HOPE THERAPY CENTER: A division of Greeley Center for Independence, Inc.
2780 28TH Avenue Greeley, CO 80634
Phone: 970-339-0011; Fax: 970-339-0068

Welcome to ***Hope Therapy Center***. We would like to thank you for choosing us for your outpatient rehabilitation.

Our goal is to help you maximize your health, independence and well-being in a warm and inviting environment where a professional team makes meeting your needs our #1 priority. As our patient, your care will be individually evaluated and matched with a trained therapist who has the experience and knowledge that best fits your area of need.

To serve you efficiently and respect your time, please answer all the questions on the enclosed documents. Bring the **completed packet** of forms along with **your insurance card, a photo ID** and your **doctor's prescription for therapy** to your appointment.

The packet includes 4 items:

1. Billing Policy & Billing Authorization Form (Page 2)
2. Patient Cancellation and No Show Policy/Notice of Health Information Privacy Practices (Page 3)
3. Medicare Part B Outpatient Therapy Limitations (Page 4)
4. Health History Information Sheet (Pages 5 & 6 – **It is important to fill out ALL information on both pages**)

The above tools enable our therapists to review your medical history with you, complete your evaluation, develop your treatment plan and begin your therapy, all at this initial appointment.

In order to maximize the benefits of your therapeutic session, please wear comfortable and loose fitting clothing. If applicable, take your pain medicine as prescribed by your physician. Additionally, you may be fatigued after the initial session so plan your transportation accordingly.

Again, thank you for choosing ***Hope Therapy Center***. We look forward to meeting you and assisting in your rehabilitation progress. Please let us know if you have any questions prior to your visit. We can be reached at (970) 339-0011.

Sincerely,

Hope Therapy Center

Appointment Date _____Appointment Time _____Therapist _____

PLEASE ARRIVE 15 MINUTES BEFORE YOUR APPOINTMENT TO ENSURE ALL NEEDED DOCUMENTS ARE COMPLETED, OR CALL 24 HOURS PRIOR IF YOU CANNOT MAKE THIS APPOINTMENT!

BILLING POLICY AND BILLING AUTHORIZATION

Patient Name: _____**Date of Birth**: _____**SS#**_____

Street Address: _____**Apt#**:_____**City**: _____**State**:_____**Zip**:_____

Home Phone:_____**Cell Phone**:_____**Work Phone**:_____

If Minor, Responsible Party: _____**Relationship**: _____**SS#**_____

Street Address: _____**City**: _____**State**: _____**Zip**: _____**Phone**: _____

Primary Insurance Co.:_____**Secondary Insurance Co.**:_____ **Auto Accident? Yes or No**

Emergency Contact: _____**Relationship**:_____**Phone**:_____

Please be aware of your therapy benefits before your evaluation. You may have a copay due at each visit .

PARTICIPANT RELEASE

I understand that there are risks, both foreseeable and unpredictable, associated with Physical Therapy, Occupational Therapy and the use of the pool. I am aware of the risks and agree that my participation is at my own risk. I hereby release Hope Therapy Center, its employees and agents from any and all liability connected to my participation in the programs at the Hope Therapy Center. I furthermore consent to therapy treatment at Hope Therapy Center.

PLEASE INITIAL THAT YOU HAVE READ AND UNDERSTAND THE ABOVE PARAGRAPH → _____

BILLING POLICY AND BILLING AUTHORIZATION

As a courtesy, Hope Therapy Center will obtain benefits from your insurance company. Benefits quoted by your insurance company are not a guarantee of payment. Payment will be considered at the time a claim is received by the insurance company. **THE PATIENT/PARENT/RESPONSIBLE PARTY WILL BE RESPONSIBLE FOR VERIFYING THERAPY BENEFITS WITH YOUR INSURANCE.** Although Hope Therapy Center will attempt to obtain payment from third party payers, it is understood that any amount not paid by the health care plan, insurance or other third party payer of the patient will remain the responsibility of the undersigned. I further understand that Hope Therapy Center will charge interest on all patient responsibility balances 30 days after the original statement date. If payment is not received from the patient/responsible party within the 30 days as stated, interest will accrue at 1.5% per month (18% per year) and charged to the patient's account.

PRIVATE PAY PATIENTS: Hope Therapy Center **WILL NOT FILE or BILL** patient's insurance company after they have agreed to the Private Pay terms. Payments **MUST** be received at time of service **ONLY**.

CO-PAY: Co-pay is due at the time of service. Arrangements can be made to establish terms of payment.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby assign all medical benefits associated, to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plan to Hope Therapy Center, a Division of Greeley Center for Independence, Inc. This assignment will remain in effect until revoked by me in writing**, I hereby agree to pay any and all charges that exceed or that are not covered by insurance**. I hereby authorize said assignee to release all information to secure payment. To ensure continuity of care, I hereby authorize the release of all medical records to my primary and referring physicians. I authorize Medicare, private insurance, and any other health plan to furnish said assignee any information regarding payment of my claim.

_____ _____

Signature of Patient or Responsible party Date

_____ _____

Witness/HTC (GCI) Representative Date

These therapy benefits were quoted by your insurance company. They are not a guarantee of payment. Please contact your insurance with questions.

Deductible: _____**Copay**: _____**Covered %**_____ **Out of Pocket Max** _____**Max. Visits** per year per incident____

Patient Cancellation and No-Show Policy

Failure to attend your appointment may hinder your recovery process. If you are unable to attend your appointment**, YOU MUST NOTIFY HOPE THERAPY CENTER 24 HOURS PRIOR TO YOUR APPOINTMENT**. Failure to attend or cancel an appointment will result in one or more of the following:

- If you do not show up for an evaluation you will not be allowed to re-schedule an evaluation for 1 year unless approved by administration.
- Your therapist reserves the right to discontinue your therapy if you show a pattern of irregular appointment attendance.
- Two unattended/no-show appointments will be cause for you to be discharged from therapy.
- Your physician will be notified of the reason for discharge from therapy.

I understand the Patient Cancellation and No-Show Policy of **Hope Therapy Center** and know my responsibilities.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Notice of Health Information Privacy Practices

I have been given the option of a copy of **Hope Therapy Center's *Notice of Health Information Privacy Practices*** according to HIPPA guidelines.

I DO or **DO NOT** (circle one) want a copy

_____ _____

Patient Signature Date

Medicare Part B Outpatient Therapy Limitations

Under the Balanced Budget Act (BBA) of 1997 Congress placed an annual cap on rehabilitation services under Medicare. As part of the Deficit Reduction Act (DRA) in 2006, Congress passed legislation implementing the therapy caps but authorizing the Centers for Medicare and Medicaid Services (CMS) to create and employ an exceptions process to permit medically necessary physical therapy, occupational therapy, and speech language pathology services above the cap. Since enacting the BBA, Congress has long recognized the cap's potential harmful effect on Medicare beneficiaries and has acted several times to prevent implementation of a hard cap.

There is a two-tiered exceptions process, an automatic exceptions process and a manual medical review exceptions process. The automatic exceptions process applies when patients reach the $1,960 threshold and the manual medical review exceptions process is required at the $3,700 threshold.

On April 15, 2015, the US Senate passed the Medicare Access and CHIP Reauthorization Act (H.R. 2) legislation to repeal and reform the Sustainable Growth Rate (SGR) formula and includes an extension of the Medicare therapy cap exceptions process through December 31, 2017 and provisions to allow CMS to better target manual medical reviews.

Medicare has a set Fee schedule for therapy.

- They have a set dollar amount that they will pay for different types of physical, speech, and occupational services provided to the patient.
- Hope Therapy Center will keep track of the services provided to each patient.
- We will notify each patient when they are approaching the $1960 Medicare limit.
- It is *estimated* that the Medicare limit will allow a patient between 15-17 one hour visits.
- Most Medicare supplemental insurances will not pay for therapy after the cap amount has been reached. Check with your insurance.
- If a patient requires outpatient services exceeding the cap amount and wish to continue receiving therapy at Hope Therapy Center, other payment arrangements can be made.

It is the patient's responsibility to inform Hope Therapy Center if they have received therapy in the following outpatient therapy settings: physical therapists in private practice, physician offices, skilled nursing facilities (Part B), rehabilitation agencies (or ORFs), and comprehensive outpatient rehabilitation facilities (CORFs), and outpatient hospital departments.

I understand the Medicare Part B Therapy Limitations, and have received a copy of this form.

_____ _____

Patient Signature Date

HISTORY INFORMATION SHEET

PLEASE FILL OUT 2 PAGES *COMPLETELY*

PATIENT NAME:_____ TODAY'S DATE:_____
EMERGENCY CONTACT:_____ PHONE#_____

The following information is needed in order for your treating therapist to understand why you are here and how they can best help you. Please answer all questions to the best of your ability.

MEDICAL HISTORY

List Surgeries/Hospital Admissions and Dates: _____
_____
List Medical Allergies: _____
List Current Medications: _____
_____

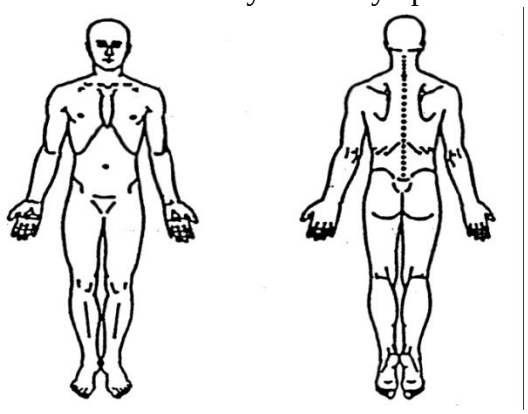
Check the following conditions that apply to you:

___Diabetes	___Cancer	___Hepatitis	___Fractures	___Vision Problems
___COPD/Respiratory	___Vascular Disease	___Osteoporosis	___Back/Neck Injury	___Menier's
___CHF/MI/Heart	___Neuropathy	___Arthritis	___Fusion	___Dizziness/Vertigo
___CVA/TIA/Stroke	___Fibromyalgia	___Jt. Replacement	___Headaches	___Hearing Loss
___Pacemaker	___MS/ Parkinson's	___Skin Problems	___Head Injury	___Depression
___High Bld Pressure	___Muscle Weakness	___Incontinence	___Seizures	___Panic Attacks

Other:_____

PAIN DIAGRAM

Below is a body diagram. Please mark the areas where you feel symptoms.



Height_____ Weight_____

SYMPTOM HISTORY

When did your problem start? _____ Cause of pain: ___Auto ___Work ___Sports
___Daily Life ____Surgery

Pain Scale: 0 = no pain and 10 = emergency pain 0----------5----------10
Pain at rest: _____ Pain w/daily tasks:_____ Average Pain: _____

Since the onset of your symptoms, are the symptoms: ___improving ___worsening
___not changing ____fluctuating ____come and go

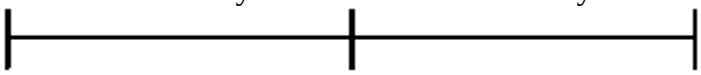
What diagnostic tests have you had? ___X-rays ___CT Scan ___Bone Scan ___MRI
___Arthrogram ___Discogram ___Other _____
Results: _____
Have you previously had therapy for this diagnosis? Y / N
Below is a list of words. Please check the ones that best describe your symptoms.

___lightheaded	___sharp	___hot/burning	___radiating	___stiff
___unsteady	___stabbing	___cold	___tingling	___constant
___nauseous	___shooting	___deep	___numb	___intermittent
___spells	___pinching	___dull	___heavy	___ringing in ear/fullness
___dizzy	___swollen	___ache	___pressure	___disabling

OPTIMAL INSTRUMENT
Difficulty-Baseline

Instructions: Please circle the Level of difficulty you have for each activity today.	Able to do without any difficulty	Able to do with little difficulty	Able to do with moderate difficulty	Able to do with much difficulty	Unable to do	Not applicable
1. Lying Flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving-lying to sitting	1	2	3	4	5	9
4.Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking-short distance	1	2	3	4	5	9
10. Walking long-distance	1	2	3	4	5	9
11. Walking outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about **all** the activities you would like to do, please mark an "X" at the point on the line that best describes your overall level of difficulty with these activities today.



I have extreme difficulty doing any of the activities that I would like to do.

I have no difficulty doing any of the activities that I would like to do.

23. From the above list, choose 3 activities that are being affected by the problem you are currently receiving therapy for, and that you would like to be able to do without any difficulty.
(For example: If you would most like to be able *to* ***climb stairs***, ***knee***l, *and hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)
1.___ 2.___ 3.___

Patient Signature_____ Date_____