A. Notifier: Pleasanton Physical Therapy Services, Inc dba Back on Track

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.** PT TREATMENT below, you may have to pay.

Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.** PT TREATMENT below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
PHYSICAL THERAPY CAPS	MEDICARE WILL PAY FOR TREATMENTS UP TO ITS LIMITS SET EACH YEAR. THEY OFFER AN EXEMPTION TO THE CAPS FOR PATIENTS WHO QUALIFY FOR CAP EXEMPTIONS	$100.00 PER VISIT

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.** PT TREATMENT listed above.

Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.** PT TREATMENT listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN**.** If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.** PT TREATMENT listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed**.

☐ **OPTION 3.** I don't want the **D.** PT TREATMENT listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0566. The time required to complete this information collection is estimated to average 7 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CONSENT FORM

The following is a list of modalities and procedures that may be used during the course of your physical therapy. At your initial evaluation, your physical therapist will discuss your treatment options and create some goals with you.

- Evaluation
- Heat/Ice
- Electrical Stimulation
- Massage/Muscle Release Techniques
- Postural Training
- Functional Training
  (Body Mechanics, Activities of Daily Living)
- Cold Laser
- Cupping
- Joint Mobilization
- SASTM/Rock Blade Certified
- Muscle Stretching
- Traction
- Therapeutic Exercises
- Iontophoresis
- Biofeedback Training
- Pain Eraser

Consent for Treatment

I give my consent for treatment by the health care professional staff of Back on Track Physical Therapy and Pleasanton Physical Therapy to provide physical therapy and rehabilitation services and necessary treatment as prescribed by my physician. I understand that to evaluate and treat my condition, the physical therapy staff must have visual or physical access to the areas of my body which may be experiencing and/or causing my pain and/or dysfunction. I understand that it is my responsibility to immediately communicate any difficulties or concerns that I have regarding my therapy to the staff of Back on Track/ Pleasanton Physical Therapy Services. Furthermore, I understand that my physician shall be kept informed regarding my current health status and my response to any treatment received. As with any course of treatment or therapy, there is always the possibility of an unexpected complication, and no guarantee or assurance has been made as to the result of treatment.

Patient Signature:____ Date: ____________________

Therapist Signature:____ Date: ____________________

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Informed Consent for Physical Therapy Services

__________ *Initial Here*

Physical Therapy: The purpose of physical therapy is to treat disease, injury, and disability by use of rehabilitative procedures, and to aid the patient in achieving their maximum potential and reduce the length of functional recovery. All procedures will be thoroughly explained to me before they are performed.

__________ *Initial Here*

Informed Consent for Treatment: The term "informed consent" means that the potential risks, benefits, and alternatives of physical therapy treatment have been explained to me. I understand that the physical therapist provides a wide range of services and I will receive information at the initial visit concerning the treatment and options available for my conditions. I will notify my practitioner if I am pregnant or am trying to get pregnant. I understand I am encouraged to communicate with a physician the potential benefits and risks of treatment relevant to my pregnancy.

__________ *Initial Here*

Potential Benefits: Benefits may include an improvement in my symptoms and increase in my ability to perform my daily activities. I may experience increased strength, awareness, flexibility, and endurance in my movements. I may experience decreased pain and discomfort. I should gain a greater knowledge about managing my condition and the resources available to me.

__________ *Initial Here*

Potential Risks: I may experience an increase in my current level of pain or discomfort, or aggravation of my existing injury during physical therapy; if it does not subside in 24 hours, I agree to contact my physical therapist.

__________ *Initial Here*

No Warranty: I understand that my physical therapist cannot make any promises or guarantees regarding a cure for or improvements in my condition. I understand that my physical therapist will share with his/her opinions regarding potential results of physical therapy for my condition and will discuss treatment options with me before I consent to treatment.

__________ *Initial Here*

Insurance: I, the patient, am ultimately responsible for payment of my account. As a courtesy, Pleasanton Physical Therapy/Back on Track Physical Therapy will bill my insurance on my behalf. I am responsible for paying any deductible, co-insurance, and/or payment due at the time of service.

I may elect to pay out of pocket for physical therapy services. For patients without insurance or those who elect to pay out of pocket, a discounted "cash rate" of $150 for the initial evaluation and $100 for follow-up appointments will apply. Payments will be due at the time of service.

__________ *Initial Here*

***Cancellation Policy*: "In the event that I need to cancel a scheduled appointment, I agree to provide the courtesy of 24-hour notice so that we can offer my appointment to patients waiting on the standby list. If I fail to give 24-hour notice of a cancellation, I understand I will be subject to a $75.00 missed appointment fee."**

I have read the above information and I consent to a physical therapy evaluation and treatment. My signature below acknowledge that I have read, understood and will abide by the conditions and policies noted on this consent form.

____ ____

Print Name of Patient Patient Signature and D

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Patient Information		Employment Information	
Name:		Name of Employer:	
SSN:	DOB:	Occupation/Position:	
Age:	Sex:	Work Phone:	
Address:		**Emergency Contact Information**	
		Name:	Relationship:
Home Phone:		Phone:	
Cell Phone:		**Physician Information**	
Email:		Referring MD:	Phone:
		PCP:	Phone:

PATIENT HISTORY OF CURRENT INJURY/ILLNESS

MANDATORY FOR ALL MEDICARE/MEDI-CAL PATIENTS

MEASURES 128: PREVENTITIVE CARE AND SCREENING: Height:____________ Weight: ___________

MEASURE 131: Pain Rating: Indicate your average level of pain by circling the appropriate number on the scale below:

0 1 2 3 4 5 6 7 8 9 10

Pain Free — Unconscious Pain

Have you ever been a patient here before? □**YES** □**NO** If yes, is it for □**Same** □**Different** problem?

Have you ever had similar symptoms in the past? □**Yes** □**No If yes**, when? ___________________________

Are you: □**Right-handed** or □**Left-handed**

Indicate below for which body region you are seeking treatment:
□**Neck** □**Mid-Back** □**Low Back** □**Shoulder** □**Elbow** □**Hand/Wrist** □**Hip** □**Knee** □**Ankle/Foot** □**Other** ________

When did symptoms start?______________Can you identify a cause for your symptoms? □**Yes** □**No**
If yes, Specify: ___________________________

____

Have you recently had the following tests? □**Yes** □**No If yes,** check all that apply below:
□**X-Rays** □**Bone Scan** □**Myelogram** □**EKG** □**CT Scan** □**EMG** □**MRI** □**Stress Test** □**Blood Test**
□**Echocardiogram** □**Pulmonary Function Test** □**Other**: ___________________________

Do you have any implanted medical device? (Ex: Pacemaker, Insulin pump, Pain pump)
□**Yes** □**No If yes,** what kind? ___________________________

What are your goals:___________________________.

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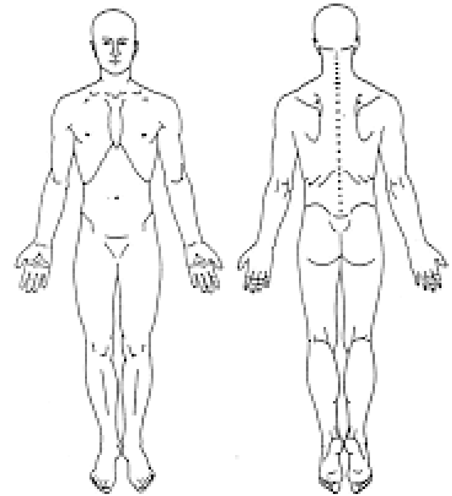
***Please use the body diagram on the right and Shade Areas of pain**



Describe the character of pain: (what does it feel like… sharp, dull, achy, etc.)

____
____
____

Is the pain constant? □**Yes** □**No**
Does the pain move or radiate anywhere? □**Yes** □**No**
If Yes, describe location of radiation: ______________________
____
____

Any (Check all that Apply): □Numbness □Tingling □Weakness

Have you fallen in the past 2 years? Please Circle: YES / NO. If yes, please fill out Fall Efficacy Scale below:

<u>FALL EFFICACY SCALE:</u>
One a scale from 1 to 10 with 1 being very confident and 10 being NOT confident at all, how confident are you that you can perform the following activities without falling:

Activity	**Score**
Taking a bath or shower	
Reaching into cabinet or closet	
Walking around the house	
Preparing meals, not requiring carrying heavy/hot objects	
Getting in and out of bed	
Answering the door or telephone	
Getting in and out of a chair	
Getting dressed or undressed	
Personal Grooming (Ex. Washing your face)	
Getting on and off toilet	
Total Score:	

Have you been discharged from the hospital, a skilled nursing facility, or home health agency in the past 30 days related to this condition? □**Yes** □**No** If Yes, describe: ____
____

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Existing or Relevant Previous Conditions (Check all the apply)

Allergies	□Yes □No	Diabetes	□Yes □No	Metal Implants	□Yes □No
Anemia	□Yes □No	Emphysema/Bronchitis	□Yes □No	MRSA	□Yes □No
Anxiety	□Yes □No	Fibromyalgia	□Yes □No	Multiple Sclerosis	□Yes □No
Arthritis	□Yes □No	Fractures	□Yes □No	Muscular Disease	□Yes □No
Asthma	□Yes □No	Gallbladder Problems	□Yes □No	Osteoporosis	□Yes □No
Autoimmune Disease	□Yes □No	Headaches	□Yes □No	Pacemaker	□Yes □No
Blood Disorders	□Yes □No	Hearing Impairments	□Yes □No	Parkinson's Disease	□Yes □No
Broken Bone/Fracture	□Yes □No	Heart Problems	□Yes □No	Seizures	□Yes □No
Cancer	□Yes □No	Hepatitis	□Yes □No	Smoking	□Yes □No
Cardiac Condition	□Yes □No	Rheumatoid Arthritis	□Yes □No	Speech Problems	□Yes □No
Cardiac Pacemaker	□Yes □No	High Cholesterol	□Yes □No	Strokes	□Yes □No
Chemical Dependency	□Yes □No	High/Low B.P.	□Yes □No	Thyroid Disease	□Yes □No
Circulations Problems	□Yes □No	HIV/AIDS	□Yes □No	Tuberculosis	□Yes □No
Currently Pregnant	□Yes □No	Hypoglycemia	□Yes □No	Ulcers/Stomach Problems	□Yes □No
Kidney Problems	□Yes □No	Incontinence	□Yes □No		
Depression	□Yes □No	Infectious Diseases	□Yes □No		

If "Yes" to any of the above, please explain the given dates: ____

____

MEASURE 130: DOCUMENTATION OF CURRENT MEDICATIONS IS MANDATORY FOR ALLMEDICARE/MEDI-CAL PATIENTS: Please list all current medications with dosages (Any prescription, over the counter, herbals, vitamins/ mineral/ dietary nutritional supplements)

Medication	Dosage	Reason for Taking

If you have a list, please provide a copy to your therapist at the time of your evaluation and initial here: __________
Request additional sheet up front if more space is needed.

Patient Signature:____ Date:______________

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