Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

Reset

INSURANCE REGISTRATION INFORMATION

For proper reimbursement we need all the boxes that apply to you to be filled in detail. We also require:

1. A valid script &/or referral for PT from your physician dated back **3 months or less**
2. Copies of Health Insurance Card/s or C4/MG2 forms for ALL workers' comp cases
3. A valid ID: Driver's License/ Passport/ State ID

Are You the Patient: ☐**Yes** ☐**No** **Are You the Insured:** ☐ **Yes** ☐ **No** Have You Had PT This Year? ☐**Yes** ☐ **No** **Emergency Contact Name/Tel. #**	
Patient's Last Name, First Name:	
Patient's Date Of Birth**:** **SSN:** **Email:**	
Patient's Address: **Street:**	
City: **State, Zip:**	
Patient's Telephone Number**: Cell:** **Home:**	
Patient's Relationship to Insured: ☐**Self** ☐ **Spouse** ☐ **Child** ☐ **Other**	
Patient's Marital Status**:** ☐**Single** ☐ **Married** ☐ **Other** Employed: ☐ **Yes** ☐ **No** **Student:** ☐ **Yes** ☐ **No**	
Method of Reimbursement: ☐Through Insurance **(proceed to the appropriate sections below)** ☐ Self-Pay **(proceed to next page)**	
Name of referring MD/PCP **:** **Tel #:** **NPI:**	
PRIMARY PLAN NAME: **ID:**	
Insured's Last Name, First Name:	
Insured's Date of Birth: Insured's SSN**:**	
Insured's Address**: Street:**	
City: **State, Zip:** Tel #:	
SECONDARY PLAN NAME: **ID:**	
Insured's Last Name, First Name:	
Insured's Date of Birth**:** Insured's SSN:	
Insured's Address**: Street:**	
City: **State, Zip:** Tel #:	
TERTIARY PLAN NAME: **ID:**	
Insured's Last Name, First Name:	
Insured's Date of Birth**:** Insured's SSN:	
Insured's Address**: Street:**	
City: **State, Zip:** Tel #:	
Is your condition related to an injury☐Yes/ No☐ **Accident Date:** **SSN(Mandatory):** If Yes, fill all the following boxes, in complete detail ➔	
Indicate cause of accident ➔	☐ **Auto Accident (No Fault)** ☐ **Employment (Workers' Comp)**
Claim # ➔	
Policy # ➔	
Carrier Case # ➔	
Name of Employer	**Tel. #**
Employer's Mailing Address:	**Street:** **City:** **State, Zip:**
Name of Case Worker	**Tel#** Fax #
Name of Attorney (If applicable)	**Tel#** **Fax #**
Claim Mailing Address:	**Street:** **City:** **State, Zip:**

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

Reset

PATIENT INTAKE FORM

Age: ____years. Male/Female: ☐ ☐ (R)/(L)Handed ☐ ☐ Height: ___Ft. __inches Weight:_____lbs BMI:_____

BMI Calculator: http://www.acefitness.org/acefit/healthy_living_tools_content.aspx?id=1

Diagnosis: _____

Describe your current problem: _____

_____

Is it constant 76-100% of the day:_____☐ Intermittent: 1-75% of the day:☐____

How did it start: _____

Date it started:_____Ocurred before: Yes/ No: If yes, when:_____ ☐ ☐

Is it ☐ A new Injury ☐ Aggravation of an old problem ☐ Chronic

Is your condition getting better or worse: _____

How do you feel today: ***Enter number:*** _____

1 2 3 4 5 6 7 8 9 10

No symptoms Unbearable symptoms

Are you using any assistive devices: ***Check*** all that apply:

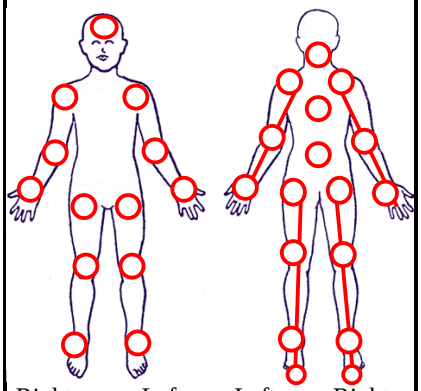
Orthotics/Splints/Corset/Crutches/Cane/Walker/Wheelchair /Other: _____

☐ ☐ ☐ ☐ ☐ ☐ ☐

Describe briefly any treatment & # of visits (chiropractic, physical therapy etc.) you had:_____

_____

_____which did (or did not) benefit. ☐ ☐



Indicate on the diagram where you have pain or other symptoms

Checkmark your area of pain inside the red circles. Type details if needed:

Past Surgical History: Date of Surgery: _____

Shoulder, Hip, Knee, Ankle joint replacement, Arthroscopy, Fractures, Spine, any other _____

Is there any crepitus, clicking or locking present during movement? ( ) Yes ( ) No _____

Is there any twitching or involuntary movement of muscle or joint? ( ) Yes ( ) No _____

Smoker: ( ) Yes ( ) No Alcohol Consumption: ( ) Yes ( )No_____

Difficulty in speech: ( ) Yes ( ) No Difficulty in writing: ( ) Yes ( ) No_____

Have you had: X-rays, MRI, CAT: Spine, R/L hip/knee/ankle Tests: EMG-NCV on upper extremity or lower extremity Yes/ No_____

Medical History/Precautions: Check all that apply on the list below with approximate year of onset:

Condition		Medications Taken	
Do you suffer from:	**Check box**	**Name of Medication**	**Dosage & Frequency**
Obesity			
Hypertension			
Diabetes			
Rheumatoid and Osteoarthritis			
Osteoporosis/osteopenia			
Migraine			
Dizziness			
Anxiety			
High/Low Thyroid	☐ High ☐ Low		
Asthma			
Gangrene			
Peripheral Vascular disease/Varicose veins	☐ PVD ☐ Varicose veins		
Congestive Heart failure /COPD			
Dementia/Cognitive deficits			
Other Medications or Supplements taken (attach list)			

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

Reset

SELF-ASSESSMENT

1. Are you currently on work restrictions: ( ) Yes ( ) No Since when:_____
2. Live ( ) alone ( ) with family

Function That May Be Affected By Pain Etc.	Not Applicable	No Difficulty	Little Difficulty	Moderate Difficulty	Much Difficulty	Unable To Perform
Dressing: • Pullover • Shirt • Buttoning • Shoes						
Transfers: • Bed • Chair • Tub • Toilet • Car						
Activities of Daily Living: (ADL) • Bathing • Grooming • Lifting • Carrying • Pushing • Pulling • Bending • Stooping • Squatting						
Overhead Tasks: • Reaching for objects on high shelf • Painting ceiling etc.						
Work Tasks • Writing • Driving • Housework includes cleaning & cooking						
Static Activity: Ability to perform with no pain for 10-15 mins in: • Lying down • Sitting • Standing • Walking						
Dynamic Activity i.e. Moving to/from: • Lying to sitting • Sitting to standing • Stand to walk						
Loss of Balance						
Difficulty in using arm						
Any other difficulty						

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

ASSIGNMENT AND RELEASE/AUTHORIZATION OF PAYMENT

PRIVATE INSURANCE AND/OR MEDICARE ASSIGMNMENT OF BENEFITS

I, the undersigned, have insurance coverage with _____ (name of your insurance company) and assign directly all fiscal medical payments and benefits paid by said insurance carrier, for services rendered, to Caroline Konnoth Physical Therapy, P.C., otherwise payable to me.

If another health insurance is indicated in item 9 of the HCFA -1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charges determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

I hereby authorize the provider to release all information necessary to secure the payment of benefits.

I authorize the use of this signature on all my insurance submissions whether manual or electronic.

I give consent to Caroline Konnoth Physical Therapy, P.C. to carry out all procedures required for the evaluation, treatment and future treatment planning for my condition.

PRIVATE INSURANCE/ NO FAULT/WORKER'S COMPENSATION AUTHORIZATION TO PAY

I, the undersigned, have insurance coverage with _____ (name of your insurance company) and request that payment of authorized fiscal benefits be made on my behalf, even in cases of liens held, to Caroline Konnoth Physical Therapy, P.C. for any services furnished to me by the therapist. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature below requests that payment be made to Caroline Konnoth Physical Therapy and authorizes release of medical information necessary to pay claim.

FOR ASSIGNMENT OF BENEFITS OR AUTHORIZATION OF PAYMENT:

I understand that I am financially responsible for all charges, viz: copays, co-insurance, liens, deductibles or for those claims that were denied payment by my insurance company &/or *my insurance company states that I am financially responsible for the same.* ***Any failure in payment for services may require arbitration or a recovery process and any cost incurred for that recovery process that vary from 20% to 50% of the owed amount, will be my responsibility, if this applies.***

_____ _____

(Signature of Beneficiary) (Date)

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

Reset

HIPAA PRIVACY RULE SUMMARY

Below is a summary of the HIPAA Act. For complete details and disclosures visit:

http://www.hhs.gov/ocr/privacy/hipaa/understanding/summary/privacysummary.pdf

Protected Health Information: The Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The Privacy Rule calls this information "protected health information (PHI)." "Individually identifiable health information" is information, including demographic data (e.g., name, address, birth date, Social Security Number), that relates to:

1. an individual's past, present or future physical or mental health or condition,
2. the provision of health care to an individual, or
3. past, present, or future payment for the provision of health care to an individual.

The Privacy Rule excludes from protected health information employment records that a covered entity maintains in its capacity as an employer and education and certain other records subject to, or defined in, the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g.

De-Identified Health Information: There are no restrictions on the use or disclosure of de-identified health information. De-identified health information neither identifies nor provides a reasonable basis to identify an individual. There are two ways to de-identify information; either:

1) a formal determination by a qualified statistician; or
2) the removal of specified identifiers of the individual and of the individual's relatives, household members, and employers is required, and is adequate only if the covered entity has no actual knowledge that the remaining information could be used to identify the individual.

General Principle for Uses and Disclosures

Basic Principle. A major purpose of the Privacy Rule is to define and limit the circumstances in which an individual's protected heath information may be used or disclosed by covered entities. A covered entity may not use or disclose protected health information, except either:
(1) as the Privacy Rule permits or requires; or
(2) as the individual who is the subject of the information (or the individual's personal representative) authorizes in writing.

Signature: _____

Name:_____ Date: _____

Caroline Konnoth Physical Therapy
Office Phone: 718-359-1006 Office Fax: 718-359-4123

Patient Name	Insurance Name	Member ID	DOB	Today's Date

Reset

IMPORTANT COMPANY POLICIES

We strive to provide you with the best personal care available. To make this possible we adhere to a set of very important guidelines. Please read them carefully, initial at every policy and indicate your agreement by signing at the bottom.

_____**A Referring Physician Script** is necessary for proper reimbursement. *The absence of a script and the possible non-reimbursement by the Insurance Company will make me (your name)* _____*responsible* for the charge.

_____**24-Hour Advance Notice Fee**: A minimum 24-hour advance notice is required in order to change/cancel an appointment. Anything less than that will result in a full-service fee charged to your account. **. An allowance of only 1 missed/cancelled visit without 24-hour cancellation is made in dire circumstances.**

_____**No shows:** If you fail to show for your appointment without prior notice, all further appointments will be removed and **a full-service fee will be assessed to your account**. You may reschedule appointments again on a "first-come, first serve basis".

_____**ALL payments are due in advance of your treatment session.**

_____**Cell phones must be SILENT.** We realize that emergencies may arise and therefore allow you to carry your cell-phone during your session, but please turn it to "silent" mode, to give yourself the full benefit of an undisturbed session.

_____ **A Typical session goes for 40-50 minutes with the physical therapist present in person as needed. This includes:**

- An Initial Evaluation on your first visit
- Physical therapy modalities using electrical equipment as per your need-about 20-25 minutes
- Manual therapy-about 10 minutes
- An exercise program, that may start on day 1 but typically starts on day 3-about 10 minutes

_____**TCPA Regulations:** In keeping with the Telephone Consumer and Protection Act compliance regulations, you must agree to receive automated appointment reminders from our office before we start sending you these reminders.

_____**Updating Information**: Any changes in your demographics, telephone # or insurance plans must be promptly shared with our office. This will ensure accurate generation of all insurance claims. *Failure to do so may result in your claims being denied by your insurance company for timeliness.* Consequently, as per the "assignment and release" signed by you, you will be responsible for all remaining dues.

I agree to all the policies on this form.

Signature:_____

Name:_____Date: _____

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

Reset

ADVANCE BENEFICIARY NOTICE OF NONCOVERAGE (ABN)

A. Notifier: CAROLINE KONNOTH PHYSICAL THERAPY, P.C.

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

NOTE: ***If Medicare doesn't pay for D. Physical Therapy 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. Physical Therapy below.(The following descriptors may be used in the header of Blank (D): • Item • Service• Laboratory test• Test • Procedure • Care• Equipment)

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Physical Therapy Session	• Medicare does not pay for physical therapy as often as this (denied as too frequent) • Medicare does not deem that this service is medically necessary	$100 per session

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 G below about whether to receive the D. Physical Therapy *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. Physical Therapy *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. Physical Therapy *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. Physical Therapy *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.

Form CMS-R-131 (Exp. 03/2020) Form Approved OMB No. 0938-0566

THIS PAGE IS TO BE FILLED IN ONLY BY PATIENTS COVERED BY FEDERAL MEDICARE

Caroline Konnoth Physical Therapy

Patient Name:	Insurance Name:	Member ID:	DOB	Today's Date

Please Understand Your Charges-Effective January 1st 2024: Choose A **or** B **or** C Please Make Note of the Office Policies section below

A Traditional PT Sessions-Confirm your session

Status	Insurance Type		Dues
Copay & Co-Insurance %	Commercial Insurance	Medicare's Secondary	As applicable/insurance plan
Till Deductible Applies	Commercial Insurance	Medicare's Primary/ Secondary	As per deductible amount due/session
Self-Pay	No insurance coverage		Self-Pay: $125 IE & $100 /session after

B Holistic Treatments: Check Your Choice of Treatments from this List of Services

- Craniosacral Therapy +Cellular Memory Discovery
- Visceral Manipulation/Neural Manipulation
- Lymphatic Drainage
- Manual Articular Approach
- Spinal Flow
- Emotion Code (offered via Zoom as well)
- Body Code (offered via Zoom as well)
- Belief Code (Offered vis Zoom as well)
- Access Bars

There is no Initial Evaluation charge for the sessions in this column

Confirm your Session

Single Sessions	Self -Pay	In Network*	Out of Network**
Initial Evaluation has a separate 1-time charge	$225	$225*	See Below**
Each Subsequent Session (Commercial Insurance)	$200	$160*	See Below**
Each Subsequent Session (Medicare)	NA	$85 + applicable copay	NA**

* **Using In-Network**, excludes BCBS & Emblem Plans. It includes insurances offering unlimited PT visits with no pre-authorization requirement

****Out Of Network**: We offer to bill your insurance company on your behalf to cover all the costs of your sessions provided your plan allows for sufficient payment for these services. If there is a deficit you will be informed and will be responsible for any payment deficit per session.

Payment Packages-Confirm your Sessions

Multiple Sessions	Self -Pay	In Network*	Out of Network**
Package of 5: discounted by $5 per session (completed within 3 months)	$975	$775*	See Above**
Package of 10: pay for 9 sessions only (completed within 6 months)	$1,800	$1,440*	See Above**

C Weekend Intensives and Halo Packages for Holistic Treatment

Weekend Intensives	$2,000 (completed over 1 weekend). See description below in Session Times C
Halo Packages	$10,000 (completed within 1 year). See description below in Session Times C

§ Office Policies

Payments	All payments will be made in advance of sessions, through cash, check, credit card or Zelle (to clientcare@myhealingdynamics.com)
Cancellation Policies	A Cancellations must be made ***24 hours prior*** to the session or a full charge will apply. An allowance of only 1 missed/cancelled visit without 24-hour cancellation is made in dire circumstances.
	B Cancellations must be made ***24 hours prior*** to the session or a full charge will apply. An allowance of only 1 missed/cancelled visit without 24-hour cancellation is made in dire circumstances.
	C **Weekend Intensives**: Cancellations must be made ***one week*** in advance of the Weekend Intensive Start date or a full charge will apply. For **Halo Packages** cancellation rules for single sessions as in B & Weekend Intensives apply
Sessions Times	A Typically, 40-45 mins in total: Includes therapist hands-on time + exercises, varies case to case (10-25 mins) +electric modalities (20-30 mins)
	B Typically, 45mins to 1.25 hours in total: Includes therapist hands-on time:40-45 mins + electric modalities for 20 mins (if needed)
	C **Weekend Intensives** run for 7.5 hours = 450 minutes or 10 sessions - divided into 3 x 2.5 hours sessions: i.e., 2.5 hours each, on Saturday evening, Sunday morning and Sunday afternoon. Details will be discussed prior to event.
	C **Halo Packages**: includes 30X45 minute Hands-On Sessions @ $6,000 + 2 Weekend Intensives @ $4000+ 1 Free Weekend Intensive ($2000 bonus). Details will be discussed upon signing up.

The Above Payment Schedule Has Been Read and Understood by Me.

Patient name:		Patient Signature:		Date:	