Confluent HEALTH

Medicare Secondary Payer (MSP) Form

Patient name: _____ Acct#: _____

Medicare requires us to identify if Medicare is the primary or secondary payer, please answer all the required questions below.

Part I - INFORMATION ABOUT BLACK LUNG, WORKERS' COMPENSATION (WC), NO-FAULT AND LIABILITY

1. Are you receiving benefits under the Black Lung Program? ☐ Yes ☐ No
   If yes, date benefits began _____
   Black lung is primary payer only for claims related to black lung.
2. Was this injury/illness due to a work-related accident/condition? ☐ Yes ☐ No
   If yes, date of injury/illness _____; *Please provide the WC information.*
3. Was the injury/illness covered under no-fault (and/or medical-payment coverage) including premises or automobile?
   ☐ Yes ☐ No
   If yes, date of accident _____
   Is no-fault insurance available? ☐ Yes ☐ No
   If yes, please provide no-fault insurance information.
4. Was this injury/illness related to an accident in which you intend to file liability suit or litigation pending? ☐ Yes ☐ No *If yes, please provide the Attorney's information.*

If answered YES to any of the questions above, Medicare is the secondary payer and you do NOT need to fill out Part II or III

Part II - INFORMATION ABOUT MEDICARE ENTITLEMENT AND GROUP HEALTH PLANS

1. Are you entitled to Medicare based on:
   ☐ Age (65 & older) – go to question #2
   ☐ Disability – go to question #2
   ☐ End Stage Renal Disease—Go to **Part III**
2. Do you have group health plan (GHP) coverage based on your own current employment, or the current employment of either your spouse or another family member? ☐ Yes ☐ No
   If yes, how many employees, including yourself or spouse, work for the employer from whom you have GHP coverage:
   ☐ Aged (65 & over) - If you are aged and there are 20 or more employees, your GHP is primary.
   ☐ Disability - If you are disabled and your employer, spouse, or family member employer, has 100 or more employees, your GHP is primary.

Part III - INFORMATION ABOUT THE PATIENT IF ESRD MEDICARE ENTITLEMENT APPLIES

Medicare benefits are secondary to benefits payable under a GHP for individuals eligible for or entitled to benefits on the basis of ESRD during a period of up to 30-month period if Medicare was not the proper primary payer for the individual on the basis of age or disability at the time that this individual became eligible or entitled to Medicare on the basis of ESRD.

1. Do you have group health plan coverage? ☐ Yes ☐ No
2. Are you within the 30-month coordination period? ☐ Yes ☐ No
   If yes to both questions, GHP is primary during the 30-month coordination period.

_____ _____

Signature of Patient/Representative Date

Relationship to patient: _____

Elder Abuse Suspicion Index © (EASI)

EASI Questions

Q1-Q5 asked of Patient. Q6 answered by doctor.
(Within the last 12 months)

1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?	YES	NO	Did not answer
2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aids, or medical care, or from being with people you wanted to be with?	YES	NO	Did not answer
3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	YES	NO	Did not answer
4) Has anyone tried to force you to sign papers or to use your money against your will?	YES	NO	Did not answer
5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	YES	NO	Did not answer
6) Doctor: Elder abuse may be associated with findings such as poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?	YES	NO	Not sure

Mark J. Yaffe, MD — McGill University, Montreal, Canada
Maxine Lithwick, MSW — CSSS Cavendish, Montreal, Canada
Christina Wolfson, PhD — McGill University, Montreal, Canada

Did You Know Before You Go? Medicare Part B

Patient Name: _____ DOB: _____

Medicare Policy#: _____ Dx: _____

Part B effective date: _____ DOS: _____ Acct#: _____

Patient portion—Please mark appropriately:

Are you currently receiving:

Home Health ☐ Yes ☐ No
Hospice ☐ Yes ☐ No

Or residing in:

Skilled Nursing Facility ☐ Yes ☐ No
Intermediate Care Facility ☐ Yes ☐ No

Have you been seen for therapy at another facility at any time this year? ☐ Yes ☐ No

Your benefits:

- The annual deductible is $203.00; the remaining deductible amount is $ _____
- Medicare Primary: YES NO
  - Medicare will pay 80%; you will be billed 20% of the allowable.
- Your therapy benefits allowed: ☐ $2110.00 therapy threshold PT/SPT combined for 2021
  ☐ $2110.00 therapy threshold OT for 2021
  - Medicare Therapy benefits used this year: PT: _____ OT: _____
- Currently receiving Home Health: YES NO
- Special instructions _____

If your deductible has not been met, you will be responsible for the outstanding charges in addition to any other co-insurance and/or co-pays. Medicare only pays for covered benefits; ALL BENEFITS ARE SUBJECT TO MEDICAL NECESSITY. This verification is performed by a staff member as a courtesy and DOES NOT represent a guarantee of payment by your insurance company.

I fully understand that I am financially responsible for any services not covered by my insurance.

Patient/guardian signature: _____ Date _____

Question about your bills, statements or claims? Just give us a call, we can help!

Verified By: _____ Date: _____

HPRC
PHYSICAL THERAPY

WELCOME TO THE HUMAN PERFORMANCE AND REHABILITATION CENTERS, LLC.

Welcome to Human Performance and Rehabilitation Centers, LLC (HPRC). The following information will give you a better understanding of our payment, insurance filing and information policies:

PAYMENT POLICY: Payment is requested at the time of service unless other arrangements are made prior to treatment. We accept cash, check, MasterCard, Visa or American Express and most Health savings and Flexible Spending Accounts.

INSURANCE: HPRC will file your primary insurance if you provide the appropriate insurance information. You will receive a statement each month if your account has a balance. You are responsible for payment of that balance. If your insurance does not pay, you should contact the insurance company. This office will not negotiate the settlement of a disputed insurance claim.

MANAGED CARE CONTRACTS: HPRC is enrolled in numerous managed care and participating provider insurance programs. Please advise our staff if you are a member of this type program. All co-pays or estimated patient balances are due at time of service. Our participation is not a guarantee of payment from your insurance. You will receive a statement for any balance after insurance has responded to our claim.

MEDICARE: The therapists at HPRC are participating Medicare providers. We will file your Medicare and one supplement if you provide us with the appropriate insurance information. You will receive a statement each month until your account is paid out. Pay only amounts in patient responsibility on your statement. Medicare will pay 80% of covered services after your deductible is met. You are responsible for your deductible and 20% of covered charges if your supplement does not pay timely. Medicare requires that you see your physician at least every 90 days while you are receiving therapy.

WORKERS' COMPENSATION: Please provide HPRC with the proper information required to verify coverage. Except for acute cases, treatment will not begin until we have authorization from your workers' compensation carrier.

NON-COVERED SERVICES: Some or all of the services provided to you may not be covered by your insurance. You will be responsible for payment of these services.

INFORMATION DISCLOSURE: Federal and state law allows us to use and disclose information about you for purposes of treatment, billing and receiving payment, and routine heal care operations. In order to use or disclose information about you for any other purpose, we need your specific authorization. The "Notice of Privacy Practices" posted in our lobby explains how we use and disclose information. If you request, we will provide you with a copy of the Notice of Privacy Practices.

LEGAL CASES: We cannot treat patients on a contingency basis; therefore, where legal cases are pending settlement, we ask that the full charge be paid at the time treatment is rendered.

IF YOU HAVE ANY QUESTIONS, SOMEONE FROM OUR BUSINESS OFFICE WILL BE GLAD TO ASSIST YOU.

CONSENT FOR TREATMENT & AUTHORIZATION: I do hereby consent to treatment by Human Performance and Rehabilitation Centers, LLC. I authorize HPRC to release medical and supporting documentation of same as compiled in my medical record during this treatment or subsequent treatments for purposes of benefit payment. I further authorize my insurance benefits to be paid directly to Human Performance and Rehabilitation Centers, LLC when indicated on claim. I understand that I am financially responsible for the charges for services rendered.

Signed _____ Date _____

Relationship to Patient: _____

Witnessed By: _____

HPRC
PHYSICAL THERAPY

PATIENT INFORMATION SHEET

Referring Doctor _____ Primary Care Provider _____
What part of the body are we treating? _____

Personal Information

First Name _____ Middle Initial _____ Last _____ Nickname _____
Home Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____
SSN _____-_____-_____ DOB ___/___/___ Gender M___F___ Marital Status Married___ Single ___
Height __ foot, __ inches Weight _____ Are you disabled? Y__ N __ If yes, what is your disability _____

Employer _____ Occupation _____ Phone (____) _____
Emergency Contact _____ Relationship _____
Home Phone (____) _____ Cell (____) _____ Work (____) _____

Can we communicate with you by Email? Yes / No Email address _____ (optional)

Insurance Information

Primary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB __/__/_____ Policy Holder's SSN _____-_____-_____
Policy Holder's Address (if different): _____

Secondary Insurance _____ Policy Number _____
Policy Holder Name _____ Policy Holder's Phone (____) _____
Policy Holder's DOB __/__/_____ Policy Holder's SSN _____-_____-_____
Policy Holder's Address (if different): _____

If this is an approved claim through Worker's Compensation, please answer the following:
Injury Date _____ Employer when injury occurred (if different) _____
Insurance Carrier Name _____ Contact/Adjuster _____
Claim Number _____ Adjuster's Phone (____) _____

Please complete this section if the patient is a Minor and/or covered under parent's insurance:
Mother's Name _____ Phone (____) _____ SSN ___-___-____
Address (if different) _____ Employer _____
Father's Name _____ Phone (____) _____ SSN ___-___-____
Address (if different) _____ Employer _____

Please be advised it is your responsibility to consult your insurance regarding coverage for outpatient therapy.
We do check eligibility as a courtesy, but your failure to check could result in an unpaid bill for which you are responsible.

Signature: _____ **Date:** _____

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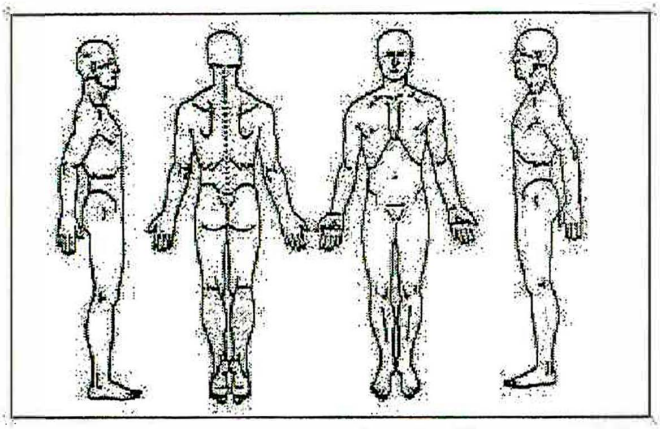
Name:	Date:	Gender:	DOB:
Email:	Cell Phone:		

CURRENT INJURY: _____

Please mark below where your pain is located



Please rate your current pain (0 = no pain)

0 1 2 3 4 5 6 7 8 9 10

Date started?
Describe the onset and history of current condition _____ _____
Occupation?
□ Full Time □ Retired □ Not employed □ Part Time □ Disabled □ Modified □ Full or Part Time Student

Over the past 6 months, have you been diagnosed with or are you currently experiencing any of the following symptoms?

□ Abnormal Bleeding	□ DVT/ blood clot	□ Multiple Sclerosis
□ Abuse □ Neglect	□ Falls to the ground	□ Muscle Cramps
□ Angina (chest pain)	□ Fibromyalgia	□ Heart Attack □ Heart Disease
□ Anxiety	□ Frequent UTI	□ Numbness
□ Arrythmia	□ Gastroesophageal reflux dis.	□ Osteoarthritis
□ Asthma	□ Glaucoma	□ Osteoporosis
□ Bipolar Disorder	□ Gout	□ Psoriatic Arthritis
□ Blood Clotting Disorder	□ Hard of Hearing □Hearing aid	□ PVD(Peripheral Vascular Dis)
□ Bowel Incontinence	□ Hepatitis □ B □ C	□ Rheumatoid Arthritis
□ Cancer Type:	□ Hiatal Hernia	□ Scoliosis
□ Cellulitis	□ High Blood Pressure □Low	□ Seizure Disorder
□ Closed Head Injury	□ High Cholesterol	□ Shortness of Breath
□ Colitis	□ HIV/AIDS	□ Sleeping Disorder
□ Congestive Heart Failure	□ Hypothyroidism □ Hyper	□ Tuberculosis □Current □ Past
□ COPD	□ Irritable Bowel Syndrome	□ Urinary Incontinence
□ Chron's Disease	□ Kidney Stones	□ Allergies:
□ CVA (stroke)	□ Liver or gallbladder issues	**FEMALE:**
□ Depression	□ Lymphedema	□ Currently Pregnant
□ Diabetes Type1 □ Diabetes 2	□ Migraine Headaches	□ Regular Menstrual Cycle
□ Dizziness □Clumsiness	□ MRSA	□ Menopausal symptoms

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Please list any other symptoms or conditions not listed:

_____

Have you had any of the following procedures?

- □ Bypass Surgery
- □ Cardiac Ablation
- □ Pacemaker
- □ Stent Placement
- □ Joint Replacement
- □ Metal Implants

Please list your current medications, vitamins or supplements. *(If your medications are written down, please allow us to scan into your chart)* ***Please specify blood thinners and NSAID's***

_____

_____

_____

Please list any major surgeries (past 5 years) ***or pertinent to current condition***

_____

_____

Please list any diagnostic tests you've had performed ***specific to current condition***

- □ Biopsy
- □ Blood work/Lab Tests
- □ Bone Density Scan
- □ CT Scan
- □ EEG
- □ EMG
- □ Lower GI Study
- □ Motility Study
- □ MRI
- □ Nerve Conduction Study
- □ Swallow Study
- □ Upper Endoscopy
- □ Ultrasound
- □ X-Ray
- □ Other

Living Situation

- □ Single Story Home
- □ 2 Story Home
- □ Ground Floor Apartment
- □ Upper Level Apartment
- □ Assisted Living Facility
- □ Skilled Nursing Facility

Are there stairs at home? □ Yes □ No Is there a handrail present? □ Yes □ No

□ Other situation Comment: ___

Who do you live with?

- □ Spouse
- □ Spouse + Children
- □ Child(ren)
- □ Other Family Member
- □ Alone
- □ Other

Are those checked available to help if needed? □ Yes □ No Comment: _____

What is your primary role at home?

- □ Caregiver for others
- □ Financial Provider
- □ Housework
- □ Home Maintenance
- □ Yard Maintenance
- □ Other

Is the patient currently able to perform these roles? □ Yes □ No Comment: _____

Social Habits:

Smoker/Tobacco Use? □ Yes □No Packs/day:	□Frequency □Occasionally □ Rarely □Never	Past Smoker? □ Yes □ No Year stopped?
Do you consume alcohol?	□Frequency □Occasionally □ Rarely □Never	Drinks/week? Drinks/time?
Do you consume caffeine? □ Coffee □ Soda □ Energy drinks		Drinks/day___ Days/wk ___
Current or Prior Exercise Program?		Frequency/Duration?

HPRC
PHYSICAL THERAPY

ACKNOWLEDGEMENT OF NOTICE OF INFORMATION PRACTICES

(To be retained by Medical Provider)

I understand that Human Performance and Rehabilitation Centers, LLC (referred to below as "the clinic") will use and disclose **health information** about me in the course of providing treatment.

I understand that my **health information** may include information both created and received by the clinic, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand that the clinic is permitted to use and disclose my health information in order to:

- make decisions about and plan for my care and treatment;
- refer to, consult and coordinate with other health care providers in the course of my treatment;
- determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support the clinic's ability to provide me with appropriate care and arrange for payment.

I also understand that I have the right to receive a written **Notice of Privacy Practices** that describes how the clinic uses and discloses health information, the information practices followed by the clinic staff and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time and that I am entitled to receive a copy of any revised Notice of Privacy Practices upon request. I also understand that a copy of the most current version of the clinic's Notice of Privacy Practices in effect will be posted in waiting/reception area.

I understand that the Notice of Privacy Practices describes how I can exercise my right to ask that some or all of my health information not be used or disclosed, and I understand that the clinic is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I will be provided with a copy of the Notice of Privacy Practices upon request.

By:_____ Date:_____
(Patient)

-OR-

By:_____ Date:_____
(Patient's Representative)

Description of Representative's Authority:_____

(PPAck, Rev 9/22)

Missed Appointment Agreement

HPRC cares about the health and well-being of the patients we serve.

Consistent attendance is important to maximize our patient's progress. We understand sometimes circumstances occur that prevent the patient from coming to therapy. When that happens, it is important you let us know that you will be unable to attend the scheduled session.

No Shows: when a patient does not show or misses their appointment, they will be subject to a $30 fee that will be billed directly to the patient.

Timely Cancellations: If you need to cancel or reschedule your appointment, we ask that you give us at least 24 hours' notice. Cancellations made with less than 24 hours' notice may be considered a "no-show" and a $30 fee may be added to your account.

On Time Arrivals: We ask that you notify us in advance if you're going to be more than 10 minutes late for your appointment. Failure to do so may result in a $30 no-show fee being added to your account.

This procedure has been put in place to limit the number of "no-shows" so that we can provide high-quality therapy services to all patients. Thank you for your understanding and cooperation.

_____

Print Name

_____ _____

Signature Date