Patient Summary Form

PSF-750 (Rev: 7/1/2015)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name — Last — First — MI

◯ Female
◯ Male

Patient date of birth

Patient address — City — State — Zip code

Patient insurance ID# — Health plan — Group number

Referring physician (if applicable) — Date referral issued (if applicable) — Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)
2. Federal tax ID(TIN) of entity in box #1
3. Name and credentials of the individual performing the service(s)

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

4. Alternate name (if any) of entity in box #1
5. NPI of entity in box #1
6. Phone number
7. Address of the billing provider or facility indicated in box #1
8. City
9. State
10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

(1) Traumatic (2) Unspecified (3) Repetitive (4) Post-surgical → (5) Work related (6) Motor vehicle

Date of Surgery

Type of Surgery

(1) ACL Reconstruction
(2) Rotator Cuff/Labral Repair
(3) Tendon Repair
(4) Spinal Fusion
(5) Joint Replacement
(6) Other ____________

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Patient Type

(1) New to your office
(2) Est'd, new injury
(3) Est'd, new episode
(4) Est'd, continuing care

Nature of Condition

(1) Initial onset (within last 3 months)
(2) Recurrent (multiple episodes of < 3 months)
(3) Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

◯ 98940 ◯ 98942
◯ 98941 ◯ 98943

Current Functional Measure Score

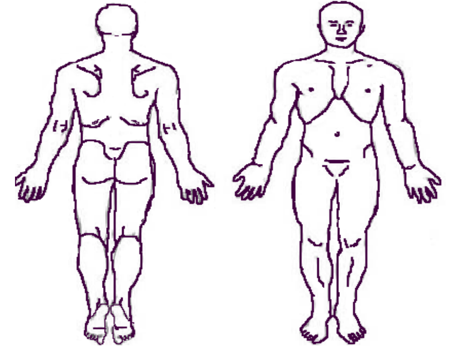
Neck Index ____ DASH ____ ____ (other FOM)
Back Index ____ LEFS ____

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

Past week: **no pain** (0) (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) **worst pain**

4. How often do you experience your symptoms?

(1) Constantly (76%-100% of the time) (2) Frequently (51%-75% of the time) (3) Occasionally (26% - 50% of the time) (4) Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

(1) Not at all (2) A little bit (3) Moderately (4) Quite a bit (5) Extremely

6. How is your condition changing, since care began at *this* facility?

(0) **N/A — This is the initial visit** (1) Much worse (2) Worse (3) A little worse (4) No change (5) A little better (6) Better (7) Much better

7. In general, would you say your overall health right now is...

(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor

Patient Signature: X ______________________ **Date:** ____________

MORE PHYSICAL THERAPY, INC.

PATIENT HEALTH HISTORY (page 2)

1. If you have ever had a listed symptom in the *past,* please check the *past* column. If you are *presently* experiencing a particular symptom, check the *present* column.

Symptom	***Past***	***Present***	***Symptom***	***Past***	***Present***
Neck pain			Jaw Pain		
Shoulder Pain			Fainting		
Pain in upper arm/elbow			Seizures		
Hand pain			Dizziness		
Upper back pain			Headache		
Low back pain			Neuropathy		
Pain in upper leg or hip			Dermatitis or Eczema		
Pain in lower leg or knee			Abnormal weight [ ] gain [ ] loss		
Pain in ankle or foot			Difficulty speaking or swallowing		
Numbness/tingling/weakness in arm/leg (circle one)			Balance/Coordination Problems (stumbling, tripping, dropping items)		
Stiffness in joint Specify joint:			Swelling in joint Specify joint:		

2. How often have you completed at least 20 minutes of exercise such as jogging, cycling, or brisk walking prior to the onset of your condition?
   [ ] At least three (3) times a week [ ] Once or twice a week [ ] Seldom or never
3. Have you ever received treatment for this condition before? [ ] Yes [ ] No
4. If you take medication, please list them: ____
   ____
   Medication allergies? [ ] Yes [ ] No If yes, please list: ____
5. How many surgeries have you had for the problem for which you are being treated? [ ] None [ ] 1 [ ] 2 [ ] 3 [ ] 4 or more
   Please note any surgeries which may impact your care: ____
6. How many days ago did your condition begin? [ ] 0 – 7 days [ ] 8 – 14 days [ ] 15 – 21 days [ ] 22 – 90 days [ ] 91 days – 6 months [ ] Over 6 months

7. Check the following that apply to you.

Condition		***Condition***		***Condition***	
Arthritis		Peripheral Vascular Disease (or Claudication)		Incontinence	
Osteoporosis		Headaches		Anxiety or Panic Disorders	
Asthma		Diabetes Type I or II		Depression	
Chronic Obstructive Pulmonary Disease, acquired respiratory distress syndrome, or emphysema		Gastrointestinal Disease (ulcer, hernia, reflux, bowel, liver, gall bladder)		Other disorders	
Angina		Visual Impairment (such as cataracts, glaucoma, macular degeneration)		Hepatitis, Tuberculosis, or other blood-borne condition	
Congestive Heart Failure or Heart Disease		Hearing Impairment (very hard of hearing, even with hearing aids)		Prior Surgery	
Heart Attack (Myocardial Infarction)		Previous Accidents		Prosthesis / Implants	
High Blood Pressure		Allergies		Sleep dysfunction	
Neurological Disease (such as Multiple Sclerosis or Parkinson's)		Back pain (neck, low back, degenerative disc disease, spinal stenosis)		Cancer	
Stroke or TIA		Kidney, Bladder, Prostate or Urination Problems			
Pacemaker					
Seizures					

8. Height: ________________ Weight: _________________
9. Are you currently pregnant? [ ] Yes [ ] No
10. Are you allergic to latex? [ ] Yes [ ] No
11. How would you rate your general stress level? [ ] none [ ] minimal [ ] moderate [ ] high
12. Activity level at work: [ ] sit more than 50% of time [ ] light manual labor [ ]moderate manual labor [ ] heavy manual labor
13. List activities that are currently limited by this condition: ____
14. Do you: [ ] smoke # of packs per day: _______ [ ] Drink alcohol # of drinks per week: _______
15. Do you have permanent Disability status? [ ] yes [ ] no If so, location: ________________ date rating received: ______ rating percentage:____
16. Is your present problem affecting your ability to work or otherwise be active? [ ] no effect [ ] some physical restrictions [] need limited assistance [ ] need assistance often [ ] significant inability without assistance [ ] I am totally disabled and cannot care for myself
    Specific activities that you cannot perform since your problem began: ______________________________________
17. Home environment: Do you live alone? [ ] yes [ ] no Does someone assist you with activities? [ ] yes [ ] no if yes, who? ______________
    Do you live in a [ ] 1 story or [ ] 2 story home? Must you use stairs to enter/exit your home? [ ] yes [ ] no
18. Do you have an advance health care directive? [ ] yes [ ] no

Patient Signature: ____ Date: ________________________

Patient's representative: ___________________________________ Relationship to patient: ___________________ Rev. 8-19

Statement of Office Policies

Welcome to MORE Physical Therapy, Inc.! We are pleased that you have chosen us for your rehabilitation needs. Please read this form in its entirety, initial each point to indicate your acknowledgment, and sign where indicated.

The staff and management of MORE promise to:

- Welcome you to a caring and professional environment where you will receive the best standard of care at all times.
- Provide you with an individually designed treatment plan to meet your specific needs and goals.
- Answer any questions you may have.
- Do our best to respect your time by staying on schedule, as well as respecting your privacy and dignity during treatment sessions.
- Make no charges for appointment changes or cancellations where 24 hours notice has been given.
- Request authorization for services rendered, (when required) in a timely manner.
- Provide you with flexible payment options in order to insure continued access to quality treatment.
- Provide you with a dedicated Patient Account Representative who is available to assist you with insurance and payment concerns.

We appreciate your commitment to:

_____Being an active participant in your physical therapy treatment by arriving on time for appointments, informing your clinician of any concerns or questions you may have, and complying with home exercise instructions or other recommendations.

_____Notifying us **by phone** 24 hours in advance if you must cancel or change an appointment. *A $50.00 fee will result when 24 hour advance notification is not given*. This fee is not billable to insurance and must be paid prior to receiving any further services. This fee does not apply to workers compensation patients, however the adjuster will be informed of any missed appointments which may result in the denial of additional visits.

_____Paying co-payments, where applicable, at the time of service. Patients without insurance are asked to pay in full at the time of each appointment. Failure to pay at the time of service may result in a billing fee of $25.00 for each missed payment. We accept VISA, MasterCard, and checks. We do not accept American Express or Discover and for your security, we do not accept cash. There will be a $20.00 fee imposed for all returned checks.

_____Knowing the provisions and limitations of your insurance coverage; and understanding that your policy is a contract between you and your insurance carrier.

_____Understanding that your treatment plan is based on medical necessity as determined by your referring physician and/or MORE, not the limitations of your insurance policy; and requesting alternate treatment or payment arrangements if necessary.

_____Providing us with accurate insurance information and the cause of your condition at the start of each episode of care, immediately upon changing insurance carriers, and/or when a new injury occurs.

_____Paying MORE directly at the time of service for supplies, including but not limited to exercise bands, stim pads and ice sheets used during treatment and/or for home use. Please note that supplies are not covered by many insurance plans but receipts can be provided for use with FSA and HSA accounts.

_____Paying any balance due on your account over 60 days past due regardless of insurance reimbursement status.

_____Understanding that balances over 90 days past due will incur a 1.5% monthly charge (18% APR) and accounts over 120 days past due may be referred to our collection agency.

Statement of Office Policies Cont'd.

Person to Contact in Case of Emergency

Name: ____ Best phone #: ____________________________

Additional person with whom we may discuss your insurance and billing details (such as a spouse, partner or adult child)

Name: ____ Best phone #: ____________________________

Additional person/entity with whom we may discuss appointment times:

[ ] Transit service: __________________________ [ ] Interpreter service: ______________________________

Authorization and Assignment

I hereby authorize MORE Physical Therapy, Inc. to release information necessary to my insurance company in order to process claims for charges incurred by me, and I release MORE Physical Therapy, Inc. of any consequence thereof. In consideration of the services rendered to me by MORE Physical Therapy, Inc., I authorize and direct my insurance carrier to remit payment directly to MORE Physical Therapy, Inc.

Signature: ____ Date: _________________

Agreement to Pay for Services Rendered

(Not applicable for authorized Workers Compensation patients)

My signature below verifies that I have read and agree to the above-stated office policies, including an understanding that: Regardless of insurance coverage, I am responsible and liable for payment of all charges assessed for professional services rendered; supplies used and/or dispensed; and any fees charged due to my failure to follow the above-mentioned policies. I am responsible for paying the balance due for services billed to my insurance on my behalf if the insurance company has not paid within 60 days. I understand that MORE cannot guarantee the accuracy of any quotation of benefits it receives from my insurance carrier and that I am responsible for knowing the limitations of my own insurance policy. In the event that my insurance company remits payment to me for services rendered by MORE, I will promptly forward payment to MORE. If it becomes necessary for MORE to commence legal action for collection of any outstanding charges on my account, I will be responsible for all reasonable fees incurred to collect said charges including collection fees, court costs, and attorney fees.

Signature: ____ Date: _________________

Your feedback is important to us; whether it is praise or constructive criticism. Please take a few moments to complete the patient satisfaction survey that will be emailed to you following your visit, and help our practice thrive by recommending MORE Physical Therapy, Inc to your friends, family and healthcare providers.

PATIENT ACKNOWLEDGEMENT OF MORE PHYSICAL THERAPY, INC. PRIVACY PRACTICES

I acknowledge that I have read, understand, and have been given a copy of MORE Physical Therapy, Inc.'s "Notice of Privacy Practices."

I, ____________________________________,understand that MORE Physical Therapy, Inc. may use and disclose my health and medical information for the purposes of treatment*, payment, and health care operations***.**

> **Treatment* includes activities performed by all MORE Physical Therapy, Inc. staff and other types of health care and administrative professionals involved in providing care to the above-mentioned patient, including those coordinating or managing care with third parties, and consultations with and between other health care providers and administrative professionals.
>
> ***Payment* includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities which may include review of health care services for medical necessity, justification of charges, pre-certification and pre-authorization.
>
> ****Health Care Operations* includes the necessary administrative and business functions of our office.

Because MORE Physical Therapy, Inc. has reserved the right to change our privacy practices in accordance with the law, the terms contained in the Notice may change also. A summary of the Notice will be posted in our office indicating the effective date of the Notice in the upper right hand corner. We will give you a copy of the Notice on your first visit to us after the effective date of the then current Notice.

As more fully explained in the Notice, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment and health care operations purposes. We are not required to agree to your request. If we do agree, we are required to comply with your request unless the information is needed to provide you emergency medical treatment.

I understand that I have the right to revoke this signed Acknowledgement, provided that I do so in writing, except to the extent that MORE Physical Therapy, Inc. has already used or disclosed the information in reliance on this acknowledgement.

____ ____________________
Signature of patient Date

Or

____ ____________________
Signature of person authorized by law Date

rev 1204/srb

E-MAIL POLICY AND PROCEDURES

Although Internet use is a common occurrence in our daily lives, it bears repeating that the Internet is not secure and information sent over the Internet such as e-mail, could be intercepted and re-disclosed by parties other than the person to whom it is addressed. Please note the following as they pertain to e-mail exchanges with MORE Physical Therapy, Inc., hereafter referred to as "MORE":

- Patients may e-mail MORE for routine matters that do not require an immediate response; e-mail is NOT intended for emergency or urgent situations. In an emergency call 9-1-1. Urgent issues should be addressed via telephone.
- Communications appropriate for email include: scheduling, billing or insurance questions, and non-urgent advice in regard to your physical therapy care.
- We cannot guarantee a timely response to e-mail. If you have not received a response within two business days, please contact us via telephone.
- Copies of e-mail communications between you and MORE will be placed in your medical record and treated like other information contained there.
- When sending e-mail to us, please include your full name and the clinic location where you are being treated, failure to include this information will cause delays in the routing of your email. In addition, please include the topic of your message in the subject line so that your e-mail can be routed efficiently.
- Please do not use e-mail for any communications you consider confidential. Please note issues including but not limited to mental health, substance abuse, work-related injuries, disability, AIDS or HIV are not appropriate for email discussion. MORE reserves the right to utilize alternate means of communication as we deem necessary.
- Should you request that we communicate with a third party via e-mail, you will be required to complete a written authorization for email communication.

E-mail Consent:

By providing your email address below, you consent to receive email communications with the understanding that email is not a secure form of communication.

E-Mail Address: ____

I have read, understand and agree to MORE Physical Therapy's Email Policy:

Patient name (please print): ____________________________ Date: __________

Signature of patient or legal guardian: ____________________________________

ef/August 2015

CREDIT CARD SIGNATURE ON FILE AUTHORIZATION

Authorization
I authorize MORE Physical Therapy, Inc. to keep my signature and credit card information on file and to directly charge my credit card account for:

[ ] Charges I personally incur
[ ] Charges incurred by the following person(s):

____

____

____

Description
Said charges shall be in the form of:

[ ] Co-payments of $________ due at the time of each visit
[ ] Deductible and/or coinsurance. Please call me in advance if the balance owed exceeds $________ per charge.

Credit Card Information
[ ] Master Card
[ ] Visa
Credit card number (last four digits only):

Card holder's name (please print): ____

Card holder's signature: ____

Date: ________________

100506

NOTICE OF PRIVACY PRACTICES

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

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at MORE Physical Therapy, Inc. We need the record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

Federal and State Laws Require Us to:

1) Keep your medical information private.
2) Make available to you this notice describing our legal duties, privacy practices, and your rights regarding your medical information,
3) Follow the terms of this notice that is now in effect.

We Have the Right to:

1) Change the Privacy Practices and the terms of the notice at any time, provided that the changes are permitted by law.
2) Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.
3) Before we make an important change in our privacy practices, we will change the notice and make the new notice available upon request.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

This is how we use and disclose medical information. Note: We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

For Treatment: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical assistants, or other people who are providing health care services to you.

Example: You are receiving post-operative rehabilitation for a repaired knee tendon. You are experiencing excessive pain and swelling with therapy sessions.

- *The doctor treating you needs to know about the increased pain.*
- *The medical assistant in the doctor's office needs to relay new symptom information to the doctor and return the doctor's response to us in a timely fashion.*
- *Relaying the information about your symptoms may help in further diagnosing any underlying problem*

For Payment: We may use and disclose your medical information for payment purposes.

Example: You are receiving rehabilitation services for a repaired knee tendon.

- *We may need to give your health insurance plan information about specific treatments you are receiving from us so that your health plan will pay us or repay you for any treatments provided.*
- *We may also tell your health plan about a treatment or piece of equipment you may receive in order to get prior approval or to determine if your plan will pay for it*
- *We may utilize a collections agency in the event of non-payment*

For Health Care Operations: We may use and disclose your medical information for our health care operations.

Examples:

- *Training programs for employees may require the use of medical records*
- *Medical records may be required when obtaining certificates, licenses, or credentials we need to serve you.*

Incidental Disclosures: Although MORE Physical Therapy, Inc. will make every effort to protect your health information, due to the design of our systems and physical structures, the possibility exists for incidental disclosure. The following examples are ways in which (minimal) incidental disclosures might occur:

We may:
announce your arrival over a P.A. system to the scheduled clinician.
call you at home or at your place of work.
leave a message on your answering machine or in voicemail.
provide rehabilitation services in an open environment
provide rehabilitation services in a public gym or pool setting
utilize a large master schedule in order to schedule appointments
operate a sign-in system
produce and mail newsletters periodically
store medical records in the clinics as well as at an off-site storage facility

ADDITIONAL USES AND DISCLOSURES

In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following (specialized) purposes:

Public Health Risks: We may disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required by Law: We will disclose health information about you when required to do so by federal, state or local law. We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements. If you are involved in a lawsuit or dispute, we may also disclose health information about you in response to a court or administrative order.

Health Oversight Activities: We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes.

Special Governmental Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for correctional institutions and other law enforcement custodial situations and for government programs providing public benefits.

Research: We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or if the researcher will be involved in your care at the clinic.

Medical Examiner or Coroner: We may share medical information about a person who has died with a coroner or medical examiner.

Notification: We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the treatment room during treatment or while treatment is discussed.
In situations where you are not capable of giving acknowledgment (because you are not present or due to incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only the health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the clinic that your condition has worsened and you are unable to weight-bear. We may further instruct that person in how best to assist you into a car and to transport you to a physician's office or an emergency room for diagnosis and treatment. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, medical supplies or X-rays.

Workers' Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers' compensation or other similar programs.

Disaster Preparedness: We may disclose health information to respond in a disaster situation (natural or other) in order to provide maximum safety to our patients and staff.

Your Individual Rights:
You have the right to:

1) Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may ask the receptionist for the form needed to request access. There may be charges for copying and for postage if you want the copies mailed to you. Ask the receptionist about our fee structure.
2) Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3) Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4) Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to our Privacy Officer.
5) Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you with a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted changed. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the change and to include the changes in any future sharing of that information.
6) Upon admission to our clinic, you will be given a copy of this Privacy Notice.

Questions and Complaints:
If you have any questions about this notice, please ask to speak to our Privacy Officer, Liz Fedyna or contact her at (408) 248-6886. If you think that we may have violated your privacy rights, contact the person named above. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

These privacy practices are currently in effect and will remain in effect until further notice.

CONSENT TO TREATMENT OF MINOR CHILD

Re: ____
(Name of Minor Child)

Date of birth: ____/____/____

I do hereby state that I have legal custody of the aforementioned Minor. I grant my authorization and consent for MORE Physical Therapy, Inc. to provide physical therapy treatment to said child.

In an emergency, it is understood that authorization is granted to MORE Physical Therapy, Inc. to provide first aide and/or to notify Emergency Medical Services of the need for intervention.

I acknowledge that I am responsible for any portion of charges that are not covered by insurance.

This consent form will remain in effect until revoked in writing by me.

Signed this _____day of________________, 20____.

Parent / Legal Guardian Signature: ____________________________________

Printed Name: ____