



MEDICARE GUIDELINES FOR PHYSICAL THERAPY

We would like to make you aware of Medicare’s rules for outpatient physical therapy in order to provide you with the most effective care.

- The annual limit for 2010 is \$1860, which we **estimate** to be approximately 15 visits of treatment. This limit changes annually.
- Medicare claims for physical therapy require a physician’s prescription/referral.
- Medicare requires that your physician certify a “Plan of Care” if one is not included in your physician’s prescription/referral. Your therapist will send your physician a Consultation Report including a Plan of Care for him/her to sign and return to MTI.
- Your therapist will send a progress report to your physician at least once every 10 treatment days or at least once during each 30 calendar days, whichever is less.
- Your Plan of Care, which can be included in your Progress Notes, must be recertified with your physician’s signature when a significant change in the plan of care becomes evident or at least every 90 days.

If you have any comments regarding these rules, please direct them to:

State of Washington Carrier:
1-800-633-4227 or
www.medicare.gov/Coverage/Home.asp

By signing below, I understand the rules described above and realize that claims may be denied if we do not comply with these requirements. We appreciate your help in working with MTI and all your medical providers to meet these guidelines for the continuity of your care.

Signature

Date



PATIENT INFORMATION

NAME HOME PHONE.....
ADDRESS WORK PHONE.....
CITY/STATE/ZIP..... EMERGENCY #.....
EMPLOYER EMERG. CONTACT
ADDRESS RELATION TO YOU
CITY/STATE/ZIP..... REFERRING DOCTOR.....
SPOUSE'S EMPLOYER..... PHONE NUMBER.....
SPOUSE'S WORK # PRIMARY CARE DR.
PATIENT'S GENDER [] MALE [] FEMALE PHONE NUMBER.....
SSN-.....-..... DATE OF BIRTH BODY PART INJURED
SUBSCRIBER'S NAME HAVE YOU HAD PT THIS YEAR
SUBSCRIBER'S DOB DATE OF ONSET/INJURY
IS INJURY FROM [] AUTO [] WORK [] OTHER

INSURANCE POLICY INFORMATION

PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY
ADDRESS
CITY/STATE/ZIP.....
PHONE NUMBER
GROUP NUMBER
IDENTIFICATION NUMBER.....
SUBSCRIBER'S NAME
RELATION TO PATIENT

SECONDARY INSURANCE (MEDICARE ONLY)

INSURANCE COMPANY
ADDRESS
CITY/STATE/ZIP.....
PHONE NUMBER
GROUP NUMBER.....
IDENTIFICATION NUMBER
SUBSCRIBER'S NAME
RELATION TO PATIENT

AUTO/L&I INFORMATION

INSURANCE COMPANY
ADDRESS
CLAIM NUMBER
ADJUSTER'S NAME
PHONE #

ATTORNEY

NAME
PHONE NUMBER

PATIENT AGREEMENT-PLEASE READ CAREFULLY

I GUARANTEE PAYMENT OF ALL PHYSICAL THERAPY CHARGES FOR TREATMENT PROVIDED TO THE ABOVE NAMED PATIENT TO MANUAL THERAPY INTERNATIONAL. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCLUDING BUT NOT LIMITED TO ALL COPAYMENTS, DEDUCTIBLES AND EXPENSES NOT COVERED OR PAID BY MY INSURANCE. I UNDERSTAND THAT THE UNPAID BALANCE IS DUE IN FULL UPON COMPLETION OF CARE, AND THAT THERE IS A MONTHLY FINANCE CHARGE OF 1.5% (18% PER ANUM) APPLIED TO THE UNPAID BALANCE AFTER 30 DAYS FROM DISCHARGE. IF LEGAL ACTION IS TAKEN AGAINST THIS ACCOUNT I AGREE TO PAY FOR ALL REASONABLE LEGAL FEES ASSOCIATED WITH THIS ACTION. I AGREE TO COMPLY WITH THE POLICIES OF SAID CLINIC AS EXPLAINED HEREIN. I UNDERSTAND THAT I MUST GIVE 24-HOUR NOTICE OF CANCELLATION IF I AM UNABLE TO KEEP A SCHEDULED APPOINTMENT. IN THE EVENT THAT INDUSTRIAL OR AUTO INSURANCE EXHAUSTS OR REFUSES TO PAY, I AUTHORIZE MANUAL THERAPY INTERNATIONAL TO BILL MY HEALTH INSURANCE. I, THE UNDERSIGNED, GIVE PERMISSION TO RELEASE INFORMATION TO 3RD PARTY CARRIERS AND DO ASSIGN ALL INSURANCE BENEFITS FOR TREATMENT TO BE PAID DIRECTLY TO MANUAL THERAPY INTERNATIONAL AND REQUEST THAT THIS ASSIGNMENT REMAIN ON FILE WITH MY INSURANCE CARRIER. I CERTIFY THAT A COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.

[Signature box]

[Date box]

Patient or Legal Guardian Signature

Date



PATIENT HEALTH QUESTIONNAIRE

NAME WEIGHT HEIGHT AGE SEX

Check all boxes that apply.

Have you or any immediate family member ever been told you have:

	You	Family
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Angina/Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>

Do you have a history of:

- | | |
|--|--|
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Kidney Disease/Stones | <input type="checkbox"/> Ulcers |

Check all boxes that apply.

With current problem do you experience:

- | | |
|--|--|
| <input type="checkbox"/> Nausea/Vomiting | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Fever/Chills/Sweats | <input type="checkbox"/> Night Pain |
| <input type="checkbox"/> Unexplained Weight Change | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Muscular Weakness |
| <input type="checkbox"/> Bowel or Bladder Changes | <input type="checkbox"/> Surgery |

For this problem have you received treatment from:

- | | |
|--|---|
| <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Osteopath |
| <input type="checkbox"/> Physiatrist | <input type="checkbox"/> Acupuncturist |
| <input type="checkbox"/> Neurosurgeon | <input type="checkbox"/> Psychologist |
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Other Physical Therapist |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Other |

Have you had any recent illness, to include upper respiratory infections (flu) or urinary tract infections?

- No Yes
Describe:

Do you use caffeine?

- No Yes # of cups per day?

How often do you feel stress is a significant factor in your life?

- Never Seldom Regularly Always

List all medications and supplements:

.....
.....
.....

Date of last complete physical examination?

List regular exercise/activity:

.....
.....
.....

Do you smoke?

- No Yes How many packs?.....
For how long?

Other comments:

.....
.....



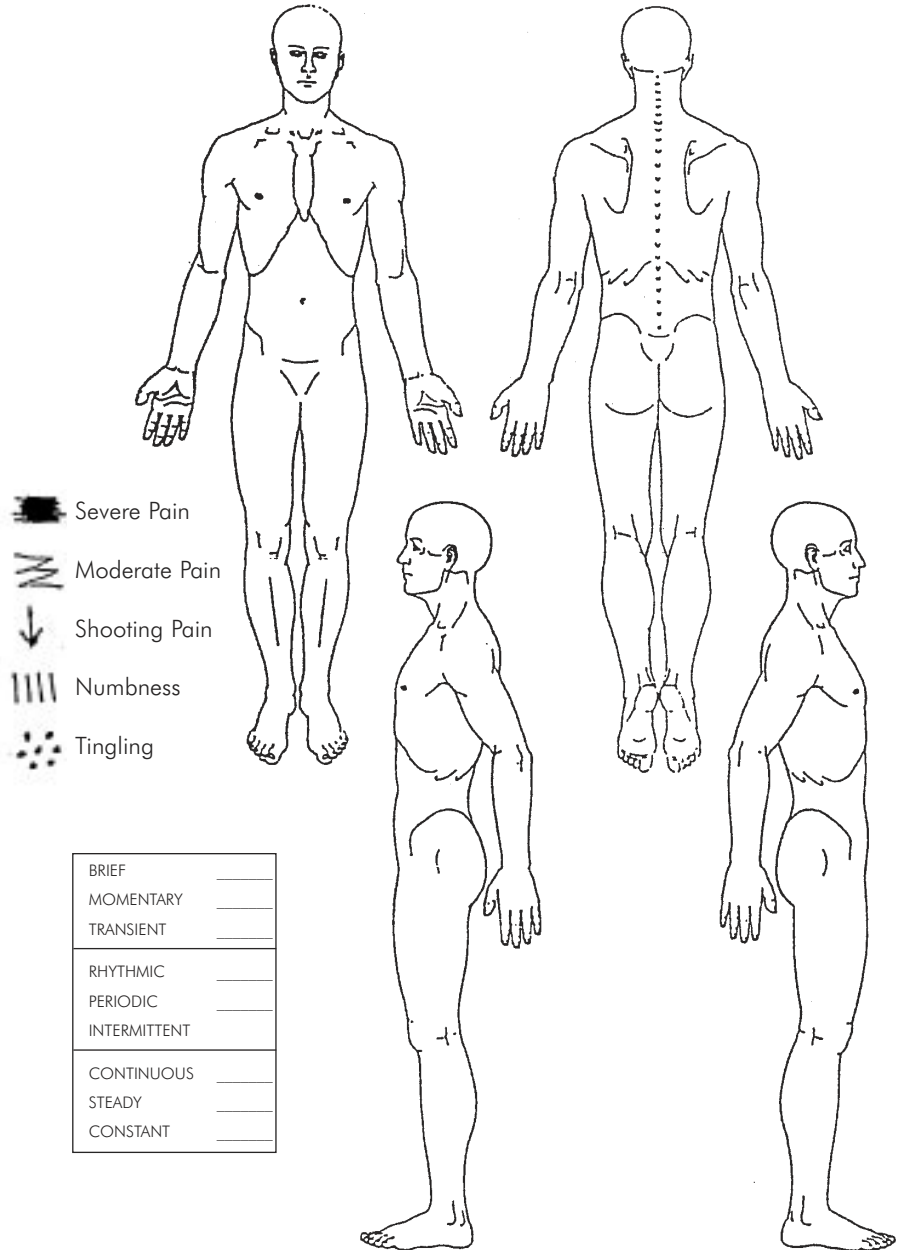
McGILL PAIN QUESTIONNAIRE

Patient Name

Date

DIRECTIONS: There are many words that describe pain. Some of these words are grouped below. IF YOU ARE EXPERIENCING ANY PAIN, check (✓) any words that describe your pain.

1. Flickering _____ Quivering _____ Pulsing _____ Throbbing _____ Beating _____ Pounding _____	13. Fearful _____ Frightful _____ Terrifying _____
2. Jumping _____ Flashing _____ Shooting _____	14. Punishing _____ Grueling _____ Cruel _____ Vicious _____ Killing _____
3. Pricking _____ Boring _____ Drilling _____ Stabbing _____ Lancinating _____	15. Wretched _____ Blinding _____
4. Sharp _____ Cutting _____ Lacerating _____	16. Annoying _____ Troublesome _____ Miserable _____ Intense _____ Unbearable _____
5. Pinching _____ Pressings _____ Gnawing _____ Cramping _____ Crushing _____	17. Spreading _____ Radiating _____ Penetrating _____ Piercing _____
6. Tugging _____ Pulling _____ Wrenching _____	18. Tight _____ Numb _____ Drawing _____ Squeezing _____ Tearing _____
7. Hot _____ Burning _____ Scalding _____ Searing _____	19. Cool _____ Cold _____ Freezing _____
8. Tingling _____ Itchy _____ Smarting _____ Stinging _____	20. Nagging _____ Nauseating _____ Agonizing _____ Dreadful _____ Torturing _____
9. Dull _____ Sore _____ Hurting _____ Aching _____ Heavy _____	ACCOMPANYING SYMPTOMS: Nausea _____ Headache _____ Dizziness _____ Constipation _____ Diarrhea _____
10. Tender _____ Taut _____ Rasping _____ Splitting _____	ACTIVITY: Good _____ Some _____ Little _____ None _____
11. Tiring _____ Exhausting _____	SLEEP: Good _____ Fitful _____ Can't sleep _____
12. Sickening _____ Suffocating _____	FOOD INTAKE: Good _____ Some _____ Little _____ None _____



BRIEF	_____
MOMENTARY	_____
TRANSIENT	_____
RHYTHMIC	_____
PERIODIC	_____
INTERMITTENT	_____
CONTINUOUS	_____
STEADY	_____
CONSTANT	_____

No Pain Worst Possible Pain

COMMENTS:

SLEEP:

FOOD INTAKE:

Good _____

Good _____

Fitful _____

Some _____

Can't sleep _____

Little _____

None _____



PROCEDURES AND FINANCIAL POLICY

OFFICE HOURS: TO MEET YOUR INDIVIDUAL NEEDS, WE OFFER EARLY AND LATE APPOINTMENTS. AS EACH OFFICE HAS UNIQUE OFFICE HOURS, PLEASE CHECK THE SPECIFIC HOURS OF THE CLINIC YOU ARE BEING TREATED AT. OUR VOICEMAIL SERVICE WILL ANSWER CALLS OFF HOURS AND ON WEEKENDS. **CALL 911 IF THERE IS AN EMERGENCY.**

APPOINTMENTS: WE REALIZE UNEXPECTED SITUATIONS OCCUR. IF YOUR SCHEDULE DOES CHANGE AND YOU HAVE TO CANCEL YOUR APPOINTMENT, PLEASE CALL IN ADVANCE SO THAT WE MAY OFFER THAT TIME TO ANOTHER PERSON. IF YOU WILL BE LATE PLEASE CALL AS WE MAY NEED TO RESCHEDULE YOUR APPOINTMENT. IF YOU MISS 3 APPOINTMENTS WITHOUT PROPER NOTICE, YOUR CARE MAY BE TERMINATED AT YOUR THERAPIST'S DISCRETION. **WE DO CHARGE A \$45 FEE FOR MISSED OR CANCELLED APPOINTMENTS WITHOUT AT LEAST 24 HOURS NOTICE.**

PRIVACY POLICIES STATEMENT/HIPAA: YOU WILL HAVE AN OPPORTUNITY TO REVIEW AND QUESTION OUR PRIVACY POLICIES STATEMENT AT YOUR REQUEST. THIS STATEMENT WILL OUTLINE OUR POLICIES THAT PROTECT YOUR PRIVACY. WE WILL RELEASE YOUR PERSONAL HEALTH INFORMATION FOR BILLING PURPOSES TO BE REIMURSED FOR SERVICES RENDERED. YOU MAY REQUEST (IN WRITING) TO PREVENT US FROM DOING SO WITHOUT PENALTY OR CESSATION OF YOUR CARE. IF YOU EXERCISE THIS RIGHT, YOU WILL BE RESPONSIBLE FOR YOUR BALANCE. AND IT WILL BE YOUR RESPONSIBILITY TO SUBMIT YOUR INSURANCE CARRIER FOR REIMBURSEMENT.

FINANCIAL INFORMATION: COPAYS ARE DUE AT THE TIME OF SERVICE. WE WILL TRY TO REMIND YOU AT YOUR APPOINTMENT TIME TO MAKE SURE THEY ARE PAID. WE WILL VERIFY YOUR BENEFITS, HOWEVER, IT IS HELPFUL FOR YOU TO ALSO VERIFY YOUR BENEFITS TO PREVENT UNEXPECTED COSTS. **WE WILL BILL YOUR HEALTH INSURANCE, PIP OR L&I DIRECTLY. ANY REMAINING BALANCE IS YOUR RESPONSIBILITY.**

WE DO NOT BILL SECONDARY INSURANCE UNLESS THE PRIMARY INSURANCE IS MEDICARE.

BALANCES UNPAID AFTER 60 DAYS WILL ACCRUE A 1.5% FINANCE CHARGE EACH BILLING CYCLE.

BALANCES UNPAID AFTER 90 DAYS MUST HAVE PAYMENT ARRANGEMENTS MADE WITH OUR BILLING OFFICE.

BALANCES UNPAID AFTER 120 DAYS WILL BE TURNED OVER TO COLLECTIONS.

CHECKS RETURNED WITH NON-SUFFICIENT FUNDS WILL BE CHARGED A \$35.00 FEE.

NOTE FOR WASHINGTON ATHLETIC CLUB MEMBERS: THE SERVICES PROVIDED UNDER THIS AGREEMENT, OR OTHERWISE, ARE BEING PROVIDED SOLELY BY Manual Therapy International AND NOT THE WASHINGTON ATHLETIC CLUB (WAC). THE PROVIDER IS AN INDEPENDENT CONTRACTOR. THE WAC IS MAKING SPACE AVAILABLE TO THE PROVIDER BUT IS NOT AFFILIATED WITH THE PROVIDER. THE WAC IS NOT AND HAS NOT REVIEWED OR MONITORED THE QUALITY OR PROPRIETY OF ANY SERVICES OFFERED BY THE PROVIDER. ANY PERSONS USING THESE SERVICES MUST MAKE AND RELY UPON THEIR OWN INDEPENDENT INVESTIGATION AND JUDGEMENT.

I HAVE READ AND UNDERSTAND THIS INFORMATION AND AGREE TO COMPLY WITH THE POLICIES SET FORTH HERE.

Signature

Date