Medicare Packet

PATIENT HEALTH HISTORY & QUESTIONNAIRE

Patient Name:
Occupation: ______________________ Sex: ☐ Male ☐ Female ☐ Gender Diverse Height: __________ Weight: __________

Please list current medications (Including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Medication	Dosage	Freq	Please indicate route by checking box:
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐

If you are currently not taking any medications, please indicate NO by checking the box: ☐

Surgery / Hospitalization, please include date and reason.
Date: ______________ Reason: ______________________________________

Please list any known allergies (including medications, latex, etc.) ______________________________

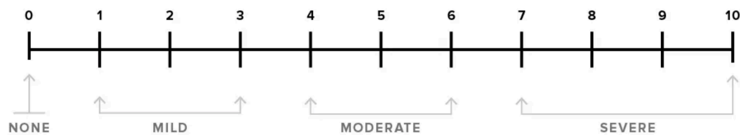
Any **significant** weight gain or loss in the last year? ☐ Yes ☐ No (+/-) _______ lbs

Are you currently experiencing any of the following?			
Nausea or vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No

Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Falls	☐ Yes ☐ No

Please indicate the body part(s) in which you are experiencing pain: ____

I would rate my current pain (please indicate appropriate number): ____



I will advise my treating therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature:____ Date: _________________________

Patient Name/Responsible Party: ______________________ Guardian (if applicable): ________________________

Consent to Treat

Full Name: ____

Address: ______________________________ Apt: _________ City: ______________________ State:_________ Zip: ____________

INTRODUCTION:
The purpose of physical therapy is to rehabilitate individuals following injury, surgery or disease with the goal of achieving maximal patient potential and accelerate recovery. Treatment is patient specific, and will include careful evaluation followed by intervention. Intervention may include, but is not limited to manual techniques, functional stretching, strengthening, home exercise prescription as well as the use of modalities.

POTENTIAL BENEFITS:
I understand that my physical therapist cannot make any promises nor guarantees regarding a cure for, or improvements in my condition. My physical therapist will educate me on potential results of treatment for my condition and will discuss treatment options with me before I consent to care.

POTENTIAL RISKS:
As with any health care procedure complications may arise during the course of treatment. Adverse effects may include but are not limited to possible increase in my current level of pain discomfort, or aggravation with an existing injury. This discomfort is usually temporary, but if it persists or if I do not tolerate any part of my prescribed interventions I agree to inform my physical therapist. I am aware that every precaution is taken to deliver modalities safely, there is a small risk of skin irritation or burning with the use of electrical modalities, ice, heat or tape.

I acknowledge I have discussed the potential risks and benefits of physical therapy with my referring provider. __________ (Initials)

COMMUNICATION:
It is my responsibility to notify my physical therapist of any known physical conditions, including pregnancy, the intent to become pregnant, and any changes to my health or medication(s). I will also notify a member of the physical therapy team if I experience any discomfort during therapy so that treatment can be adjusted.

INFORMED CONSENT FOR TREATMENT:
The term "Informed Consent" means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. I understand all procedures will be thoroughly explained to me before they are performed and any questions will be addressed to my satisfaction. I allow this consent form to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment, with its validity extending for 1 year from the date of endorsement. By consenting below, I acknowledge that I have weighed the risks involved in undergoing treatment, determined it is in my best interest to proceed with the recommended treatment, and understand that I can decline any part of my therapy program at any time.

If you agree to allow access to your or your dependent's medical records by another individual, please check the box,

YES _____ or NO _____. The 'QOPT Authorization for the Release of Protected Health Information' form will follow.

I have read the above consent for Quinn Orthopedic Physical Therapy. My signature below acknowledges that I have understood and will abide by the conditions and policies noted on this consent form.

Signature: ____Date: ____________________________

Patient Name/Responsible Party: ___________________________ Parent/Guardian (if applicable): __________________________

Emergency Contact: ______________________Relation: _______________________ Phone Number: ______________________

Acknowledgement of Receipt of Notice of Privacy Practices

As part of my health care, **Quinn Orthopedic Physical Therapy** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among the company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for the company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that the company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours at each of our clinics and on the company website.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

My signature below acknowledges that I have received a copy of the Notice of Privacy Practices of Quinn and agree to the liability limitations explained therein.

Signature: ____Date: ___________________________

Patient Name/Responsible Party: _________________________Parent/Guardian (if applicable): ______________________

Medicare Part B Coverage and Payment Responsibility

PATIENT INFORMATION:

Name: ___________________________________ Date of Birth: ______________ Medicare ID #: ______________________

Medicare Part B Effective Date: ___________________ Status of Visits Applied to Annual Therapy Cap:_________/ 27 visits

Status of Deductible: ▢ Met ▢ Not Met ▢ Check if, No Home Health, Hospice and HMO Subscription

Additional Coverage (if applicable):

Secondary/ Supplemental Insurance Provider:________________________________Member ID #:_____________________

PHYSICAL THERAPY NOTICE:

Physical Therapy will be covered under Medicare Part B, and requires oversight from a qualified medical provider MD (Medical Doctor), DO (Doctor of Osteopathy), DPM Doctor of Podiatry). A written prescription from your doctor is required, and your therapy Plan of Care must be signed and approved by your doctor within 30 days of your initial visit. Additionally, your Plan Of Care will be reviewed and updated once every 10 treatment days or at least once every 30 calendar days. As mandated by Medicare, in order to continue receiving physical therapy, your referring provider must sign the Plan of Care submitted by your therapist. This document will be faxed to your provider at the aforementioned cadence.

The annual Medicare therapy cap for 2025 is $2410, covering approximately 27 visits. After meeting your $257 annual deductible. Medicare will cover 80% of approved charges. You are responsible for the remaining 20% in coinsurance, which equates to approximately $36.50 for initial visit and $15.50 for subsequent visits. These amounts may be billed to secondary insurance if you provide the necessary coverage details.

TERMS & AGREEMENT:

Please review the financial policy outlined below, which must be signed before treatment can begin. All patients are required to provide a valid photo ID. To ensure accuracy in the health care record and proper insurance verification, we will also request to make copies of your ID and insurance card for our records. You are responsible for providing current and accurate insurance information, including any updates or changes in coverage. Failure to do so may result in you being held financially responsible.

As a courtesy, Quinn Physical Therapy will bill your insurance company on your behalf. Once your Medicare Part B deductible is met, you are responsible for 20% coinsurance for each visit. Medicare will cover 80% of the cost, with no out-of-pocket maximum. If you have secondary or supplemental insurance, it may cover some or all of this amount. However, please note that some secondary or supplemental plans may not cover this amount, leaving any remaining charges as your responsibility.

Payment for deductible, coinsurance or non-covered services are due at time of service. Services may be suspended if the balance exceeds $300 or is unpaid after 60 days, unless advanced payment arrangements are made.If payment is not received within 60 days, or if the outstanding balance exceeds $300, services may be suspended until a reasonable payment arrangement is made. With financial hardship, please seek collaboration with our billing manager for possible situational accommodations.

CANCELATION & NO SHOW POLICY:

Your appointment with us is a professional engagement with a licensed medical provider. In fairness to our providers, our practice and to our other patients, we must insist that you take responsibility to keep and attend your appointments as scheduled. If you are unable to keep a scheduled appointment, we ask that you give us the courtesy of 24 hours notice of cancellation so that we may offer the appointment to other patients. Appointments can be adjusted via email (reception@quinnpt.com) or phone. Please be sure to leave a message, should you not connect with a team member directly. Failure to give 24 hours advance notice of a missed appointment will be considered a no-show. We will waive the first no-show as a courtesy, but subsequent no-shows will each result in a $50 charge to your account balance.

ACKNOWLEDGMENT:

By signing below, you acknowledge that you have received this notice and agree to pay Quinn Orthopedic Physical Therapy according to the outlined terms.

Signature:____Date:_________________________

Patient Name/Responsible Party:_________________________Parent/Guardian (if applicable)::__________________