Patient Intake Form

All information kept confidential

Name: ________________________________ Today's Date: _______________________

Age: ______ Date of Birth: ____ /____ /______ Best Phone #: (_____)__________________
MM DD YYYY

Email Address: ____@___________________

What is the best way to get in touch with you? Phone call Text Email

Local Address: ____
Street City State Zip

"Up North" Address: ____
Street City State Zip

How did you hear about Bridging The Gap Physical Therapy? __________________________

What are your current symptoms?

Location: ____

How often do you feel discomfort? ____

Type of discomfort: Achy Burning Dull Radiating Sharp Shooting Stiff Tight
Circle all that apply
Other: ____

Circle the number indicating your level of discomfort…

Right now:	0	1	2	3	4	5	6	7	8	9	10
At your worst:	0	1	2	3	4	5	6	7	8	9	10
At your best:	0	1	2	3	4	5	6	7	8	9	10
	No Pain										*Unbearable Pain*

What makes your symptoms worse? ____

What makes your symptoms better? ____

What, if any, medications have you taken to manage your symptoms?

____________________________________ ____________________________________

____________________________________ ____________________________________

FOR INTERNAL USE ONLY: __JANE __ICAL __SCAN

What, if anything, do your symptoms prevent you from doing?

____

What do you think initially caused your symptoms? When?

____

Have you experienced similar symptoms in the past? *Yes* *No* *Yes, but not this severe*

Do your symptoms limit any of your daily activities? *Yes* *No*

Please list all medical conditions and/or health concerns, including history of cancer, blood clots and vein problems, seizures, night sweats, unexplained weight loss, and strokes:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Please list all current medications:

____________________ ____________________ ____________________

____________________ ____________________ ____________________

Please list all surgeries, including dates

____________________ ____________________ ____________________

____________________ ____________________ ____________________

These are five reasons people often hesitate to seek help from a physical therapist. Please circle the appropriate answers so we can better understand your needs:

- I'm afraid of PT *Not true* *Somewhat true* *Very true*
- I don't have time for PT *Not true* *Somewhat true* *Very true*
- My problem just isn't urgent *Not true* *Somewhat true* *Very true*
- I'm skeptical that PT can help me *Not true* *Somewhat true* *Very true*
- My budget doesn't allow for PT *Not true* *Somewhat true* *Very true*

Office Policies & Procedures

Florida currently allows direct access to outpatient physical therapy services for up to 30 consecutive days. If your treatment should exceed 30 days, the State of Florida Physical Therapy Board requires patients to have a written referral from a licensed medical professional (MD, DO, DDS, ARNP, PA, DPM, DC). **It is the patient's responsibility to obtain a referral** should treatment exceed 30 days.

As a courtesy to our practitioners, we require at least 24 hours's notice for cancelations. **You will be charged in full for your session upon violation of this policy.** Exceptions for emergencies will be considered on a case-by-case basis at the discretion of Bridging The Gap Physical Therapy.

Consent to Treatment

Bridging The Gap Physical Therapy is a hands-on physical therapy clinic. The techniques and modalities used on each patient require deep pressure, which may cause bruising and periods of increased soreness lasting up to 72 hours. Symptoms may also change and move to other parts of the body over the course of the treatment. This is normal and rarely concerning.

I have read and completely understand the policies and procedures outlined above.

____

Signature of patient or legal guardian *Printed Name* *Date*

Notice of Privacy Practices Acknowledgement

I acknowledge that I have been given a copy of or an opportunity to read the practice's Notice of Privacy Practices.

____

Signature of patient or legal guardian *Printed Name* *Date*

Patients of Berman Physical Therapy

As a current or former client of Berman Physical Therapy, I attest that I chose to do business with Bridging The Gap Physical Therapy under my own power. I confirm that I was not directly or indirectly approached, enticed, induced, influenced, or solicited by any former employees of Berman Physical Therapy.

____

Signature of patient or legal guardian *Printed Name* *Date*

☐ By checking this box, I confirm that I am **not** a current or former client of Berman Physical Therapy.

Payment Agreement

Thank you for choosing Bridging the Gap Physical Therapy, LLC as your physical therapy provider. Before we begin services, please sign below indicating you have read, understand and agree to the following payment policies.

- You agree to be financially responsible for all charges regardless of any applicable insurance or benefit payments, third-party interest, or the resolution of any legal action or lawsuits in which you may be involved.
- Payment is expected at time of service unless you have made other payment arrangements with us.
- **Out-of-Network Policy.** (Commercial Health Plans—Does not apply to Medicare) If we are out-of-network with your health plan and you have out-of-network benefits, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. You are responsible for contacting your insurance company to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
- **Medicare Policy (for Medicare Part B).** If you are a Medicare beneficiary, you understand that our licensed physical therapists are ***not*** enrolled as Medicare providers. Medicare has onerous technical and administrative requirements that must be met for services to be considered medically necessary covered benefits. We believe those requirements take unnecessary time away from the services we provide and many of the wellness and post-rehab services we offer are not covered by Medicare. Since we are not enrolled providers, we cannot submit claims to Medicare ***and*** Medicare will not pay for our services even though the same services might be paid by Medicare if you obtained them from a Medicare enrolled provider. By choosing to receive our services, you are agreeing to pay cash at the time of service for all services you elect to receive from us with no expectation that Medicare will reimburse you. You understand that we will not submit claims to Medicare on your behalf or provide you with a statement or billing codes that you can submit to Medicare yourself. If you want Medicare to pay for services that might be considered covered benefits, you should seek those services from a Medicare enrolled provider. If you decide at any point after you start services with us that you want Medicare to pay for the services it covers, we will be happy to terminate your services with us. You agree that you, your caregivers, family members, authorized representatives or power of attorney will not, under any circumstance, submit our claims, invoices, receipts or statements to Medicare for reimbursement or to obtain a denial for a Medicare supplemental insurance plan.
    - **Medicare Advantage Plans and Medicare Replacement Plans.** We are not in-network with any Medicare Advantage or Replacement Plans. If your Medicare Advantage or Replacement Plan offers out-of-network benefits for services received from providers not enrolled with Medicare and we don't have to directly submit your claims, we will provide you with a copy of your bill that you can, at your discretion, submit to your health plan for reimbursement for the services your health plan covers. However, you should be prepared that your health plan may not pay for services by providers not enrolled with Medicare. You are responsible for contacting your health plan to determine what your benefits are and obtain any necessary physician referrals and/or pre-authorizations for services. We are not responsible if your health plan denies, in whole or in part, your claims for our services.
    - **Medicare as a Secondary Payer.** If you have a commercial insurance plan, we will provide you with a copy of your bill that you can, at your discretion, submit to your commercial health plan for reimbursement for the services your health plan covers. However, since we are not Medicare enrolled providers, Medicare will not pay your copays, co-insurance or deductibles as a secondary payer. You understand and agree to carry out whatever procedures are necessary to prevent your commercial insurer from automatically forwarding our bills to Medicare.
- **Wellness & Fitness Services.** Most commercial health plans and Medicare do not cover the wellness or fitness services we offer. Therefore, we will provide you with a receipt for these services upon request.
- **Service Packages.** If you purchase a discount package of services, the package discount is applied to the last visit in the package. You must use your visits within 12 months. If you don't use your visits within that time frame or you request a refund for the unused visits, we will refund the excess amount paid, if any, after applying the package discount to the last visit and our regular cash payment fee to all other visits.

- **Use of Health Savings Accounts (HSA).** If you purchase a prepaid package plan through your HSA account we will give you a receipt for the prepaid services that you can, at your discretion submit to your HSA plan in accordance with your HSA plan rules. If you request a refund for unused services that you paid for through your HSA, we will make the refund directly to your HSA account. If your HSA requires you to actually receive the services before submitting claims for reimbursement, we will provide you with a receipt for services actually received to date upon request. You are responsible for complying with HSA rules when determining whether the services you purchase from us can be paid from an HSA account.
- **Use of Health Reimbursement Arrangement (HRA) or Flexible Spending Account (FSA).** An HRA and FSA will only reimburse for actual services received (not pre-paid services). Therefore, if you purchase a discounted prepaid package plan and want your HRA or FSA to reimburse you, we will provide you with a receipt that you can submit for reimbursement after you have used your entire package. Upon request, we will also provide a receipt for visits used to date that you can, at your discretion and in accordance with your HRA or FSA rules, submit for reimbursement. Please note that HRA and FSA plans have rules about what services qualify for reimbursement. You are responsible for complying with your HRA and/or FSA plan rules when determining whether the services you purchase from qualify for reimbursement.

- **Privacy Rights.** You have a right to privacy under the Health Insurance Portability and Accountability Act (HIPAA) that includes restricting disclosure of your records and claims to your health plan, including Medicare, if you pay privately for your services at the time of service. If you pay for your services at the time of service, we assume you are exercising this right to privacy. We will not disclose your medical records to any third party, including your health insurance carrier or Medicare. If you want your records disclosed to any third party in the future, you will need to obtain and sign our Authorization to Release Protected Health Information form before we will disclose your health information.
- **Appeals Policy.** You understand that you are responsible for filing all appeals of adverse benefit determinations. If you need assistance filing an appeal with your health plan, contact the consumer assistance agency on your denial letter.
- **Termination Policy.** If we determine at any time that conditions in your home create a potentially unsafe environment for our providers, we may, at our sole discretion, terminate our services with you. If we do so, we will make reasonable efforts to refer you to the services you need to resolve the issue that is causing a potentially unsafe environment. If you have prepaid for any services, we will refund any monies paid for services not yet received as of the date or our termination.

I HAVE READ, UNDERSTAND AND AGREE TO THESE PAYMENT TERMS. I acknowledge that I have chosen, of my own free will, to obtain the services provided by Bridging the Gap Physical Therapy, LLC, and have agreed to pay out of pocket for my services without any expectation that my health plan will reimburse me. If I am a Medicare beneficiary, I attest that I have chosen not to use my Medicare benefits for the services I am purchasing and am restricting Bridging the Gap Physical Therapy, LLC and my therapist from submitting any claims to Medicare pursuant to my right to privacy under HIPAA.

Signature of patient or legal guardian *Printed Name* *Date*

A photocopy of this agreement is to be considered valid, the same as if it was the original.