



GERIHAB PHYSICAL THERAPY AND WELLNESS
1296 Union University Dr, Suite C,
Jackson, TN 38305
Tel: 731-215-0919
Fax: 1-800-559-7091
Patient Information

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH ___/___/___ SEX: M F (Circle one)

YOUR SOCIAL SECURITY #: _____

HOME ADDRESS _____ Apt # _____

CITY _____ STATE _____ ZIP _____

HOME TELEPHONE #: (____) _____ WORK TELEPHONE # (____) _____

EMERGENCY CONTACT _____ TEL #: _____

DATE OF YOUR INJURY ___/___/___

PRIMARY INSURANCE COMPANY: (WHO DO WE BILL?): _____

YOUR POLICY #: _____ CLAIM #: _____

POLICY HOLDER (IF NOT YOU) Last Name _____ First Name _____

LIST ALL SECONDARY INSURANCES _____

WORKERS COMP. ONLY. PLEASE LIST THE FOLLOWING:

EMPLOYERS NAME _____

EMPLOYER ADDRESS _____ TEL#: _____

INS CO. NAME _____

INITIAL VISIT \$RATE ALL FOLLOW-UPS \$RATE

NOTE: MANY INS. CARRIERS NOW REQUEST BILLING BY PROCEDURE CODE EACH CODE: \$RATE

ALL PATIENTS ARE PERSONALLY RESPONSIBLE FOR FULL PAYMENT OF ALL CHARGES INCLUDING INSURANCE COMPANY DENIALS, DEDUCTIBLES AND COPAYMENT FEES. CANCELLATIONS SHOULD BE MADE 24 HOURS IN ADVANCE.

NOTICE OF ADVICE: THE TREATMENT MAY NOT BE COVERED BY THE PATIENT'S HEALTH CARE PLAN OR INSURER WITHOUT A REFERRAL AND THAT SUCH TREATMENT MAY BE A COVERED EXPENSE IF RENDERED PURSUANT TO A REFERRAL.

I, THE UNDERSIGNED, AGREE TO BE TREATED IN THIS THERAPY OFFICE AND HEREBY AUTHORIZE MY INSURANCE CARRIER TO PAY THE PROVIDER DIRECTLY FOR SERVICES RENDERED. I HAVE READ THE ABOVE AND AGREE TO COMPLY FULLY, SIGNED:

SIGNATURE _____ TODAYS DATE ___/___/___

HOW DID YOU FIND OUR FACILITY? _____

THE TREATING THERAPIST'S SIGNATURE _____



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Patient Authorization and Guarantee Form

Release of Information

I hereby authorize the release of any information by telephone or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by **GERIHAB PHYSICAL THERAPY AND WELLNESS** to the physician who referred me for therapy as well as any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Assignment of Insurance Benefits

I hereby authorize that the payment of authorized benefits be made directly to **GERIHAB PHYSICAL THERAPY AND WELLNESS** of any services that are reimbursable by Medicare, Medicaid, or any third party source.

Valuables

I hereby understand that **GERIHAB PHYSICAL THERAPY AND WELLNESS** is not responsible for valuables and personal property brought to the facility.

Consent for Treatment

I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of **GERIHAB PHYSICAL THERAPY AND WELLNESS**

Guarantee of Account

In consideration of services rendered to me by **GERIHAB PHYSICAL THERAPY AND WELLNESS**, I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon presentation. I understand that the patient responsibility portion of my bill shall be due and payable at time of services.

Medicare

I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance.

I, _____, by signing this document, acknowledge my consent to the above.

Signature: _____

Date: _____

Address: _____



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The following information is very important to us in taking care of your health.

Please take the time to completely and accurately fill out all of this information.
 Please also make sure you update this information as charges occur.

- | | |
|--|----------------------------|
| 1. Name_____ | 5. Height_____ Weight_____ |
| 2. Age_____ | 6. Medications:_____ |
| 3. Are you now under the care of physician therapist
or physiatrist? Yes <input type="checkbox"/> No <input type="checkbox"/> | _____ |
| 4. Please list the dates of: | _____ |
| - Hospitalizations_____ | _____ |
| - Surgeries_____ | _____ |

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

Please circle if you have ever had or presently have any of the following:

- | | |
|---------------------------------|--|
| 1. High blood pressure | 17. History of fall. How many episodes did
you have in past 12 month____? |
| 2. Diabetes | 18. Bronchitis |
| 3. Cancer | 19. Pneumonia |
| 4. Heart disease/ heart attack | 20. Persistent cough |
| 5. Chest discomfort | 21. Tuberculosis |
| 6. Heart murmur/ valve disease | 22. Hay fever |
| 7. Shortness of breath | 23. Sinusitis |
| 8. Swollen ankles | 24. Abdominal discomfort |
| 9. Palpitations | 25. Indigestion/heartburn |
| 10. Lightheadedness / Dizziness | 26. Nausea |
| 11. Rheumatic fever | 27. Vomiting |
| 12. Asthma | 28. Diarrhea |
| 13. Persistent swollen glands | 29. Blood in stool |
| 14. Hearing problems | 30. Constipation |
| 15. Bone fractures | 31. Vision problems |
| 16. Depression | |

Patient Signature_____ Date_____

For Office Use Only:

BMI _____ Blood Pressure _____/_____ Heart Rate _____



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Patient Financial Policy

Contracted/Commercial Insurance:

GERIHAB PHYSICAL THERAPY AND WELLNESS Participates with several insurance companies and will file claims on your behalf. As a patient, it is in your best interest to know if your plan is contracted with GERIHAB PHYSICAL THERAPY AND WELLNESS and to understand your insurance plan benefits and your responsibility for any deductibles, co-insurance, or co-payment amounts prior to any visit.

It is also important to understand your insurance plan's current benefits and coverage rules. Policies and coverage determinations may vary from year to year. Please be aware that your insurance carrier may send you a payment for the services provided by GERIHAB PHYSICAL THERAPY AND WELLNESS (depending on your plan's benefits). In this case, you are required to remit the payment to GERIHAB PHYSICAL THERAPY AND WELLNESS

In case you will fail to remit the above mentioned payment, GERIHAB PHYSICAL THERAPY AND WELLNESS holds the right to report the case to an outside collection agency. In the event that your account is turned over for collections, you agree to pay all additional fees associated to the collection of debt. These fees may include collection agency fees and attorney fees.

Assignment of Benefits:

I certify that the information given by me in applying for payment from my insurer is correct. I request that payment of authorized benefits be made on my behalf to GERIHAB PHYSICAL THERAPY AND WELLNESS I understand that I am fully responsible to GERIHAB PHYSICAL THERAPY AND WELLNESS for all charges not paid by my insurer within 60 days of claim filing.

I authorize GERIHAB PHYSICAL THERAPY AND WELLNESS to release medical information pertinent to my treatment for appeal purposes.

The undersigned acknowledges receipt of GERIHAB PHYSICAL THERAPY AND WELLNESS Financial Policy and understands the patient rights and responsibilities. The undersigned agrees to the above terms.

Printed Patient Name

Patient Signature

Date



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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996(HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

Patient's Name

Patient's Signature

Date

Legal Representative

Relationship to Patient



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 (Name of Facility)

Fall Risk Assessment Form

Resident's Name:			Physician:			
			Examiner →			
			Assessment Date →			
PARAMETER	SCORE	RESIDENT STATUS/CONDITION	Enter Evaluation Score Below			
A. Level of Consciousness/ Mental Status	0	ALERT (oriented X 3) OR COMATOSE				
	2	DISORIENTED X 3 at all times				
	4	INTERMITTENT CONFUSION				
B. History of Falls (past 3 months)	0	NO FALLS in past 3 months				
	2	1 - 2 FALLS in past 3 months				
	4	3 OR MORE FALLS in past 3 months				
C. Ambulation/ Elimination Status	0	AMBULATORY/CONTINENT				
	2	CHAIR BOUND - Requires restraints and assist with elimination				
	4	AMBULATORY/INCONTINENT				
D. Vision Status	0	ADEQUATE (with or without glasses)				
	2	POOR (with or without glasses)				
	4	LEGALLY BLIND				
E. Gait/Balance	To assess the resident's Gait/Balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; and make a turn.					
	0	Gait/Balance normal				
	1	Balance problem while standing				
	1	Balance problem while walking				
	1	Decreased muscular coordination				
	1	Change in gait pattern when walking through doorway				
	1	Jerking or unstable when making turns				
F. Systolic Blood Pressure	0	NO NOTED DROP between lying and standing				
	2	Drop LESS THAN 20 mm Hg between lying and standing				
	4	Drop MORE THAN 20 mm Hg between lying and standing				
G. Medications	Respond below based on the following types of medications: Anesthetics, Antihistamines, Antihypertensives, Antiseizure, Benzodiazepines, Cathartics, Diuretics, Hypoglycemics, Narcotics, Psychotropics, Sedatives/Hypnotics.					
	0	NONE of these medications taken currently or within last 7 days				
	2	TAKES 1 - 2 of these medications currently and/or within last 7 days				
	4	TAKES 3 - 4 of these medications currently and/or within last 7 days				
	1	If resident has had a change in medications and/or change in dosage in the past 5 days = score 1 additional point				
H. Predisposing Diseases	Respond below based on the following predisposing conditions: Hypotension, Vertigo, CVA, Parkinson's disease, Loss of limb(s), Seizures, Arthritis, Osteoporosis, Fractures.					
	0	NONE PRESENT				
	2	1 - 2 PRESENT				
	4	3 OR MORE PRESENT				
Total score of 10 or above represents HIGH RISK			TOTAL SCORE:			



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AGREEMENT OF RELEASE AND WAIVER OF LIABILITY

This form covers all classes and/or programs offered by GeriHab Physical Therapy and Wellness

Please fill out the following, being sure to read and initial each paragraph.

I, _____, hereby agree to the following:

That I am participating in group physical therapy classes or other programs offered by GeriHab PT and Wellness during which I receive education, information and instruction about exercise, wellness and prevention. I recognize that these group physical therapy classes and programs may require physical exertion, which may be strenuous. Although unlikely, physical injury could occur. I am fully aware of the risks and hazards involved and I agree to assume any responsibility to any injury. I will follow all instructions and modifications recommended by GeriHab PT and Wellness.

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in group physical therapy classes and/or programs. I represent and warrant that I am physically able to participate in exercises classes and I have no medical condition that would prevent my full participation in these group physical therapy exercise classes and/or programs.

____ I have read and understand the Exercise Guidelines for participation in Group Exercise class

____ I agree to inform GeriHab PT and Wellness of any physical limitations, physical discomforts and/or injuries before or during fitness classes and/or programs, and I take full responsibility for nondisclosure.

____ I have read the above release waiver of liability and fully understand its contents.

____ I voluntarily agree to its contents. I voluntarily agree to the terms and conditions stated above.

Name/Signature: _____ Date: _____



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PHOTO AND VIDEO CONSENT FORM

To be completed following discussion with the patient

PATIENT NAME: _____
PATIENT'S ADDRESS: _____

This authorization grants permission to use your image (still or moving) and/or your spoken words in perpetuity for educational purposes.

By signing this document, you agree:

- To allow the recording of your image and voice (e.g., photographs, audio, or video).
- To distribute your image or recording in any medium, be it print or electronic form, which may include the Internet.
- To grant permission to other entities to reproduce the images or recording for educational purposes.
- That there is no reimbursement for the right to take, or to use your photograph or video or recording.

Nature of image and/or spoken words to be recorded: _____
Purpose of recording, image and/or spoken words, including the intended audience: _____

RESTRICTIONS AND LIMITATIONS:

None _____
Specify, if applicable: _____

I have read and fully understand the intent and purpose of this document and am signing it without reservation.

Name (please print): _____
Signature: _____
Date: _____
Witness: _____



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Good Faith Estimate
Initial Visit/Evaluation

Patient Name:	DOB:	State of Service Provided:	
Date Service Requested/Referral Received:	Diagnosis Code:	Date of Estimate:	Expected Start Date:

INSURED

Primary Insurance:	Deductible Remaining:	Co-insurance:	Co-pay:
Secondary Insurance:			
If Medicare Beneficiary:	PT Cap Amount Used:	Home Health Care Status:	
Initial PT Evaluation/ Treatment Cost:	Mod Complexity Eval: 97162	Cost: \$125.00	Total Patient's Responsibility:
	Treatment Codes: 97530 – Ther Activity	\$55.00	
	97110 – Ther Exercises	\$45.00	
	97112 – NMR	\$50.00	
	97116 – Gait Training		
	97140 – Manual Therapy	\$40.00	

UNINSURED/SELF-PAY

Service/Item	Location	Service Code	Cost	Est. Cost
Initial PT Session Estimated Cost (PT Evaluation/2 Units of Tx) *Cost varies depending on Tx Units	Home/ Office	97162	\$125.00	
		97530	\$55.00	
		97110	\$45.00	
		97112	\$50.00	
		97116		
		97140	\$40.00	
Initial PT Evaluation 1 Hour (Prompt Pay Discount) Evaluation + 2 Tx Units	Home	2425		
Home Safety Evaluation (Not Covered by Insurance) 1.5 hours Evaluation Onsite/Written report	Home	2425		
Estimated Total Cost				



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Good Faith Estimate
Follow Up Visit

Patient Name:	DOB:	State of Service Provided:	
Date Service Requested/Referral Received:	Diagnosis Code:	Date of Estimate:	Expected Start Date:

INSURED

Primary Insurance:	Deductible Remaining:	Co-insurance:	Co-pay:
Secondary Insurance:			
If Medicare Beneficiary:	PT Cap Amount Used:	Home Health Care Status:	
PT Treatment Estimated Cost Per 1 Hour Session:	Treatment Codes:	Cost:	Estimated Total Patient's Responsibility:
	97530 – Ther Activity	\$55.00	
	97110 – Ther Exercises	\$45.00	
	97112 – NMR	\$50.00	
	97116 – Gait Training		
	97140 – Manual Therapy	\$40.00	

UNINSURED/SELF-PAY

Service/Item	Location	Service Code	Cost Per Unit	Est. Units Per Session	Est. Sessions	Est. Cost
PT Treatment	Home/Office	97530	\$55.00			
		97110	\$45.00			
		97112	\$50.00			
		97116				
		97140	\$40.00			
PT Treatment (Prompt Pay Discount)	Home					
Home Safety Follow-Up Visit 1 Hour	Home					
Wellness Visit		N/A				
Wellness Visit (Package)		N/A				



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Estimated Total Cost	
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*The estimated costs are valid for 12 months from the date of the Good Faith Estimate.

Disclaimer: This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The initial estimate is based on 1 evaluation unit and two treatment units. You will be charged more if initial treatment lasts beyond one hour.

The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur and if initial treatment lasts beyond one hour. If this happens, federal law allows you to dispute (appeal) the bill.

If you are billed for more than this Good Faith Estimate, you have the right to dispute the bill.

You may contact the health care provider or facility listed to let them know the billed charges are higher than the Good Faith Estimate. You can ask them to update the bill to match the Good Faith Estimate, ask to negotiate the bill, or ask if there is financial assistance available.

You may also start a dispute resolution process with the U.S. Department of Health and Human Services (HHS). If you choose to use the dispute resolution process, you must start the dispute process within 120 calendar days (about 4 months) of the date on the original bill.

There is a \$25 fee to use the dispute process. If the agency reviewing your dispute agrees with you, you will have to pay the price on this Good Faith Estimate. If the agency disagrees with you and agrees with the health care provider or facility, you will have to pay the higher amount.

To learn more and get a form to start the process, go to www.cms.gov/nosurprises or call 800-985-3059.

For questions or more information about your right to a Good Faith Estimate or the dispute process, visit www.cms.gov/nosurprises or call 800-985-3059.

Keep a copy of this Good Faith Estimate in a safe place or take pictures of it. You may need it if you are billed a higher amount.

Patient Signature: _____

Date: _____

HTS Agent Signature: _____

Date: _____



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Patient Name: _____ Patient Phone #: _____ DOB: _____

Reason for Referral: _____

Referring Physician: _____

Treatment Plan:

- Evaluate & Treat
- Continue Plan of Care
- Dementia Education
- GeriHab Group Ex
- Post Covid – Breathing / Training / Exercise

Exercise:

- HEP
- PROM
- AROM / AAROM
- PRE's
- Strengthening

Frequency: 1x , 2x, 3x, 4x, 5x per week for: _____ weeks.

Comments:

I CERTIFY THAT PHYSICAL THERAPY IS MEDICALLY NECESSARY.

 Physician / Physical Therapist

 Date