Patient Information

Name _____

Address _____

City _____ State _____ Zip _____

Birth Date _____ Age: _____

Phone (Best number to reach you) _____ (home/work/cell – circle one)

Phone (Alternate) _____ (home/work/cell – circle one)

Email Address: _____

Employer: _____

Job Title: _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Emergency Contact's Relation to You: _____

Primary Physician _____

Referring Physician _____

Physician's Diagnosis _____

Brief Description of your Symptoms _____

_____

Have you had surgery related to the condition for which you are coming to physical therapy?

If yes, please list, with dates: _____

_____

Were you injured at work? _____ Date: _____

Were you injured in an Auto Accident? _____ Date: _____

Patient Signature: _____ Date: _____

PREVIOUS MEDICAL HISTORY

Please indicate yes if you have now, or have previously had, any of the following:

High blood pressure	_____	Pregnancies	_____
Low blood pressure	_____	Depression	_____
Heart disease	_____	Asthma	_____
Cancer	_____	Emphysema	_____
Diabetes	_____	Thyroid disorder	_____

Other medical history (please list):

_____

_____

Allergies (please list – if any):

_____

Surgeries (please list, with dates - even if they seem unrelated):

_____

_____

Musculoskeletal injuries/strains other than those for which you are coming to physical therapy (Please list - even if they seem unrelated):

_____

_____

Medications (please list):

_____

_____

Have you experienced previously the condition for which you are seeking treatment? _____ (yes/no)
If yes, please describe how frequently, whether you have sought treatment, and if so, what type of treatment.

_____

_____

_____

Patient Signature: _____ Date: _____

POLICIES AND CONSENTS

Welcome

Our goal at Back to Life is to provide you with precise, effective and compassionate physical therapy. Please take the time to read the following office policies carefully and to then sign the statements of consent.

Financial Policy

The financial responsibility for services rendered is yours. Payment of charges is due at the time of service.

Appointment Policy

You are responsible for scheduling your appointments.

Appointments are scheduled for one hour each. 55 minutes are spent one on one in the physical therapy session. The treatment schedule is booked so that you will not be kept waiting. Failure to arrive at your scheduled appointment time will result in less time available for your treatment.

Appointment cancellations require a minimum of 2 business days' notice. In the case of Monday appointments, please call by Thursday, and for Tuesday appointments, please call by Friday.

You will be responsible for confirming that you will attend your physical therapy appointment at least 48 business hours in advance. If you do not confirm your appointment, Back to Life will offer that appointment time to our waiting patients.

I have read the above policies and agree to comply with them. I authorize release of any information regarding my treatment in this facility to my referring physician.

Patient Signature:_____ Date: _____

Consent to receive services: I hereby authorize Amy Selinger, DPT, OCS, Iris Warchall, PT, DPT, Janette Cariad, PT and/or Elizabeth Williams, PT, MPT to render appropriate physical therapy services to me. I recognize and agree that I have the right to refuse treatment or to terminate treatment at any time by notifying Amy, Iris, Janette and/or Elizabeth. In addition, Amy, Iris, Janette and/or Elizabeth may terminate services by notifying me of the termination and reason.

Authorization for Emergency Medical Services: In the event of a medical emergency during physical therapy treatment, I authorize Amy, Iris, Janette and/or Elizabeth to provide or obtain such medical treatment as they deem advisable under the circumstances and I agree to assume sole responsibility for all charges for such treatment.

Patient Signature: _____ Date: _____

HIPAA Patient Privacy Notice

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review The Notice before signing this Consent. The terms of The Notice may change. If we change The Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reference to your prior Consent. Back to Life Physical Therapy provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Patient Rights

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and the patient has the opportunity to review The Notice.
- The Practice reserves the right to change The Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to the restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.
- The patient acknowledges that he/she has received a copy of this HIPAA practice notice.

Consent completed by: _____

Printed Name of Patient or Representative

Patient Signature:_____ Date: _____

Relationship to Patient (if other than patient): _____

Witness: _____

Printed Name of Back to Life Representative

Copy of notice provided to patient ☐

Medicare Non-Provider Agreement

Patient Full Name: _____

Patient Address _____

This agreement is between, Amy Selinger, PT, DPT, OCS, (Physical Therapist and owner of Back to Life), Iris Warchall, PT, DPT, Janette Cariad, PT and/or Elizabeth Williams, PT, MPT and the above named (Patient), who is a Medicare Part B beneficiary seeking service covered under Medicare part B pursuant to Section 4507 of the Balanced Budget Act of 1997.

The patient listed above understands that Back to Life is a non-participating Medicare provider but is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.
Based on Medicare's definition of either a "physician" or a "practitioner" an independent, physical therapy practice is not permitted to "opt out" of Medicare. Private contracts, as defined by Medicare, are not permitted between a physical therapist and Medicare Beneficiary. This agreement does not constitute a "private contract."

Amy Selinger, Iris Warchall, Janette Cariad and Elizabeth Williams agree to provide all physical therapy services available. In exchange for these services, patient agrees to make direct payments to the Back to Life.

Patient understands, agrees, and expressly acknowledges the following:

- Patient is not currently in an emergency or urgent healthcare situation.
- Patient agrees not to submit a claim (or to request that the physical therapist submit a claim) to the Medicare program with respect to services rendered, even if covered by Medicare Part B. Such action will result in immediate termination of the therapist-patient relationship.
- Patient acknowledges that neither Medicare's fee limitations nor any other Medicare reimbursement regulations apply to charges for services.
- Patient acknowledges that Medi-Gap plans will not provide payment or reimbursement for the services because payment is not made under the Medicare program, and other Medicare supplemental insurance plans may likewise deny reimbursement.
- Patient acknowledges that he or she has a right, as a Medicare beneficiary, to obtain Medicare covered items and services from physicians and practitioners who have not opted-out of Medicare, and that the patient is not compelled to enter into private contracts that apply to other Medicare approved services furnished by other physicians and practitioners who have not opted-out.
- Patient understands that Medicare payment will not be made for any items or services furnished by the therapist that would otherwise been covered by Medicare if these were not private contract and a proper Medicare claim was submitted.
- Patient elects to refuse the usage of his/her Medicare benefits and agrees to full financial responsibility of all treatment services provided by Back to Life and its affiliates.

OATH OR AFFIRMATION

The contents of this document are true and correct under penalty of perjury.

_____
Date

_____
Signature of Person Making Affidavit

_____
Printed Name

State of California
County of _____

Subscribed and sworn to (or affirmed) before me on this _____day of _____, 20 __ ,

by _____, proved to me on the basis of satisfactory

evidence to be the person(s) who appeared before me.

Signature _____(Seal)

The Medicare Non-Provider agreement **MUST** be notarized **PRIOR** to receiving treatment at Back to Life Physical Therapy, Inc.