LAKE OCONEE
REHABILITATION
PHYSICAL THERAPY

MEDICARE CAP ON THERAPY SERVICES

As of January 1, 2006 the Centers for Medicare and Medicaid Services placed a cap on outpatient physical, speech and occupational therapy.

Physical and Speech Therapy have a combined annual cap of $2,110.00 per beneficiary per **YEAR** while Occupational Therapy has a separate cap of $2,110.00 per beneficiary per **YEAR**.

The patient/beneficiary is responsible for the payment of any deductibles.

It is unfortunate that Medicare limits access of Medicare beneficiaries to therapy services however the caps described above reflect the limit of what Medicare will pay for the services that we provide.

In light of these Medicare limits, it is important that you notify us of any physical or speech therapy that you receive or have received at any other location. Accordingly, please notify your therapist if you have received physical or speech therapy at any other location this calendar year.

117 HARMONY CROSSING, SUITE 4, EATONTON, GA 31024 | 1000 COWLES CLINIC WAY, SUITE D-100, GREENSBORO, GA 30642
PHONE – (706) 454-1811 FAX – (706) 454-1812 WWW.LAKEOCONEEREHAB.COM

LAKE OCONEE REHABILITATION PHYSICAL THERAPY

Our goal is to make your visit with us a pleasant and rewarding experience. The success of your rehabilitation efforts depends on your personal commitment and participation. Based on your available insurance or the circumstances surrounding the injury that has caused you to seek this treatment, the commitment required of you may be one of both time and finances (please read carefully our Financial Policy below). We realize that your time and finances are both important. In return for your commitment we promise to dedicate our time, professional skills, effort, and compassion. We are committed to providing you with excellent professional care and customer service in a caring and professional environment. Communication is at the heart of any successful rehabilitation effort so please be sure to share with us any information that you think may be of assistance with our efforts.

OUR COMMITMENTS TO YOU:

- Excellent customer service
- Professionalism
- Flexible scheduling
- Respect for your time: Seen within 15 minutes of scheduled appointment time

OUR REQUIREMENTS OF YOU:

- Respect for our time: Prior day cancellation notice
- Timely arrival for your appointment
- Participation in prescribed home program
- Honest and open communication

We realize that unforeseen events may occur which require you to cancel your appointment on the same day it is scheduled, however we expect that this will be rare.

1) A same day cancellation is defined as contacting our office on the day of your appointment in order to cancel or reschedule.
2) A No-Show is defined as failure to show up for your appointment without canceling prior to your appointment time. Contacting us after your appointment time in order to cancel or reschedule the appointment will be considered a no-show.

In order that we might provide the best possible care to all of our patients, a no-show or multiple same day cancellations will result in one or both of the following:

- Discharge from care with a notification letter to your referring physician
- A fee of $25 being assessed to your account

If we fail in any way to meet your expectations, please notify the clinic manager so that we may correct and resolve your concerns.

I have read and understand the above requirements _____

Signature of Patient/Responsible Party

PATIENT INFORMATION SHEET

Patient Name: _____
Last First M.I.

Date of Birth: _____ SS#:_____ Email Address: _____
Home Address: _____

City: _____ State: _____ Zip Code: _____

Home PH: _____ Cell PH: _____ Work PH: _____
Emergency Contact Person: _____ Relation: _____
Phone: _____

My condition is related to:
☐ Work ☐ Auto Accident (state_____) ☐ Other: _____

Onset/Date of Injury: _____ Primary Care Physician: _____

Employer Name & Address: _____

_____

Within the last 12 months have you received care in your home for any condition, to include, Nursing, Occupational Therapy or Physical Therapy? ☐ Yes ☐ No

If yes, please list what agency you used and when your last month of service was: _____

_____

How did you hear about us?_____

Why did you choose this clinic? _____

INSURED PARTY INFORMATION

Did you obtain health insurance through YOUR employer or otherwise obtained in YOUR name?
☐ Yes ☐ No

If NO, please complete the section below with policy owner information.

Insured Name:_____
Last First M.I.
Insured Address: _____

City: _____ State: _____ Zip Code: _____ Gender: ☐ M ☐ F

Relationship to patient: _____ Date of Birth: _____

Home PH: _____ Cell PH: _____

Thank you for choosing Lake Oconee Rehabilitation Physical Therapy for your Physical Therapy needs. The following is an explanation of our Financial Policy. Please read the following material and if you have any questions about any part of this policy, we have financial specialists on staff that will be happy to explain any aspect of these policies. You will be asked to provide us with a written acknowledgement that you have read and understand these policies prior to receiving any treatment.

FINANCIAL POLICY

While our main concern is that you receive the proper care and optimal treatment needed to restore your health, financial realities and insurance regulations and contracts require that we fully understand the circumstances that gave rise to your injury so that we may determine what individual or insurer may be responsible for the payment of the charges related to your care.

ULTIMATLEY EACH INDVIDUAL IS RESPONSIBLE FOR THE PAYMENT OF ANY CHARGES RELATED TO THEIR OWN CARE AND TREATMENT. AS A COURTESY WE WILL ASSIST YOU, WHERE APPROPRIATE, BY FILING CLAIMS FOR THE PAYMENT OF YOUR CARE WITH HEALTH INSURERS OR OTHER INDIVIDUALS OR ENTITIES. IN THE EVENT THAT THE CHARGES FOR YOUR CARE ARE NOT COVERED OR PAID FOR BY OTHERS, YOU AGREE TO PAY US IN ACCORDANCE WITH THE FINANCIAL POLICIES SET OUT HEREIN.

HEALTH INSURANCE: We will file your insurance as a courtesy to you. However, you must understand the following:

1. Should your insurance require any pre-certification or authorization, please make sure that you or your referring physician have obtained such pre-clearance prior to beginning any treatment. THIS IS YOUR RESPONSIBILITY. If you are unsure whether any such preauthorization is required for your care, and whether it has been obtained, please make this inquiry as any charges incurred without the proper authorization will be the responsibility of the patient.

2. **Your insurance policy is a contract between you and your insurance company, not Lake Oconee Rehabilitation Physical Therapy.** All charges are ultimately the patient's responsibility. Not all services are a covered benefit, so please know and understand your policy. If your insurer does not pay Lake Oconee Rehabilitation Physical Therapy, our charges will be your responsibility.

3. Health Insurance co-payments are required to be paid at the time of service.

PATIENT PAYMENT: If the charges for your care and treatment are not paid for by any health insurance carrier, workers'compensation insurer, governmental payer or the insurer for some At Fault Third Party, payment for your care and treatment is due in full at the time the service is provided unless other payment arrangements are made in advance and in writing.

Our office is designed to provide the highest quality physical therapy and rehabilitation care and treatment available, our office is not designed to be a provider of credit or otherwise designed to provide the financing of patient care and treatment. At the same time, we understand that temporary financial problems or financial hardship associated with an unexpected injury or event may affect the timely payment of your account balance. If this is the case, please communicate this with our business office and we will be happy to attempt to work out a payment arrangement although such arrangements generally will not exceed a time period of six (6) months from the conclusion of our services.

For your convenience, we accept VISA, MASTERCARD and DISCOVER. In the event any payment is made on your account by check, draft or money order and such check, draft or money instrument is returned for lack of funds, you will owe, in addition to the amount of such check, a service charge in the amount of thirty dollars ($30.00) or five percent (5%) of the face amount of the instrument, whichever is greater.

In the event the patient responsibility portion of your account, or any portion thereof, is not paid within thirty (30) days of the billing of the account, finance charges will accrue on such outstanding balance at the rate of twelve percent (12%) per annum. Interest will be computed on the basis of a three hundred sixty (360) day calendar year. In addition to the finance charges, in the event that any account is not paid as and when due, the undersigned agrees to pay, in addition to such finance charges, all costs of collection specifically including, but not limited to the cost of collection associated with referral to a collection agency or an attorney at law.

We thank you for choosing Lake Oconee Rehabilitation Physical Therapy as your health care provider and we appreciate your trust in us and the opportunity to serve you.
I have read, understand and hereby agree to comply with the financial policies and arrangements described above and I hereby agree to be bound by all of the terms and provisions hereof in regard to the payment of my account.

_____

Signature of Patient/Responsible Party

_____ Date: _____

Please print patient's name

PROTECTED HEALTH INFORMATION (PHI) ACKNOWLEDGMENT STATE OF GEORGIA AUTHORIZATION

PROTECTED HEALTH INFORMATION ACKNOWLEDGMENT PURSUANT TO THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 ("HIPAA")

By my signature below, I hereby acknowledge receipt of the Lake Oconee Rehabilitation Physical Therapy Notice of Privacy Practices related to a list of the specific practices of use and disclosure of Protected Health Information (PHI) by Lake Oconee Rehabilitation 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.

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release by Lake Oconee Rehabilitation Physical Therapy of any and all of my medical information or medical records necessary to process any and all insurance claims on my behalf. I further authorize any and all other medical providers and/or holders of medical information about me to release any and all such records and information to Lake Oconee Rehabilitation Physical Therapy as requested by Lake Oconee Rehabilitation Physical Therapy to determine the eligibility for, and process the claims of, Lake Oconee Rehabilitation Physical Therapy related to the provision of rehabilitation services to me.

PAYMENT AUTHORIZATION

The undersigned hereby assigns unto Lake Oconee Rehabilitation Physical Therapy all rights to receive payment from my insurance company for the provision by Lake Oconee Rehabilitation Physical Therapy of physical rehabilitation services and I direct my insurer to pay any and all amounts due for the provision of such services directly to Lake Oconee Rehabilitation Physical Therapy.

I acknowledge having read and hereby agree to each of the above acknowledgment/authorizations.

_____

Signature of Patient/Responsible Party

Date: _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

(List any office that may request your therapy records. Ex. Attorney, non-referring physician)

I, _____ authorize release of my Lake Oconee Rehabilitation Physical Therapy medical records by written or verbal communication to the following, if requested:

_____
(Name of authorized person / office)

_____
(Name of authorized person / office

AUTHORIZATION FOR RELEASE OF APPOINTMENT/BILLING INFORMATION RECORDS

(List any person that may call, on your behalf, to make or change appointments or ask billing questions. Ex. Spouse, child, caregiver)

I, _____ authorize release of my **appointment** and/or **billing** information to the following person(s) listed below:

_____
(Name of authorized person or persons)

_____
(Name of authorized person or persons)

_____ _____
(Signature of patient) **Date**

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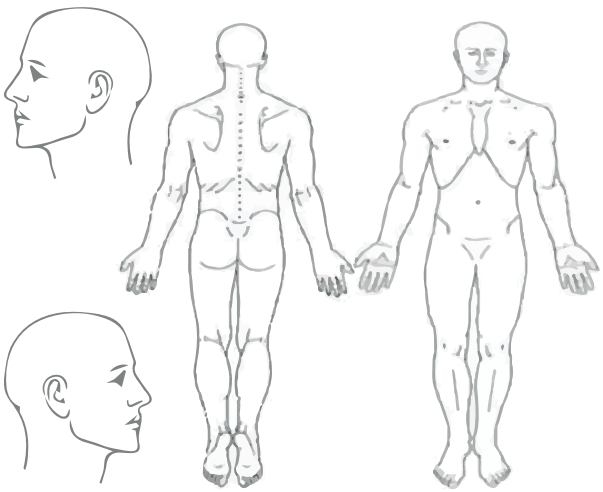
PATIENT INFORMATION SHEET
NEW PATIENT

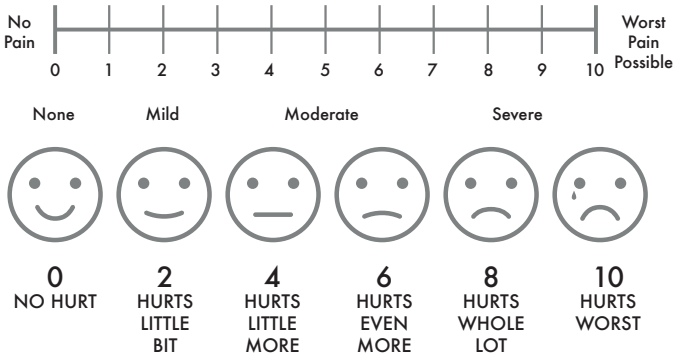
Do you have any of these conditions?

Allergies	Yes	No	Diabetes	Yes	No	Metal Implants	Yes	No
Anemia	Yes	No	Dizzy Spells	Yes	No	Multiple Sclerosis	Yes	No
Anxiety	Yes	No	Emphysema / Bronchitis	Yes	No	Osteoporosis	Yes	No
Arthritis	Yes	No	Fractures	Yes	No	Parkinson's	Yes	No
Asthma	Yes	No	Falls	Yes	No	Rheumatoid Arthritis	Yes	No
Cancer	Yes	No	2 or more Falls in past year	Yes	No	Seizures	Yes	No
Cardiac Conditions	Yes	No	Gallbladder Problems	Yes	No	Speech Problems	Yes	No
Cardiac Pacemaker	Yes	No	Hepatitis	Yes	No	Strokes	Yes	No
Chemical Dependency	Yes	No	High Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Circulation Problems	Yes	No	Incontinence	Yes	No	Tuberculosis	Yes	No
Currently Pregnant	Yes	No	Kidney Problems	Yes	No	Vision Problems	Yes	No
Depression	Yes	No						

Please circle the locations of your pain



Pain Rating Scale



Other conditions the physical therapist should know about that are not listed above? If 'yes', please provide:

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MEDICATION LIST

Patient Name: _____

PRESCRIPTION MEDS:

MEDICATION	DOSAGE	MEDICATION	DOSAGE

NON-PRESCRIPTION MEDS:

MEDICATION	DOSAGE

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