The Centers for Advanced Orthopaedics
Orthopaedic Medicine & Surgery

Therapy Services:
1015 18th Street NW, Suite 400 (WDC 20036)
(P) 202.827.8317 (F) 202.659.8724
300 M Street SE, Suite 325 (WDC 20003)
(P) 202.900.2245 (F) 202.900.2249
1001 Connecticut Ave NW, Suite 330 (WDC 20036)
(P) 202.223.8500 (F) 202.379.9299

Policy on Therapy Authorization and Visit Limits

Authorization of Therapy Services:

The clinic wants you to understand that some health insurance plans require pre-authorization for therapy services. In addition, some health insurance plans require authorization after a set number of therapy visits.

Visit Limits:

The clinic wants you to understand that many health insurance plans limit the number of therapy visits per calendar year or per plan year.

While we try to get authorization and keep track of your number of visits, it is also your shared responsibility to be aware of your therapy benefits.

It is strongly recommended that you contact your health insurance carrier to find out:

1. If pre-authorization or authorization is required after a set number of therapy visits.
2. If there is a limitation on the number of therapy visits per calendar year or per plan year.

Acknowledgement:

I understand that if my therapy visits go beyond the visit limit set by my health insurance plan, or if my visits go beyond the authorized visit number, I may be responsible for the payment of services for all denied therapy visits.

Print Name:_____

Signature: _____

Date:_____

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PATIENT INFORMATION

Full Name: _____Today's date: _____

Emergency contact name: _____Phone #: _____

Address: _____City_____State_____Zipcode_____

Home: _____Mobile:_____Work:_____

DOB:_____ Age: _____Sex: _____ Marital Status: _____ Diagnosis:_____

Date of Injury:_____ How did you find us?:_____ Referring Physician: _____

Primary Insurance: _____ Primary Holder name and DOB: _____

ID#: _____ Group#_____ Secondary?: _____ID#:_____

IF THIS IS WORKER'S COMPENSATION INJURY:

Name of Adjuster/Case Manager: _____Phone#: _____

You are responsible for payment of charges not covered by your health insurance at the time of service. As a courtesy to you, we will submit your insurance claim if your information is both correct and complete.

Signature: _____Date: _____

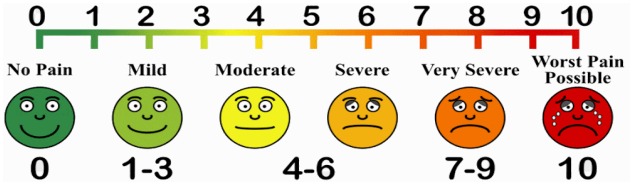
PLEASE LIST ANY MEDICATIONS YOU ARE TAKING:

Medication Name	Dosage	Frequency	Route of Admin (oral/inject)

Height: _____FT _____Inches

Weight: _____ Pounds

Do you smoke tobacco? YES ____ NO____



Pain: Please indicate current, best and worst pain using pain scale: Current: _____ Best: _____ Worst: _____

(OFFICE USE ONLY)

Effective date: _____ *Deductible:* _____ *Coinsurance:* _____ *Copay:* _____

Visits allowed: _____ *OOP:* _____ *Auth Y/N:* _____

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New Patient Forms: Medical History Review

Medical History for: _____

Patient Name (Please Print)

	Yes	No
Are you in generally good health?		
Have you had recent surgery or hospitalization? If so, please specify:		
Are you currently taking any medications? Please include over the counter medications and vitamins:		

Have you had any tests such as x-rays or MRI scans?		
Have you ever taken steroids (i.e. Cortisone, Prednisone)?		

Are you currently seeing any of the following?

Medical Doctor		
Osteopath		
Psychiatrist/Psychologist		
Chiropractor		

Have you ever been diagnosed as having any of the following?		
Cancer: Type:		
Heart Problems		
High Blood Pressure		
Asthma		
Emphysema		
Chemical Dependency (e.g. Alcoholism)		

	Yes	No
Thyroid problems		
Diabetes		
Multiple Sclerosis		
Rheumatoid Arthritis		
Other Arthritic Conditions		
Depression		
Hepatitis		
Tuberculosis		
Stroke		
Kidney Disease		
Anemia		
Epilepsy		
Latex allergies		

Are you pregnant?		
Have you recently lost or gained 10 pounds?		
Are you experiencing any bowel/bladder irregularity?		
Do you experience any numbness/tingling in your buttock or genital region?		
Do you have any numbness/tingling in BOTH hands or feet at the same time?		
Do you experience any weakness in your legs or balance problems while walking?		
Do you have any dizziness related to moving your head or neck?		
Do you experience blurred vision, nausea, or difficulty breathing?		

How would you rate your stress level? _____

How much caffeine containing beverages do you drink per day? _____

How many packs of cigarettes do you smoke per day? _____

How many days per week do you drink alcohol? _____

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NEW PATIENT AUTHORIZATION

I, _____, authorize Washington PhysioDC, LLC to apply for benefits on my behalf for covered services rendered by Washington PhysioDC, and request payment form my insurance carrier be made directly to Washington PhysioDC.

I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information, to my insurance carrier (or in the case of Medicare Part B benefits to the Social Security Administration and Centers for Medicare & Medicaid Services) in order to determine benefits to which I may be entitled.

The authorization may be revoked either by myself or by my insurance carrier at any time in writing. I permit a copy of this authorization to be used in place of the original.

_____

Signature

_____

Date

OFFICE POLICIES

Physician Prescriptions

If required, you are responsible for providing Washington PhysioDC with a current written prescription upon your initial evaluation at our clinic. The District of Columbia does not currently require a prescription for physical therapy. Medicare, however, does require a physician prescription for evaluation and treatment.

Appointments

Your initial evaluation will last approximately forty-five (45) to sixty (60) minutes. Should you arrive more than 15 minutes late to your appointment, your therapist reserves the right to late cancel the appointment.

Billing/Payments

Washington PhysioDC will submit claims for you through The Centers for Advanced Orthopedics (CAO) whenever possible. It is your responsibility to ensure that the insurance company properly processes your claims. If we are not participating providers with your insurance plan, our relationship is with you, not your insurance plan. If we are out of network for your insurance plan, you are responsible for the payment of charges not covered by your plan at the time of service, including any deductible.

In the event collection procedures are required to collect an outstanding balance, the patient shall be responsible for the reasonable cost of a collection agency, attorney, and court costs.

Acknowledgement

I have read and understood the above policies and agree to and abide by all of its terms. Further, I understand that if Washington PhysioDC is not a preferred provider for my insurance, I am responsible for all charges not covered by my insurance.

_____

SIGNATURE DATE

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are not permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include therapeutic exercise, neuromuscular reeducation, mobilization, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your health insurance for your physical therapy services.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services including release of information to friends and family members that are directly involved in your care or who assist in taking care of you. We will use and disclose your protected information when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION (PHI) to public health authorities that are authorized by law to collect information, to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding, response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We will release your PROTECTED HEALTH INFORMATION if requested by a law enforcement offi cial for any circumstance required by law. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we also may release information in order for funeral directors to perform their jobs. We may release PROTECTED HEALTH INFORMATION to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat. We may disclose your PROTECTED HEALTH INFORMATION if you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities. We may disclose your PROTECTED HEALTH INFORMATION to federal officials for

intelligence and national security activities authorized by law. We may disclose PROTECTED HEALTH INFORMATION to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations. We may disclose your PROTECTED HEALTH INFORMATION to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals or the public. We may release your PROTECTED HEALTH INFORMATION for workers' compensation and similar programs.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.
• The right to access, inspect and copy your PROTECTED HEALTH INFORMATION.
• The right to request an amendment to your PROTECTED HEALTH INFORMATION.
• The right to receive an accounting of disclosures of PROTECTED HEALTH INFORMATION outside of treatment, payment and health care operations.
• The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECTED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue SW, Washington, DC 20201
877-696-6775 (toll-free)

With my consent, PhysioDC may use and disclose my protected health information about me to carry out treatment, payment and health care operations.

Name of Patient (please print)

Signature of patient / Date _____