CLIENT NEEDS SCREEN (CNS)

Thank you for choosing FYZICAL Therapy & Balance Center of Ocean Pines. We are interested in your entire well-being, not just what you are being seen for today. The following Client Needs Screen will help us identify areas where we can better serve you. We will add services based on the feedback from our community.

1. Have you had a fall in the past year?	□ Yes □ No
2. Do you have a fear of falling?	□ Yes □ No
3. Would you like your balance to be assessed?	□ Yes □ No
4. Do you experience dizziness or imbalance?	□ Yes □ No
5. Do you lose your balance when stepping up/down curbs or stairs/steps?	□ Yes □ No
6. Do you have a difficult time walking in the dark?	□ Yes □ No

7. Do you experience muscle aches, pains and/or muscle cramping?	□ Yes □ No

8. Would you be interested in learning about a topical cream to help this?	□ Yes □ No
9. Do you use cold, heat or compression therapy at home?	□ Yes □ No
10. Are you interested in learning how compression clothing with ice could help your condition?	□ Yes □ No
11. Are you interested in learning how home heat and/or cold therapy could help your condition?	□ Yes □ No

12. Do you have foot and/or ankle pain/discomfort?	□ Yes □ No
13. Do you currently wear shoe inserts?	□ Yes □ No
14. Are you interested in learning about how laser therapy can help improve your condition?	□ Yes □ No

FYZICAL®
Therapy & Balance Centers

MEDICARE SECONDARY PAYER QUESTIONNAIRE

The information contained in this form is used by Medicare to determine if there is other insurance that should pay claims primary to Medicare.

1. Are you receiving benefits from any of the following programs?

Black Lung ☐ YES ☐ NO
Research Grant ☐ YES ☐ NO
Veteran Affairs ☐ YES ☐ NO

2. Was illness/injury due to a work related accident/condition?

☐ YES ☐ NO

If **YES,** answer the following:

Work related accident? ☐ YES ☐ NO
Non-work related accident? ☐ YES ☐ NO

3. Is the patient currently employed?

☐ YES ☐ NO

Do you have group health plan (GHP) coverage? If yes, are there under or over 20 employees?

☐ UNDER ☐ OVER

4. Is the patient's spouse currently employed?

☐ YES ☐ NO

Does your spouse have group health plan (GHP) coverage? If yes, are there under or over 20 employees?

☐ UNDER ☐ OVER

5. Is the patient entitled to Medicare benefits as a result of:

Age? ☐ YES ☐ NO
End Stage Renal Disease? ☐ YES ☐ NO
Disability? ☐ YES ☐ NO

6. Are you currently a patient in a skilled nursing facility such as a nursing home?

☐ YES ☐ NO

7. Are you currently receiving any Home Health Services?

☐ YES ☐ NO

8. Are you covered under a Medicare Part C (Medicare Advantage/Medicare+Choice) program?

☐ YES ☐ NO

I confirm that the above information if correct.

Printed Name:_____ **Relationship to Patient:**_____
Signature:_____ **Date:**_____

http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/msp105c03.pdF

FYZICAL THERAPY and BALANCE CENTER OF OCEAN PINES
AUTHORIZATION & RELEASE OF INFORMATION ACKNOWLEDGEMENT

Authorization for Treatment

- I hereby give authorization for performance of rehabilitation services as permitted by Maryland Statutes under the appropriate scope of practice which are deemed necessary by my therapist.

Authorization for Release of Information

- I agree that FYZICAL Therapy and Balance Center of Ocean Pines (hereafter referred to as FYZICAL) may provide information from my medical record to persons involved in my medical care.
- I authorize the release of medical information necessary to obtain payment of any benefits available to me to FYZICAL for services rendered.
- I agree that FYZICAL may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment.

Authorization for Release of Payment

- I authorize the direct payment of any benefits available to me be released to FYZICAL for services rendered.

Patient Agreement

- I agree to pay FYZICAL charges for services rendered to me during my course of treatment
- I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I have difficulty paying those charges, I understand that a payment plan may be worked out to allow payment of charges over time. If I do not pay for charges that are my responsibility, I agree to pay FYZICAL collection costs including attorney and court fees.

Medicare, Medicaid, and Similar Benefits

- I agree that the information given to FYZICAL in applying for benefits under Medicare, Medicaid, and Maternal or Child Health Services are complete and accurate. I agree that FYZICAL may give Social Security Administration or its fiscal intermediary's information necessary to process claims.

Medical Records Requests

- As a patient of FYZICAL, I understand that I may request the release of my medical records at any time. I understand that I must submit this request in writing and allow three business days for the request to be processed. I agree to pay $0.76 a page for all records over twenty-one pages in length. I understand that this payment will be expected in full in order to receive my records.

I have read and understand FYZICAL's Authorization & Release of Information Policies.

Printed Name:_____ **Relationship to Patient:**_____

Signature:_____ **Date:**_____

FYZICAL Therapy & Balance Centers

NOTICE OF PRIVACY PRACTICES

As part of my health care, FYZICAL Therapy & Balance Centers (The Company) 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 of each medical office and at the central billing office. 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.

I acknowledge that a copy of the Notice of Privacy Practices of FYZICAL Therapy & Balance Centers is available to me and agree to the liability limitations explained therein.

Printed Name:_____ **Relationship to Patient:**_____
Signature:_____ **Date:**_____

CANCELLATION & NO SHOW POLICY

You are coming to therapy to remedy a condition that is affecting you. It is important that you attend your scheduled appointments. If you must cancel an appointment, please give as much notice as possible, preferably 24 hours, so that we may offer your appointment time to others who desire it. We understand that situations will arise where you will be unable to make your appointment and have to cancel that day. We will make every effort possible to offer you an alternate appointment time that day or one for later in the week to make up that missed appointment. Any individual who does not show for three appointments and does not call to cancel prior to that appointment will be discharged from therapy, as we feel that those who do not show for three sessions without calling are not interested in receiving therapy services.

I have read and understand FYZICAL's Cancellation & No Show Policy.

Printed Name:_____ **Relationship to Patient:**_____
Signature:_____ **Date:**_____

FYZICAL Therapy & Balance Centers

EMAIL ADDRESS

Please provide your email address: _____

TEXT REMINDERS

Would you like appointment reminders via text? _____ Yes _____ No

Would you like to receive information about upcoming FYZICAL events via text or email? _____ Yes _____ No

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CONSENT TO DISCUSS MEDICAL INFORMATION & EMERGENCY CONTACT

Please list person(s) authorized to discuss medical information:

Name: _____ Relationship: _____

Emergency Contact: _____ Phone # _____

INSURANCE VERIFICATION POLICY

As a courtesy to our patients, FYZICAL makes every attempt to verify the patient's insurance benefits with their carrier. We verify the Physical Therapy benefits via phone or online. When benefits are verified FYZICAL is provided with the following disclaimer from all insurance carriers:

"Please be advised that a quote of eligibility and benefits is not a guarantee of payment. All benefits are subject to eligibility, medical necessity and the terms, conditions, limitations and exclusions of the patient's health benefit plan at the time the services are rendered."

We have had situations arise where the verified benefits are not the actual benefits. Unfortunately, this is not determined until the claims have been processed and an explanation of benefits is generated. If there is a discrepancy between the aforementioned verified benefits and the actual benefits, please contact the insurance carrier. They need to be aware of the fact that their verification system is providing incorrect information to their providers. Please understand that it is ultimately the patient's responsibility to be aware of their benefits and the policy that they've enrolled in through their insurance company. Any misquote of benefits from the insurance company does not waive the patient's responsibility and a statement will be sent for the correct amount.

I have read and understand the Insurance Verification Policy. I understand that the benefits provided to me are a quote provided by the insurance carrier and are verified as a courtesy. The benefits may not always be accurate, and I will be responsible for any outstanding balance as a result of the terms and conditions of my insurance policy.

Printed Name:_____ **Relationship to Patient:**_____

Signature:_____ **Date:**_____

FYZICAL® Therapy & Balance Centers