BenchMark Rehab Partners

Welcome to

Patient Name: **Patient #:** **Date:**

At BenchMark Rehab Partners we believe communication is essential to achieving the best possible patient outcomes. Understanding your needs and expectations is essential to our success. Likewise, it is vital for you to understand the services we offer and our expectations of you.

YOUR FIRST VISIT
Today, you will be introduced to our staff and facilities. The purpose of this initial visit is to evaluate your physical condition, explain the treatment your physician has prescribed, and set progressive rehabilitation goals, also called benchmarks, that will help you enhance your health and physical performance. Your therapist will initiate your treatment, using the technologies and techniques that are appropriate for your condition.

INFORMATION REQUEST
You will be asked to provide us with information about yourself and your medical insurance. As a courtesy, our staff will contact your insurance provider to verify your coverage. Please keep in mind that any and all benefits quoted are not a guarantee of eligibility and/or benefits. If your insurance company requires a co-pay or co-insurance estimate, we will collect this on each date of service.

ABOUT OUR STAFF
Our community-based treatment centers offer a very personalized level of care. A physical therapist or occupational therapist will be responsible for directing all phases of your care. This therapist is a trained, licensed professional who specializes in the treatment of patients with anatomic, neurologic and musculoskeletal disorders. You will also be introduced to support staff that will help to ensure you receive the best possible care and service.

BENCHMARKS (PROGRESSIVE REHABILITATION GOALS)
We establish benchmarks that reflect your physician's expectations and your personal expectations for the results we intend to achieve. With a shared vision for the specific physical gains to be achieved, your therapist will manage your therapeutic care and document the progress you make each visit.

APPOINTMENTS
Your therapist will recommend how often you should schedule appointments and will also discuss home exercises you can do between appointments. It is beneficial to schedule several appointments in advance to ensure the most convenient treatment time and you should always confirm the date of your next appointment at the end of each treatment session. We will make every effort to accommodate your schedule and we will make every effort to stay on schedule so you do not have to wait to be treated. **Please keep your appointment and please be on time**. To achieve your treatment goals, it is important to follow the treatment plan given by your therapist. If you have an emergency or can't come in at your scheduled time, please call us to cancel your appointment and reschedule your next visit.

COMMITMENT TO QUALITY
BenchMark Rehab Partners strives to achieve the highest standards of excellence. We welcome your feedback about the care and services you receive. We have a suggestion box that allows you to submit feedback whenever you feel it appropriate. If you ever have a question or concern, please speak with your therapist or call our corporate office at 423.238.7217.

PATIENT INFORMATION

Patient Demographics and Insurance

Patient Name: **Patient #:** **Date:**

PERSONAL INFORMATION						
Last	**First**	**MI**	**Suffix**	**Social Security #**	**Date of Birth**	**Sex**
Marital Status	**Primary Phone**		**Alternate Phone**		**Email Address**	
Address 1				**City**	**State**	**Zip**
Employer	**Emergency Contact** ,		**Patient's Relationship to Contact**		**Contact Phone** Home: Work: Cell:	

GUARANTOR/RESPONSIBLE PARTY INFORMATION			
Guarantor's Name	**Policy ID #**	**Date of Birth**	**Home Phone**
Guarantor's Address	**City**	**State**	**Zip**

INSURANCE INFORMATION				
PRIMARY INSURANCE				
Name of Insurance	**Group #**	**Policy ID#**	**Insured's Name**	**Date of Birth**
SECONDARY INSURANCE				
Name of Insurance	**Group #**	**Policy ID#**	**Insured's Name**	**Date of Birth**

I have reviewed the above information and verify that it is accurate and current.

_____ _____

Signature of Patient (Parent or Guardian) Date

PATIENT INFORMATION Patient Acknowledgement and Signature

Patient Name: **Patient #:** **Date:**

CANCELLATION POLICY

We value you as a patient and want you to receive the maximum benefit from our therapy program. We schedule patients and give specific
appointment times so that you can conveniently and efficiently make use of your time. We ask that you do the same for us by keeping your
appointment schedule. If you must change your appointment, please do so in advance. Our policy is listed below:
• If throughout the course of therapy, you cancel three appointments without rescheduling, we will ask you to discontinue therapy and we may
contact your physician.
• If through the course of therapy, you No Show or No Call three times, we may ask you to discontinue therapy and we may contact your physician.
• If you are more than 15 minutes late for your scheduled appointment time, we reserve the right to ask you to reschedule your appointment.

ASSIGNMENT OF BENEFITS AND CONSENT FOR CARE

I herein assign my right to payment and/or benefits from any/all sources of payment, regardless of whether I am the policyholder, regardless of
whether the payment source specifically identifies me as a beneficiary, to and agree to have that payment remitted to at an address that is named on a standardized UB-04 or CMS-1500 claim form. I herein assign my benefits in exchange for providing a service. I herein give consent to receive treatment from by any therapist or assistant, employee or its agents, as determined by , in conjunction with my plan of care and health care services ordered by an appropriate licensed health care professional.

FINANCIAL RESPONSIBILITY

I herein agree and understand that I am responsible for the cost of care or treatment and that will make reasonable efforts to obtain payment for services. I also agree and understand that any discussion or printed document that is for the purpose of understanding what my payment source will pay is only an estimate based upon information received from my health plan. I understand that defines a health plan to be any entity where they submit claims for payment on my behalf. I herein agree and understand that I am responsible for understanding the amount that is paid from my payment source, even if that amount is zero, regardless of what may have been explained to me by , its employees, agents or contractors. I also herein agree and understand that I am responsible for any/all costs of collection, should my account become delinquent as defined by , including but not limed to late fees, attorney's fees, court costs or fees paid to a collection agency.

MEDICARE PATIENTS

I hereby certify that the information given by me in applying for payment for Medicare benefits under the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, the Center for Medicare and Medicaid Services, or any of its intermediaries or carriers, any information needed for this or a related Medicare claim. I understand that unless I qualify for the cap exception, Medicare will not pay for therapy services that exceed the Medicare allowable caps – which in 2018 is $2,010 for PT/SLP and $2,010 for OT. If services qualify for the exception process then standard Medicare deductibles and co-insurances will continue to apply toward my charges.

I have reviewed the above information and agree to the terms for treatment at .

_____ Date:_____

Signature of Patient or Guardian

BENCHMARK REHABILITATION PARTNERS
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name: **Patient #:** **Date:**

_____(Initial Here) I acknowledge that I have been offered a copy of the Notice of Privacy Practices.
or
_____(Initial Here) I refuse to acknowledge receipt of the Notice of Privacy Practices. I understand that BenchMark will not refuse to provide services to me even if I refuse to acknowledge such receipt.

_____ _____
Signature of Patient or Personal Representative Witness

_____ _____
Name of Patient or Personal Representative Date

For Staff Only: If patient or personal representative refused to acknowledge receipt, provide an explanation here:
_____

_____ _____
Signature of Employee Date

PATIENT 1-800-Notify CONSENT FORM

Patient Name: **Patient #:** **Date:**
Date of Birth: (If patient is 18 or under, must supply Parent/Guardian Info.)

Parent/Guardian Name: _____

In caring for our patients, it may be necessary for our practice to contact you by automated calls to leave a message or text. When you are not available to speak to directly, we like to leave messages when possible. In order to protect your privacy, it is our policy to not leave specific information on an answering machine/voice mail system, unless we have permission to do so.

Please check applicable ways for us to reach you/leave messages for you.

[ ] **YES**, call me on this phone number and leave a voice mail: _____.

[ ] **YES**, text me on this mobile phone number: .

[ ] **NO**, I do not give consent for you to leave a voice message or text me with appointment reminder through 1-800-Notify.

If you have any questions, please call us at **,** .

I have the option to update and/or change my preferences of how to contact me at any time by completing a **NEW PATIENT 1-800-Notify CONSENT FORM** or otherwise putting my request in writing and submitting it to , , ,

Patient/Parent/Guardian signature: _____ Date: _____

1 For purposes of this authorization, "Benchmark Physical Therapy" includes Benchmark Rehabilitation Partners, LLC, Benchmark Growth Partners, LLC, Benchmark East Partners, LLC, Benchmark Premier Partners, LLC, Benchmark Development Partners, LLC, and Benchmark West Partners, LLC, and their respective parent companies and subsidiaries, providing outpatient therapy services under one or more of the following trade names: Benchmark Physical Therapy, MaxMotion Physical Therapy, Peak Physical Therapy, Physical Therapy & Hand Specialists, Physiofit, SERC Physical Therapy, Therapy Direct and NW Sports Physical Therapy.

Authorization to Disclose Protected Health Information (PHI)

Patient Name: **Date of Birth:** **Patient Account:**

*To designate individuals we may discuss your Protected Health Information with, please complete Section A only.
*To request we communicate and send billing or other communication to your attorney, please complete Section B only.

SECTION A – Communication Consent: I authorize BenchMark Rehab Partners1 to discuss my Protected Health and/or billing information with the persons listed below:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

SECTION B – Motor Vehicle Accidents (MVA) &/or represented by an attorney: I authorize BenchMark Rehab Partners1 to discuss, disclose & release the following information* (check all applicable)

X Billing records ☐ Other: _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse,or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s) or events. (If MVA, include Date of Accident)_____(If no time period specified, records from the previous **1 year only will be released or the related treating injury.**) During the course of treatment you can add or change your attorney information by contacting/and informing the clinic.

Please communicate with the persons listed below and forward any billing & other communication to:

Attorney Name: _____ Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

The information may be used/disclosed for each of the following purposes:

☐ For my health care ☐ Motor Vehicle Case ☐ For payment/insurance ☐ Other: _____

This authorization shall expire no later than ___/___/_____or upon the following event _____ (whichever is sooner), and may not be valid for greater than one year from the date of signature.

I understand that after my health information is disclosed, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law; however, refusal to sign would affect BMRP's ability to communicate with your attorney. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Compliance Officer. I understand that the revocation will not apply to information that has already been released in response to this authorization.

_____ _____
Signature of Patient or Guardian/ Representative Date

_____ _____
Print Name of Patient or Guardian/Representative Date

Please scan this request to Patient's chart. If you have any questions, please email MVA Unit at mhensley@bmrp.com.

1 For purposes of this authorization, "Benchmark Rehabilitation Partners, LLC" includes Benchmark Physical Therapy, Benchmark Growth Partners, LLC, Benchmark East Partners, LLC, Benchmark Premier Partners, LLC, Benchmark Development Partners, LLC, and Benchmark West Partners, LLC, and their respective parent companies and subsidiaries, providing outpatient therapy services under one or more of the following trade names: Benchmark Physical Therapy, MaxMotion Physical Therapy, Peak Physical Therapy, Physical Therapy & Hand Specialists, Physiofit, SERC Physical Therapy, Therapy Direct and NW Sports Physical Therapy.

INSURANCE VERIFICATION INFORMATION

Patient: **Patient Number:** **Insurance Co.**

As a courtesy to you, contacted your insurance company and we were provided with the following eligibility and coverage information: Because insurance policies vary, we can only estimate your coverage in good faith but cannot guarantee coverage due to the complexities of insurance contracts.

ESTIMATED BENEFIT INFORMATION QUOTED BY YOUR INSURANCE PLAN

Deductible

$ _____ Insurance Deductible, _____ Amount met

$ _____ Amount Due (this amount must be paid before your insurance pays)

Patient Responsibility (Due at time of service.)

CO-PAY $ _____ per visit

or

Co-Insurance _____ % of all charges. We will collect $_____ per visit towards your deductible/visit and any remaining balance will be your financial responsibility.

Insurance Coverage/Limits

PT ___ visits OT ___ visits SLP ___ visits.

REMINDER

This information is not a guarantee of coverage or benefits. This information is provided as a courtesy and was quoted by your insurance company, it does not guarantee payment. Co-insurance amounts are estimates. We encourage you to verify coverage with your insurance company.

DISCLAIMER

*I have been counseled regarding my deductible/co-insurance and understand my financial responsibility. I agree to make payments, towards my financial responsibility, to the clinic during the course of my treatments. I understand upon the receipt of my first statement, I am responsible to make payments to the Central Business Office for any remaining balance.

Patient Signature: _____

Reviewed By: _____ Date: _____

PATIENT INFORMATION Patient Health History: Page 1

Patient Name: **Patient #:** **Date:**

Have you had any falls in the past year? Yes No **Are you?** Right-handed Left-handed

Living Environment – Does your home have?

Stairs with no railing Stairs and railing Ramps Obstacles: _____
Uneven terrain Elevator Assistive devices (raised commode): _____

With whom do you live? Alone Spouse Children Parents Other
How did you hear about us? _____

Employment / Work (Job/School/Play)

Occupation: _____Working full-time Working part-time Homemaker / Student Retired Unemployed

Health Habits

Smoking Currently: Yes No Alcohol: Current Past Never

Do you exercise beyond normal, daily activities and chores? Yes No

Medical / Surgical History

Please check if you have ever had (circle all that apply):

The first column is used for outcome measures.

Cancer	Arthritis	Osteoporosis	Broken bones / fractures
Diabetes	Circulation/vascular problems	Depression	Skin diseases
Fibromyalgia	Stroke	Lung problems	Hypoglycemia / low blood sugar
Obesity	Thyroid problems	Kidney problems	Ulcers / stomach problems
Heart Condition	Parkinson's disease	Multiple Sclerosis	Allergies
High Blood Pressure	Latex allergy	Seizures or epilepsy	Developmental or growth problems
Multiple Treatment Area		Infectious disease (e.g. tuberculosis, hepatitis)	
Surgery for this problem		Other: _____	

Within the <u>past year</u>, have you had any of the following symptoms? (circle all that apply)

Chest pain	Bowel problems	Urinary problems
Headaches	Shortness of breath	Dizziness or blackouts
Coordination problems	Weakness in arms or legs	Loss of balance
Difficulty walking	Joint pain or swelling	Pain at night
Difficulty sleeping	Loss of appetite	Fever / chills / sweats
Difficulty swallowing	Weight gain	Weight loss
Hearing problems	Vision problems	Other: _____

Please list any surgeries and include approximate dates (month/year):

_____ _____/_____ _____ _____/_____
_____ _____/_____ _____ _____/_____

FOR MEN <u>ONLY</u>: Have you been diagnosed with prostate disease? Yes No

FOR WOMEN <u>ONLY</u>:

Are you pregnant or think you might be pregnant?	Yes	No
Have you been diagnosed with other OB/GYN difficulties?	Yes	No
Have you ever had surgery related to women's health?	Yes	No

Patient Name: **Patient #:** **Date:**

Current Conditions / Chief Complaints

When did the problem(s) begin? (month/day/year) _____/_____/_____

What happened? _____

Have you ever had this problem before? Yes No

***If yes*:** How long did the problem(s) last? _____

What did you do for the problem(s)? _____

Did the problem get better? Yes No

How are you taking care of the problem(s) now? _____

What are your goals for physical therapy? _____

Are you seeing any healthcare providers for your current problem(s)? (please list) _____

Medications

Do you take any medications? Yes (please list below, use back of page if necessary) No

_____

Have you previously taken any medications for the condition for which you are seeing the physical therapist?

Yes No If yes, please list: _____

Other Clinical Tests Performed for this Condition

Angiogram (heart catheter)	Bone scan	CT scan
EKG (electrocardiogram)	Mammogram	MRI
NCV (nerve conduction velocity)	X-rays	Stress test (e.g. tread mill, bicycle)

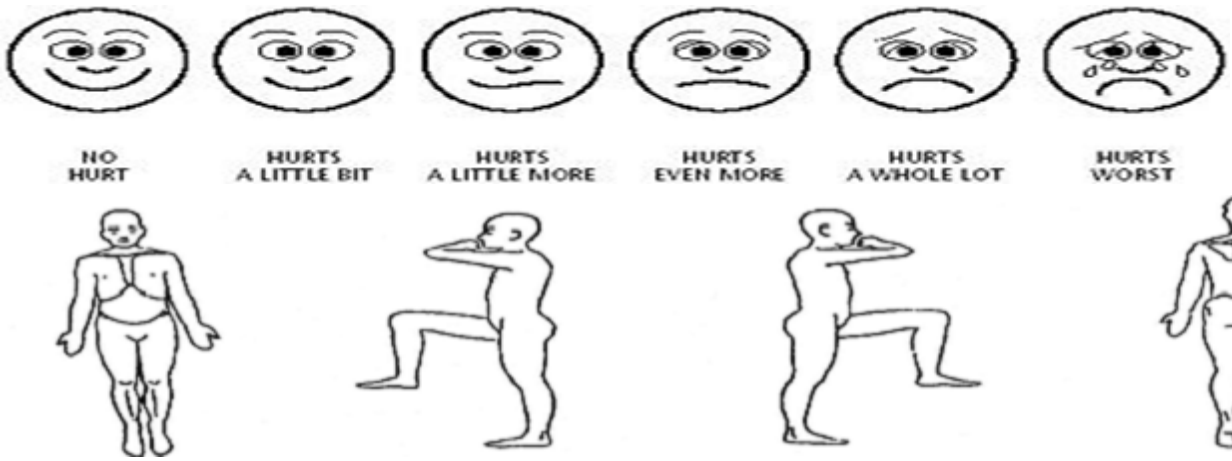
Other: _____

Pain

Please indicate your level of pain at this time by marking either the numerical or visual scale:

0 1 2 3 4 5 6 7 8 9 10

None Mild Moderate Severe Very Severe



Please mark on the diagram above where you are having your symptoms/pain