 179/Forest Hill, MD 21050
3. There is a $25.00 charge for all returned checks.
4. Cancellation policy: We reserve the right to charge a $25 fee if notice is not given 24 hours in advance of any missed appointment.

I understand that I am financially responsible to Agape Physical Therapy and Sports Rehabilitation for charges not covered by my insurance company. I agree to pay interest at the rate of 1.5% monthly. In the event that my account is placed into collection status, I agree to pay an in-house collection fee of $75.00, all applicable outside agency collection fees, and/or attorney fees of 33%, plus any applicable court costs.

Patient Name:_____Birthdate_____Social Sec._____

If patient is under the age of 18-

Mother's Name:_____Birthdate_____Social Sec._____

Father's Name:_____ Birthdate_____Social Sec._____

We may use this information to verify your identity should you contact us by phone.

Responsible Party's Info./Patient Billing Address (if other than patient) *Personal info.-NOT Insurance info*

(This does not waive the patient's financial responsibility.)

Please print legibly

Full Name: _____ Relationship to patient: _____

Address: _____ City _____ State _____ Zip _____

Home Ph#: _____ Cell Ph#: _____ Work# _____

I certify by my signature that I have read and agreed to this information.

Signature of Patient or Legal Guardian:_____(SEAL) **Date:**_____

Please Printed Name:_____

Witness:_____ Date:_____

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Agape Physical Therapy and Sports Rehabilitation

NOTICE OF PATIENT INFORMATION PRIVACY PRACTICES

This notice describes how medical information about you may be used or disclosed and how you can get access to information. Please review it carefully. We are 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 AND PERSONAL INFORMATION

Agape Physical Therapy and Sports Rehabilitation uses your personal health information for treatment, discussing treatment with your doctor, obtaining payment for treatment, conducting internal administrative activities and evaluating quality of care that we provide. For example, we may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. We disclose your personal health information to our billing department.

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

In any other situation, the policy of Agape Physical Therapy and Sports Rehabilitation is to obtain your written authorization before disclosing your personal 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.

Agape Physical Therapy and Sports Rehabilitation may change its policy at any time. When changes are made, a new Notice of Patient Information Practices will be posted in the waiting room.

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 insurance for reasons other than treatment, payment, or other related administrative purposes.

CONCERNS AND COMPLAINTS

If you are concerned that Agape Physical Therapy and Sports Rehabilitation may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosures of your personal health information, please contact our business manager at the address listed below.

Agape Physical Therapy and Sports Rehabilitation
12 Newport Drive, Suite A
Forest Hill, Maryland 21050
Phone: 410-838-6808

By signing below, I acknowledge that I was provided the information above.

Signature of Patient/Guardian: _____ Date: _____

Witness:_____ Date:_____

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NEW PATIENT INFORMATION/MEDICAL HISTORY FORM

(Please print neatly)

Patient Name:_____ Age:_____ DOB_____

Sex: M F Height:_____ Weight_____ Right Hand dominant Left hand dominant

Current Medications-Include Prescription and Over the Counter (include doses/frequency, if known)

List additional on back of page if necessary. If you have a list of your medications, we will gladly make a copy. Therapist initials_____

_____

_____

_____

Allergies:_____

Emergency Contact(s):_____Rel_____

Ph:_____ Alt Ph:_____

Social History: # of people in household_____ Approx. # of steps in house___ Are you able to drive? YES NO

Medical History:

Please mark with an "X" if you have symptoms of, are currently receiving treatment, or have been treated for, any of the following:

	Stroke		Diabetes		Swelling in the arms or legs
	Heart Attack		Seizures		Allergic reaction to bee stings
	High Blood Pressure		Dizziness		Current flu symptoms i.e.fever/coughing
	Chronic Respiratory Disease		Visual problems		Orthopedic disease
	Cardiovascular Disease		Balance problems		Other:
	Cancer: Type- *When?* *Are you currently being treated?*				

What is your primary reason for coming to Physical Therapy? (Chief Complaint)

_____

Date of your injury/date symptoms began: _____

Is this injury resulting from: Work injury?__NO __YES Auto accident?__NO __YES (list date on line above)

Have you been treated for this problem before? ___NO ___YES When?_____

When did you last see the doctor who referred you to physical therapy?_____

Are you scheduled to return to the doctor for a follow-up visit ___NO ___YES When?_____

For your current injury, list any diagnostic tests, results, and date completed *(MRI, X-Ray, EMG, CAT Scan, etc)*

_____

_____

Please indicate the level of pain or symptoms that you experience when performing the following activities:
Use 1 to 10 scale, 0= No pain whatsoever 10=Worst imaginable pain

_____Dressing ____Sleeping ____Toileting ____ Hobbies ____Driving ____Stairs ____Bathing
_____House Chores ____Meal Preparations ____Exercise/Sports ____Other:_____

Are you currently working outside the home? ___NO __YES Occupation/type of work_____

Name of Employer:_____ City/state:_____

Functions_____

Limitations/Restrictions_____

_____

Patient/Guardian Signature:_____ Date_____

Therapist Reviewed /Initial:_____ Date_____

Authorization to Release Medical Records and Personal Information

Patient Name:_____

Date of Birth:_____ Social Security #_____

I hereby authorize Agape Physical Therapy and Sports Rehabilitation to disclose all facts and information contained in my medical record to:

_____
List names

_____
List names

_____
List names

Some examples of people you may wish to include are: Spouse/Family members/friends/Attorneys/Doctors

This authorization is valid for one year and can be revoked in writing at any time.

Signature of Patient or Guardian:_____ Date:_____

Print Name: _____

Relationship to Patient, if other than patient: _____

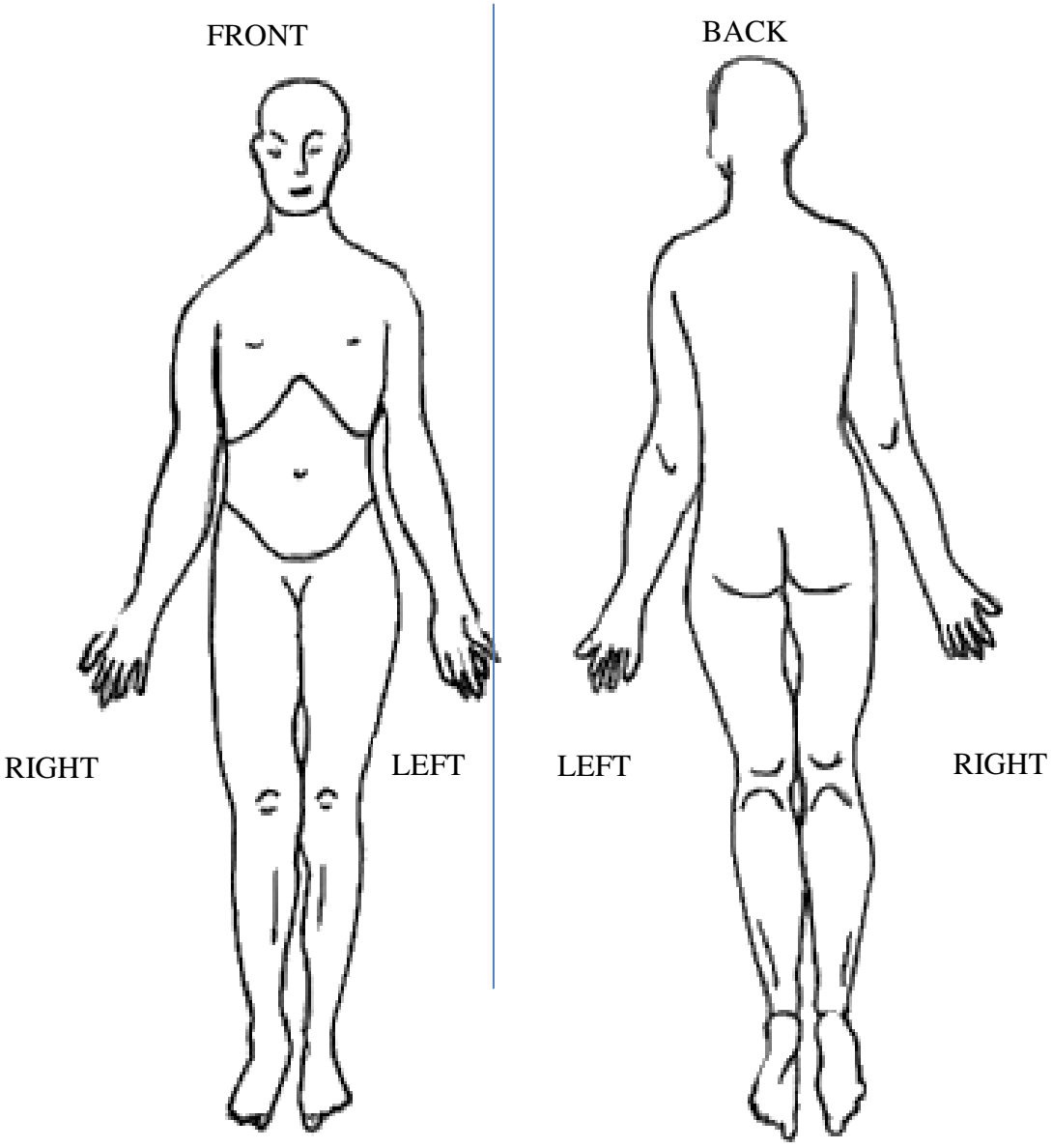
Witness:_____ Date:_____

Patient Name_____ Date of Birth_____

PAIN CHART

PLEASE MARK WITH AN "X" ALL AREAS THAT YOU HAVE **CONSTANT** PAIN

PLEASE MARK WITH AN **"O"** ALL AREAS THAT YOU HAVE **INTERMITTENT** PAIN



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

Use 1 to 10 scale, 0= No pain whatsoever 10=Worst imaginable pain

PATIENT SIGNATURE:_____ DATE:_____

REVIEWED BY THERAPIST: _____***DATE AND INITIAL***

MEDICARE AUTHORIZATION

I understand that Medicare Part B. will be billed for my services at Agape Physical Therapy and Sports Rehabilitation, LP. I also understand that Medicare will pay 80% of the allowed amount, after the annual deductible amount has been met. I will be responsible for the deductible(if not already met), coinsurance amounts and non-covered charges. I will not be responsible for the non-allowed charges.

I also understand that if I sign up for a Medicare Advantage Plan during my treatment, services may not be covered. Any changes in Medicare enrollment or other Insurance plans during my treatment should be immediately disclosed to the provider.

REQUIREMENTS
Medicare requires that all patients are under the care of their physician. Your physician must authorize your care in order for it to be covered under the Medicare physical therapy benefits.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Carroll Sports Rehabilitation and Physical Therapy, LLC to apply for benefits for services furnished to me by that provider of care, apply for, and receive payment directly from Medicare. I authorize the release of protected health information about me to the Health Care Finance Administration and its agents as needed to determine these benefits.

MEDICARE SECONDARY PAYER QUESTIONAIRE

All questions must be answered completely pursuant to Medicare requirements.

	YES	NO
1. Are you a Veteran:	_____	_____
A. Did the VA refer you here?	_____	_____
B. Do you have a VA fee basis card?	_____	_____
2. Do you have a Federal Black Lung card?	_____	_____
3. Is this medical condition due to an accident of any kind?	_____	_____
If yes, was it: (circle one) Work related Automobile related Injury at home Other_____		
4. Are you covered by an employer's health insurance plan through your own employment, or of that of a family member, other than Medicare? If yes, please indicate: _____	_____	_____

Patient Name_____
Please print clearly

Signature of Patient or Guardian_____(seal) Date:_____

Witness:_____ Date:_____