Knapp Physical Therapy
MEDICARE PATIENT & PAYOR INFORMATION FORM
***All* Patients or Patients' Legal Representative, please complete all Sections**

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ **Email:** _____
Home Other

Emergency Contact: _____ **Emergency Contact #:** (_____) _____-_____

(2) Patient **Sex: M F** **Birthdate:** ____/____/____ **S.S #** ____/____/____

(3) Condition to be treated in Physical Therapy: _____

Did this Condition Result in Surgery?	No Yes	If Yes Date of Surgery ____/____/____
Did this Condition Result from a Work Injury?	No Yes	If Yes Date of Accident ____/____/____
Have You Had PT Anywhere this Year?	No Yes	If Yes Where? _____
Are You Currently Receiving Home Health? (i.e. any healthcare worker, aide assisting or doing something to <u>or</u> for you?)	No Yes	If Yes From Who? _____
Do You Live in a Nursing Home?	No Yes	If Yes What Is Its Name? _____
Are You Covered:		
a. Under Black Lung Disease?	No Yes	
b. End Stage Renal Disease?	No Yes	
c. Large Group Insurance?	No Yes	If Yes Name/Group # _____
d. Veterans Affairs	No Yes	

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: _____

(5) Medications: (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

Knapp Physical Therapy
MEDICARE PATIENT & PAYOR INFORMATION FORM

(6) Payor Information Primary:

Primary Insurance Company: Medicare

Insured's Name:_____ **Patient ID #** _____ **Group #** _____

Regular Medicare: **Yes** **No** **Rail Road Medicare:** **Yes** **No**

(7) Payor Information Secondary/Supplemental Insurance Company: (If YES, please complete)

Ins. Co. Name: _____ **Insured's Name:** _____ **Ins. Ph#**_____

Insured is: _____**Patient** _____**Spouse** _____**Parent**

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address:_____
Street City State Zip Code

Employer Name: _____ **Employer Phone # (** **)** _____-_____

Address: _____ _____
Street City State Zip Code

(8) Payment Authorization: ***(Initials required for all 3 statements)***

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Knapp Physical Therapy for any services that are reimbursable by Medicare or by any other insurance company, if I have one.**

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Certification of Information**

Initials **I certify that the information I have provided Knapp Physical Therapy for payment under the Social Security Act (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(9) Signature/ Date:

_____ _____

Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 2

Knapp Physical Therapy

806 SW Blue Parkway
Lee's Summit, MO 64063
816-272-1427

To Our Medicare Patients

Dear patient we are in need of your help and speedy communication to avoid billing you for 100% of your therapy services.

Many of you either have had or will have home health services paid for by Medicare. We should not provide Physical Therapy to patients who are having home health services of any kind, not just physical therapy. All of the six services listed below must be provided and paid for by your Home Health Agency if your physician has determined that they are medically necessary. The services are:

- Skilled Nursing Services for the assessment and/or treatment of injuries or illnesses or for giving medications/injections, inspecting or inserting feeding tubes, catheters, wound care, etc.
- Occupational Therapy Services
- Physical Therapy Services
- Speech & Language Pathology Services
- Home Health Aide Services provide assistance with basic personal care, meal preparation, feeding, incidental household services such as preparation of meals, light cleaning, etc.
- Medical Social Services

If you have had home health services within six months of being referred to us we must know so we can verify your discharge from that service. If you are referred for home health services while you are being treated by us, we must be informed prior to you starting home health. We would like to avoid holding you responsible for payment if your Home Health Agency is not providing the services.

So, please tell us if you are receiving and/or will be receiving home health services of any kind.

Thank you for your help.

Knapp Physical Therapy Staff

Patient's Signature: _____ **Date:** _____

Knapp Physical Therapy
Medical History

Patient Name: _____ **Date:**_____

List any prior orthopedic injuries or orthopedic surgeries for this condition:

_____

_____

Please circle if you currently have or have had any of the following:

High/Low Blood Pressure	**Cancer**	**Pregnant**	**Crohns Disease**
AIDS	**Heart Conditions**	**Rheumatic Fever**	**Asthma**
Low Blood Sugar	**Lung Conditions**	**Emphysema**	**Diabetes**
Blood Thinners	**Tobacco Use**	**Herpes**	**Stroke**
Hepatitis	**Pace Maker**	**Blood Transfusion**	**Mitral Valve Prolapse**
Epilepsy	**Radiation/Chemo**	**Venereal Disease**	**Alcohol/Drug Addiction**

Other Medical Issues: _____

_____

_____

Your Condition:

When did you first have symptoms? _____

How did your symptoms occur? _____

Where are your symptoms located? _____

What makes your symptoms better?_____ Makes it worse?_____

Have your received any injections for your condition? **YES** **NO** If Yes, When? _____

Diagnostic Tests Performed for this condition: (Circle all that apply):

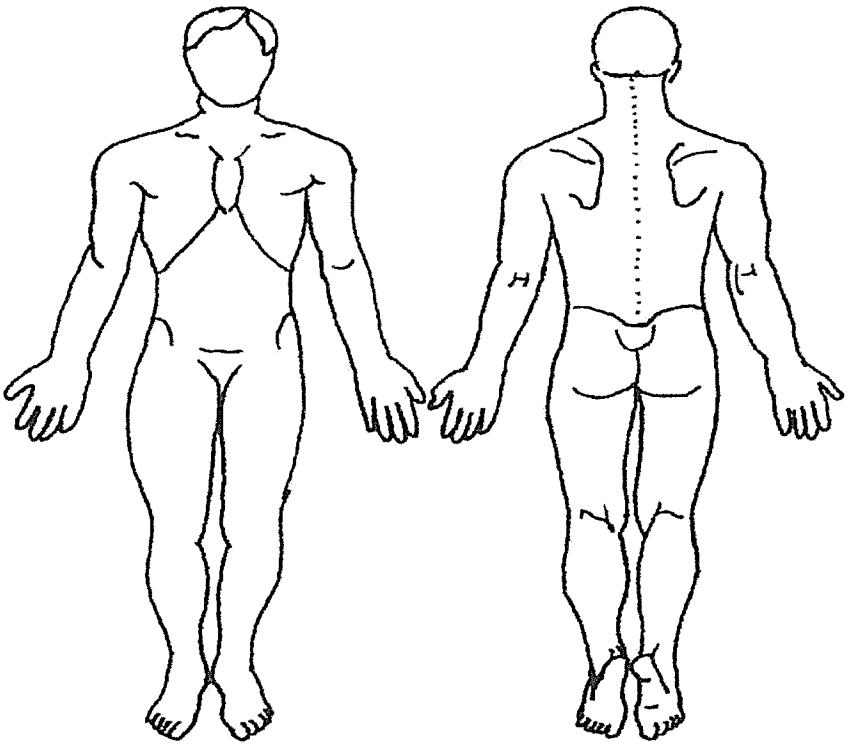
X-ray MRI Ultrasound CT Scan EMG Blood Work Myelogram Arthogram Other_____

Are you exercising? _____

What are your goals for physical therapy? What would you like to accomplish? _____

_____

PAIN SHEET



Please mark your pain or other symptoms on the diagram.

Name: _____

Date: _____

ON THE DIAGRAM PLEASE INDICATE YOUR CURRENT SYMPTOM LOCATIONS USING THE KEY BELOW:

Stabbing	//////
Burning	XXXX
Numbness	+++++
Pins And Needles	00000
Aching	SSSS

Pain Rating Scale:

0 No Pain
1-3 Achy, Sore pain/No Restriction of
4 Minor Restriction of Function
5 Moderate Restriction of Function
6 Severe Restriction of Function
7 Complete Restriction of Function
8-9 Hospital Emergency Room Pain
10 Hot Poker In The Eye Pain

Function Rating Scale:

0 Unable To Function or Get Out of Bed
10 Normal Function. The day before injury.

HEIGHT_____WEIGHT_____

BMI (Therapist Will Calculate) _____

Using the scale above what is your average pain: _____ Average Function: _____

Highest pain in the last 30 days: _____ Highest Function in the last 30 days: _____

Lowest Pain Level: _____ Lowest Function Level: _____

Therapist Use Only

I have reviewed past medical history with the patient/guardian prior to evaluation.

I have informed the patient of their plan of treatment. YES NO

I have informed the patient of their potential outcome. YES NO

NOTES: _____

Therapist Signature: _____ Date: _____

Patient Signature: _____ Date: _____

KNAPP PHYSICAL THERAPY

No-Show/Cancellation Policy

Knapp Physical Therapy charges a $50.00 cancellation fee for any appointments not cancelled within 24 hours or if you no-show. Please make every effort to let us know as soon as possible if you can't make your appointment as other patients are waiting to be treated. We do understand situations arise when you're not able to make your appointment and will work with you to re-schedule.

Printed Name: _____

Signature: _____

Date: _____

Knapp Physical Therapy
Informed Consent for Therapy Services

"Informed Consent" is a process for getting permission before we provide therapeutic services to you, the patient. A sound informed consent includes an explanation of the potential risks, benefits, and alternatives to any treatment that has been proposed to you or, in the case of a minor, your representative. We will discuss the Plan of Care established for you and give you ample time to ask questions about it; your consensus is a critical part of achieving a successful outcome.

Potential Benefits: You may experience improvement in your symptoms and functional activities as well as resolution of other key complaints or problems. In addition to treatment, we provide education to you about your condition throughout your episode of care. This education is often accompanied by handout material that you can refer to regarding proper techniques and home program execution. These resources will help you maintain a sound level of function and will also help you minimize symptoms, should they reoccur.

Potential Risks: You may experience an increase in your current level of pain, if pain is part of your complaints. Many times increased activity or therapy interventions will bring on some discomfort, this is usually temporary. If your pain or discomfort does not subside within twenty-four (24) hours, you should discontinue any home program involving that particular activity, if applicable, and contact your therapist.

Alternatives: We establish a Plan of Care based on the best interventions for your condition, but on occasion our choice of treatment is not well tolerated. You are asked to voice any unfavorable reaction you experience to any aspect of your treatment so that we can modify or terminate it promptly and progress your rehabilitation. If you decide not to continue your participation in your therapy program you will be asked to consult with your physician about other treatment alternatives.

No Warranty: Please note that we cannot make any promises or guarantees regarding a full resolution of and/or correction of your condition. We will, however, work in conjunction with you to achieve optimal improvement.

I have read the above information and I consent to the evaluation(s) and treatment provide by Knapp Physical Therapy.

_____

Signature

_____

Print name

_____

Date

Knapp Physical Therapy
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for Knapp Physical Therapy. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to Knapp Physical Therapy to release any of my protected healthcare information.

_____

Patient's or Authorized Representative's Printed Name

_____

Patient's or Authorized Representative's Signature

_____

Date

KNAPP PHYSICAL THERAPY
HEALTH INFORMATION PRIVACY NOTICE

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information. Please Review This Document Carefully.

About Protected Health Information (PHI).
In this Notice, "we", "our" or "us" means this Knapp Physical Therapy and our workforce of employees, contractors and volunteers. "you" and "your" refers to each of our patients who are entitled to a copy of this Notice.

We are required by federal and state law to protect the privacy of your health information. For example, federal health information privacy regulations require us to protect information about you in the manner that we describe here in this Notice. Certain types of health information may specifically identity you. Because we must protect this health information, we call this Protected Health Information---or "PHI". In this Notice, we tell you about:

- How we use your PHI
- When we may disclose your PHI to others
- Your privacy rights and how to use them
- Our privacy duties
- Who to contact for more information or a complaint

Some of the ways we use (within the organization) or disclose (outside of the organization) your Protected Health Information
We will use your PHI to treat you. We will use your PHI and disclose it to get paid for your care and related services. We use or disclose your PHI for certain activities that we call "health care operations". We will also use or disclose your PHI as required or permitted by law. We will give you examples of each of these to help explain them but space does not permit a complete list of all uses or disclosures. This is one reason why you can contact us and ask us questions.

1. Treatment
   We use and disclose your PHI in the course of your treatment. For instance, once we have completed your evaluation or re-evaluation we send a copy or summary of our report to your referring physician. We also maintain records detailing the care and services you receive at our facility so that we can be accurate and consistent in carrying out that care in an optimal manner; that record also assists us in meeting certain legal requirements. These records maybe used and/or disclosed by members of our workforce to assure that proper and optimal care is rendered.

2. Payment Involving a Third Party Payer
   After we treat you we will, typically, bill a third party for services you received. We will collect the treatment information and enter the data into our computer and then process a claim either on paper or electronically. The claim form will detail your health problem, what treatments you received and it will include other information such as your social security number, your insurance policy number and other identifying pieces of information. The third party payer may also ask to see the records of your care to make certain that the services were medically necessary. When we use and disclose your information in this way is helps us to get paid for your care and treatment.

3. Payment Exclusive of a Third Party Payer (fully self-pay)
   If you choose to pay for your services, in full, without involving a third party (insurer, employer, etc.) you may request that we do not disclose any information regarding your services for payment purposes.

4. Health Care Operations
   We also use and disclose your PHI in our health care operations. For example our therapists meet periodically to study clinical records to monitor the quality of care at our facility. Your records and PHI could be used in these quality assessments. Sometimes we participate in student internship programs and we use the PHI of actual patients to test them on their skills and knowledge. Other operational used may involve business planning and compliance monitoring or even the investigation and resolution of a complaint.

5. Special Uses
   We also use or disclose your PHI for purposes that involve your relationship to us as a patient. We may use or disclose your PHI to:
   - Update your workers compensation case worker or employer
   - Remind you of appointments
   - Carry out follow ups on home programs that you have been taught

Note: If we receive direct or indirect financial remuneration from a third party for marketing a product or item or for any fundraising we are engaged in we will offer you the opportunity to 'opt out' from receiving any of these materials.

6. Uses & Disclosures Required or Permitted by Law

   Many laws and regulation apply to us that affect your PHI, they may either require or permit us to use or disclose your PHI. Here is a list from the federal health information privacy regulations describing required or permitted uses and disclosures:

   Permitted:

   - If you do not verbally object, we may share some of your PHI with a family member or a friend if he/she is involved in your care
   - We may use your PHI in an emergency if you are not able to express yourself
   - If we receive certain assurance that protect your privacy, we may use or disclose your PHI for research; Knapp Physical Therapy will always obtain an authorization from you even though it is 'permitted' without one

   Required:

   - When required by law; for example, when ordered by a court to turn over certain types of your PHI, we must do so
   - For public health activities such as reporting a communicable disease or reporting an adverse reaction to the Food and Drug Administration
   - To report neglect, abuse or domestic violence
   - To the government regulators or its agents to determine whether we comply with applicable rules and regulations
   - In judicial or administrative proceedings such as a response to a valid subpoena
   - When properly requested by law enforcement officials or other legal requirements such as reporting gunshot wounds
   - To advert a health hazard or to respond to a threat to public safety such as an imminent crime against another person
   - Deemed necessary by appropriate military command authorities if you are in the Armed Forces
   - In connection with certain types of organ donor programs
   - Stricter Requirement That We Follow: Some state regulations are more stringent than federal privacy regulations so we comply with those laws.

7. Your Authorization May Be Required

   In the situations noted above we have the right to use and disclose your PHI. In some situations, however, we must ask for, and you must agree to give, a written authorization that has specific instructions and limits on our use or disclosure of your PHI. If you change your mind, at a later date, you may revoke your authorization.

8. Your Privacy Rights and How to Exercise Them

   You have specific rights under our federally required privacy program. Each of them is summarized below:

   - Your Right to Request Limited Use or Disclosure

     You have the right to request that we do not use or disclose your PHI in a particular way. However, we are not required to abide by your request. If we do agree to your request we must abide by the agreement; we have the right to ask for that request to be in writing and we will exercise that right

   - Your Right to Confidential Communication

     You have the right to receive confidential communications from us at a location or phone number that you specify. We have the right to ask for that request to be in writing noting the other address or phone number and confirmation that it should not interfere with your method of payment; we will exercise the right to have your request in writing

   - Your Right to Inspect and Copy Your PHI

     You have the right to inspect and copy your PHI. If we maintain our records in paper, that will be the format utilized; however if we maintain our records electronically you have the right to review and/or have copies made in an electronic format. Should we decline we must provide you with a resource person to assist you in the review of our refusal decision. We must respond to your request within thirty (30) days, we may charge reasonable fees for copying and labor time related to copying and we may require an appointment for record inspection; we have the right to ask for your request in writing and will exercise that right.

   - Your Right to Revoke Your Authorization

     If you have granted us an authorization to use or disclose your PHI you may revoke at any time it in writing. Please understand that we relied on the authority of your authorization prior to the revocation and used or disclosed your PHI within its scope.

- Your Right to Amend Your PHI
  You have a right to request an amendment of your record. We have the right to ask for the request in writing and we will exercise that right. We may deny that request if the record is accurate and/or if the record was not created by this facility. If we accept the amendment we must notify you and make effort to notify others who have the original record.

- Your Right to Know Who Else Sees your PHI
  You have the right to request an accounting of certain disclosure that we have made over the past six years. We do not have to account for all disclosures, including those made directly to you, those involving treatment, payment, health care operations, those to the family/friend involved with your care and those involving national security. You have the right to request the accounting annually. We have the right to ask for the request in writing and to charge for any accounting requests that occur more than once per year; we must advise you of any charge and you have the right to withdraw your request or to pay to proceed.

- You have a right to be informed of a breach your protected health information
  We are required to notify the patient by first class mail or by e-mail (if indicated a preference to receive information by e-mail), of any breaches of unsecured Protected Health Information as soon as possible, but in any event, no later than sixty (60) days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users. The notice is required to include the following information:

a) A description of the breach, including the date of the breach and the date of its discovery, if known
b) A description of the type of unsecured protected health information involved in the breach
c) Instructions regarding the measures the patient should take to protect him/her from potential harm resulting from the breach
d) Correction action Knapp Physical Therapy has/will take to investigate the breach, mitigate losses, and protect the patient from further breaches
e) Knapp Physical Therapy contact information, including a toll-free telephone number, e-mail address, Web site or postal address to allow for additional questions

- You Have a Right to Complain
  You have the right to complain if you feel your privacy rights have been violated. You may complain directly to us by contacting our HIPAA officer noted in Section 10, or to the:

  U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/

  We will not retaliate against you if you file a complaint about us. Your complaint should provide a reasonable amount of specific detail to enable us to investigate your concern.

- The Patient Has the Right to Receive a Copy of the Privacy Notice
  Knapp Physical Therapy is obligated to provide the patient with a copy of its Notice of Privacy Practices and to post the Notice in a conspicuous place for patients to access as well as on our website. We have the right to change the Notice to comply with policy, rules or regulatory changes; we are obligated to give new notices to current and subsequent patients as changes are made. We are required to maintain each version of a Privacy Notice for a minimum of six (6) years.

9. Some of Our Privacy Obligations and How We Perform Them
   - We are required by law to maintain the privacy and security of your protected health information
   - We will let you know promptly if a breach that may have compromised the privacy or security of your information
   - We must follow the duties and privacy practices described in this notice and give you a copy of it
   - We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind

If we change our Notice of Privacy Practices we will provide our revised Notice to you when you next seek treatment from us.

10. Contact Information

If you have questions about this Notice, or if you have a complaint or concern, please contact:

Name:	Anita Bean, Office Manager/HIPAA Officer
Address:	806 SW Blue Pkwy
	Lee's Summit, MO 64063
Phone:	816-272-1427
Fax:	816-600-2602

11. Effective Date: This revised notice takes effect on August 21, 2017.