WELCOME TO SHEA PHYSICAL THERAPY

Patient Name: _____A.K.A_____ Today's Date: _____

Address: _____ City/State/Zip: _____

Home Phone: (____)_____Cell Phone: (____)_____

E-Mail Address: _____

Social Security Number:_____ Date of Birth:_____ Age_____

Male / Female Married / Single / Widowed Which hand is your dominant hand? Right / Left

Employer: _____ Work Phone: (____)_____

Address: _____ City/State/Zip: _____

Race: ___American Indian/Alaska Native ___Asian ___Black/African American ___White
___More than one race ___Native Hawaiian ___Pacific Islander ___Unreported/Refused to report
Ethnicity: ___Hispanic/Latino ___Non-Hispanic/Latino ___Unreported/Refused to report

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PRIMARY Insurance Name:_____

Date of Accident: _____ Date of Surgery: _____

Guarantor's Name:_____ Relationship_____

Social Security Number: _____ Date of Birth:_____

Guarantor's Address: _____ City/State/Zip_____

SECONDARY Insurance Name:_____

Guarantor's Name:_____ Relationship_____

Social Security Number: _____ Date of Birth:_____

Guarantor's Address: _____ City/State/Zip_____

Referring Doctor's Name: _____

IN CASE OF EMERGENCY CONTACT:_____

Address: _____ City/State/Zip: _____

Phone Number: (____)_____ Relationship: _____

PLEASE ANSWER ALL OF THE FOLLOWING:

Briefly describe your injury: _____

Have you had surgery? _____Yes _____No If yes, when?_____

Are you taking medication for:

___Pain ___Diabetes ___Blood Pressure ___Cholesterol

___Heart ___Thyroid ___Vertigo ___Blood Thinner

___Rheumatoid Arthritis Other:_____

In general, you would rate your overall health as: __Excellent __Good __Fair __Poor

Have you ever experienced heart problems, including heart surgery?

_____Yes _____No

Do you have a pacemaker? _____Yes _____No

Have you ever tested positive for tuberculosis? _____Yes _____No

Do you have diabetes? _____Yes _____No

Do you have a history of seizures? _____Yes _____No

Do you have a history of dizziness? _____Yes _____No

Do you have a history of hypertension? _____Yes _____No

Do you have any joint problems, muscle problems or injuries? _____Yes _____No

If yes, please explain:_____

Are you allergic to Latex? _____

Do you have neck problems including neck surgery? _____Yes _____No

If yes, please explain:_____

_____

What are your hobbies/sports?_____

Are you able to perform them at this point? _____Yes _____No

If employed, are you working at this time? _____Yes _____No

If yes: _____Light Duty _____Modified Duty _____Regular Duty _____Not employed

Were you seen by a therapist or a chiropractor regarding this injury before your doctor referred you to us? _____Yes _____No

If yes, how many weeks were you treated?_____

_____ _____

Signature Date

Patient History

Name: _____ Date: _____

DOB: _____ AGE: _____ Referring Physician: _____

Medical History: (Please check all that apply)

- ○ Diabetes
- ○ Vascular problems
- ○ High blood pressure
- ○ Heart disease
- ○ Cancer
- ○ Broken bones
- ○ Pacemaker
- ○ Pregnant
- ○ Allergies
- ○ Thyroid problems
- ○ Lung
- ○ Kidney problems
- ○ Trauma
- ○ Metal implants
- ○ Other

Please explain any checked items: _____

_____

Medications: _____

_____

Medication Allergies: _____

Over the counter supplements: _____

Lymphedema of:

- ○ Left Arm
- ○ Right Leg
- ○ Left Leg
- ○ Right Arm
- ○ Head/neck
- ○ Genital
- ○ Other

Breast surgery: ☐ Right side Yr. ____ ☐ Left side Yr. ____ ☐ Both Yr. ____

- ○ Lumpectomy
- ○ Simple/total mastectomy
- ○ Modified/radical
- ○ Axillary node dissection
- ○ Sentinel Node Biopsy

Abnormal Surgery:

- ○ Pelvic resection (Date) _____
- ○ Hysterectomy (Date) _____
- ○ Other abnormal surgeries _____

Have you had:

- Chemotherapy Number of treatments _____ Year _____
- Radiation Number of treatments _____ Year _____
- Infections Antibiotics _____ Hospitalized _____

_____

1. Do you know how your lymphedema developed? If so, describe. _____

_____

2. How long have you had lymphedema? _____

3. Have you ever had previous intervention for your lymphedema? Yes ____ No ____

- Pump What kind? _____
- Garments What kind? _____
- Diuretics _____
- Other _____

4. Do you have any pain associated with your lymphedema? Yes _____ No _____

- Duration of pain ☐ Constant ☐ Intermittent
- Severity of pain (circle one) No pain (0) 1 2 3 4 5 (severe pain)
- What kind of pain do you feel? _____
- What relieves your pain? _____
- What aggravates your pain? _____

5. Do you wear a compression sleeve/garment? Yes ___ No ___

6. Have you ever leaked lymph fluid? Yes ___ No ___

7. Have you ever had open sores on your affected limb? Yes ___ No ___

8. What tests/studies have been done for your lymphedema? _____

_____

9. Have you traveled outside the Unites States? Yes ___ No ___

10. Do you exercise regularly? Yes___ No ___

11. Do you drink or smoke? Yes ___ No ___

12. What is your occupation? _____

13. What is your daily lifting activity? ☐ Light ☐ Moderate ☐ Heavy

14. What can't you do because of your lymphedema? _____

15. What are your hobbies and interests? Are they affected by your lymphedema?

_____

16. Do you feel tired all the time? Yes ___ No ___

17. Has your lymphedema affected any of your relationships? Yes ___ No ___

18. What are your expectations from your treatment? _____

_____

19. Other concerns or questions: _____

_____

Body picture can be put here

_____

(Patient Signature)

_____ _____

(Therapists Signature) (Date)

Lymphedema Treatment consent

Name: _____

Successful treatment of lymphedema requires commitment and dedication of the patient and therapist. It is to be understood that this program is ***not a cure,*** but a maintenance program and you will be responsible for keeping your condition under control for the rest of your life. Reduction of edema not only improves the patient's quality of life, but also decreases the incidence of severe secondary infections. If you are treated by Shea Physical Therapy Specialist, you will be required to follow a specific program at the office and at home.

This program consists of:

1. Daily/weekly visits for evaluation, treatment, and measurements by the therapist.

2. Massage/manual lymph drainage which will include the chest and groin.

3. Bandaging of the limb 20-22 hours a day.

4. Self-bandaging on weekends. (You and your family will be instructed in self-massage and self-bandaging.)

5. Therapeutic exercises to accelerate lymph flow.

6. Instruction in a home maintenance program.

7. Instructions on skin care.

Bandages and garments (unless covered by your insurance company) need to be paid for in cash, check or credit card.

Please note that non-compliance or inconsistent compliance in the above outlined program may lead to discharge.

Are you prepared to follow such program? Yes ___ No ___

This consent form has been explained to me and I certify that I fully understand its contents.

_____ _____

(Print Name) (Witness)

_____ _____

(Signature) (Date)

SHEA PHYSICAL THERAPY/HAND THERAPY SERVICES

Policy for Cancellations and No Shows

These policies have been developed to assist our therapist in scheduling their patients efficiently so that each of you will be given the appropriate time when you arrive for your treatment session. We appreciate you assisting us in the matter of **cancellations** and **no shows** for our operation.

1. We will request a 24 hour notice in the event of a cancellation. It is the patient's responsibility, when you call in, to have an alternative time in mind that will ensure that you get in the full prescribed number of treatments that week whenever possible.

2. Please understand that when you do not show, three people are affected:

   a) First the patient because you do not get the treatment you need as prescribed by the doctor.

   b) Second, the therapist who now has a space in their schedule since the time was reserved for you personally.

   c) Third, another patient could have been scheduled for treatment if there had been proper notice.

   Should you have to reschedule, please understand that you may need to see a clinician other than the one who normally treats you as a result of rearranging the appointment period. All of our clinicians are experienced professionals, and they will study your chart, so you will be in good hands. You will return to the original clinician in the next regularly scheduled visit.

Should you need to cancel or change an appointment, please contact our office directly; for Shea Physical Therapy (361) 994-5224 and for Hand Therapy Services (361) 992-1435. Again this policy is to assist our facility to offer you the patient a much more efficient operation. We strive to minimize the amount of wait time that you may have in our lobby by keeping our therapists on a regular schedule.

We look forward to having the opportunity to work with you and to assist you in your current therapy need.

Sincerely,

Daniel R. Shea, P.T
Shea Physical Therapy

Sheila Heflin, OTR, CHT
Hand Therapy Services

Patient Signature_____ Date_____

Consent for Treatment/ Privacy Policy/ Assignment of Benefits

We would like to take a moment to welcome you to our office and assure you that you will receive the very best care available for your condition. On your initial visit the therapist will evaluate you as it relates to your diagnosis. Following the evaluation, a plan of care will be developed in cooperation with your physician. Risks, side effects, complications and benefits of treatment will be discussed with you. In order to familiarize you with the financial policy of this office, we would like to explain how your medical bills are handled.

EXPLANATION OF INSURANCE COVERAGE

Most insurance policies cover physical therapy, but this office does not ensure that yours does. Insurance policies can differ greatly in terms of coverage for physical therapy. Because of the variance of one insurance policy to another, we require that you, the patient, be personally responsible for the payment of your deductible, as well as any unpaid balances in this office. We will do our best to verify your insurance coverage, and we will bill your insurance company (ies) in a timely manner.

I. ASSIGNMENT OF BENEFITS

Authorization of payment: I hereby assign all benefits directly to Shea Physical Therapy. If my insurance carrier sends me payment for services incurred in this office, I shall send or bring the full payment to your office immediately upon receipt. I understand that in the event my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full.

_____ _____

Signature Date

II. SUMMARY OF BENEFITS

Deductible: $_____-has been met\not met $_____coverage %_____co-pay$_____

- Your insurance carrier(s) covers the following:
  _____Visit(s)/dollar(s) per calendar year. _____Procedure(s) per visit.
- The following services are not covered by your insurance carrier:

_____

- _____ Your insurance will not cover these services and you will be responsible for payment of the services you receive.

Terms of Benefits

This is a description of benefits, as given to us by your insurance company. This information is provided to you as a courtesy only. It is the patients responsibility to check with your insurance to verify benefits/coverage. Summary of benfits is not a gurantee of payment and is subject to change. I fully understand that any unpaid portion of services rendered is my responsibility. Quotes are an estimated calculation, according to the description of benefits given by my insurance company. I agree to the terms and conditions presented to me by Shea Physical Therapy. I acknowledge and accept the terms and conditions set forth in Sections I and II of this statement:

_____ _____

Signature Date

III. CONSENT FOR RELEASE OF INFORMATION

The undersigned authorizes the release of any personal health information required for treatment, payment or health care operations. This may include physicians, case managers, and insurance carriers or third party payers. Further, the undersigned releases Shea Physical Therapy to provide outside healthcare providers/services such information as is necessary to facilitate proper healthcare. In addition, the patient consents to the release of prior medical records from referring physicians, hospitals, case managers, or other entities, which have records necessary for proper evaluation and treatment of the patient. All other uses and disclosures will be made only with your written authorization. You have the right to revoke authorization for further uses and disclosures at any time.

IV. CONSENT FOR TREATMENT

I consent to rehabilitation and incidental medical services at Shea Physical Therapy. I understand the expected benefits, possible risks, side effects, complications and discomforts of my rehabilitation. I know and agree that Shea Physical Therapy is not responsible for lost or damage to personal valuables.

V. PRIVACY POLICY

Shea Physical Therapy will administer your records in a confidential manner and in compliance with the Health Insurance Portability and Accountability Act. I have received a copy of the notice of privacy practices.

I acknowledge and accept the terms and conditions set forth in Sections III. IV. and V of this statement.

_____ _____

Signature Date

_____ _____

Witness' Signature (staff) Date

We hope this answers any questions you might have concerning the financial policies of this office. Once again we welcome you to our office and will be glad to answer any further questions you might have.

If the patient is a minor, or legally incapacitated, please obtain the signature of a parent or legal guardian.

SUPPLIES/HOME EQUIPMENT

Your insurance company may or may not cover certain supplies or home equipment issued to you by our facility. **Supplies** are those items required to carry out a specific treatment order (i.e. electrodes, lumbosacral rolls, instruction booklets, etc.). **Home Exercise Equipment** are those items which may be used to enhance your rehabilitation at home (i.e. theratubing, hand putty, weights, pulleys, etc.).

We try to purchase these items in bulk thus reducing the cost of these items. This savings is then passed on to the patients/insurance companies. We try to keep the pricing of these items extremely fair as we realize the purchase of these items may become the patient's responsibility.

You always have the right to choose whether or not you would like to personally purchase the equipment should your insurance company not cover those items. The supplies, however, are required for your treatment and will be your responsibility should your insurance not cover those items.

Please check with the front desk concerning your insurance coverage. An itemized list of equipment and prices will be shown to you so that you may decide if you would like to purchase the item.

If you have any questions, please do not hesitate to discuss with our office.

Thank you.

I have read and understand the above policy: _____

Signature

_____

Date

SHEA PHYSICAL THERAPY
HAND THERAPY SERVICES

January 1, 2023

To our Medicare patients: Most Current Information

MEDICARE BENEFICIARIES:

Effective January 1, 2023, Congress has permanently extended the current exceptions process for physical and occupational therapy. For the calendar year 2023 this amount is $2,230.00 for physical and speech therapy services combined and $2,230.00 for occupational therapy. Therapy claims for outpatient Medicare Part B services that go above $2,230.00 will require the use of a modifier for attestation that claims are medically necessary which may provide a higher threshold to $3,000.00, at which a targeted medical review process kicks in.

We will work with you individually to assist in determining your benefits. We will be requesting you to sign this notice (a requirement of Medicare), to acknowledge that we have educated you regarding this benefit. This threshold is for outpatient services only. If it is determined that therapy is "not reasonable and necessary", you may be requested to pay out of pocket.

POSSIBLE REQUIRED DEDUCTIBLE:

Also, ***Medicare typically has an annual deductible of $226.00 before your benefits begin for the rest of the year.*** Some secondary insurances may cover this deductible, others will not. Therefore, we will assist you in identifying your financial responsibility and will need to collect this amount if required.

We will be closely monitoring our service so we can provide you with the highest quality care available.

Should you have any questions regarding any of this information, please do not hesitate to ask.

Thank you,

Shea Physical Therapy
Hand Therapy Services

_____ _____

Patient Signature Date

SHEA PHYSICAL THERAPY
HAND THERAPY SERVICES
Medicare Patients

1. In the 2023 calendar year, have you received any of the following:

	Circle one	If yes, where?
physical therapy?	yes/no	
occupational therapy?	yes/no	
speech therapy?	yes/no	
home health services?	yes/no	
treatment at an outpatient facility?	yes/no	
seen at a doctor's office?	yes/no	

2. Have you had home assistance for:

	Circle one	If yes, by whom?
bathing?	yes/no	
household chores?	yes/no	
monitoring blood pressure?	yes/no	
administering injections?	yes/no	

3. Have you been hospitalized within the last 30 days? yes/no

   If yes, where?_____

   If yes, for what?_____

4. When did you receive any of these previous treatments or assistance?

   Start date_____ Last date treated _____

5. Are you currently receiving home health? yes/no

6. Is a nurse scheduled to see you? yes/no If yes, when?_____

Patient Signature_____Date_____

Witness_____Date_____

MEDICARE SECONDARY PAYER (MSP) FORM

Name:

Part I

1. Are you receiving benefits under the Black Lung Program? If yes, date benefits began: _____	☐ Yes	☐ No
2. Was this injury/illness due to a work-relatedaccident/condition? If yes, date of injury/illness: _____	☐ Yes	☐ No
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile? If yes, date of accident: _____ Is no-fault insurance available?	☐ Yes ☐ Yes	☐ No ☐ No
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? If yes, please provide: Attorney's Name: _____ Address: _____ Phone Number: _____ If you answered **NO** to all questions, go to Part II. If you answered **YES** to any of the questions above, Medicare is the secondary payer, you do not need to go to Part II. Please provide primary insurance information.	☐ Yes	☐ No

Part II

1. Are you entitled to Medicare based on? *Check the box that applies*
   - ☐ Age (65 & older) – go to question #2
   - ☐ Disability – go to question #2
   - ☐ End Stage – Go to **Part III**

2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? If yes, based upon if you are 65 & over or disabled, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:	☐ Yes	☐ No
☐ Aged (65 & over) - If you are aged and there are 20 or more employees, <u>your GHP is primary.</u>	☐ Yes	☐ No
☐ Disability - If you are disabled and your employer, spouse, or family members employer, has 100 or more employees, <u>your GHP is primary</u>.	☐ Yes	☐ No

Part III

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

1. Do you have group health plan coverage?	☐ Yes	☐ No
2. Are you within the 30-month coordination period?	☐ Yes	☐ No

If yes to BOTH questions, GHP is primary during the 30-month coordination period

Please provide a copy of your group health insurance if determined to be primary.

Signature of Patient/Representative:	Date:
Relationship to Patient:	