STRAIT OCCUPATIONAL & HAND THERAPY, P.S.

Lynda Guditus Williamson, OTR/L, CHT, CEAS, PBP
Occupational Therapist, Certified Hand Therapist, Certified Ergonomics Assessment Specialist, Professional Bowenwork Practitioner

MEDICAL HISTORY

Patient Name:_____Date: _____

How did you hear about us? _____

Referral Source: _____

Have you had a complete physical examination within the last year? ____YES ____NO

Have you had or do you currently have a contagious disease? ____ YES ____NO
If yes, please specify _____

PLEASE CHECK ALL THAT APPLY BELOW IF YOU HAVE **RECENTLY** HAD
ANY OF THE FOLLOWING COMPLAINTS

___Shortness of breath
___Seizure/Epilepsy
___Pulsating pain anywhere in your body
___Constant and severe pain in lower leg
___Discolored or painful feet
___Dizziness
___Persistent pain at night
___Swelling
___Constant pain anywhere in your body
___Unexplained weight loss in 2 weeks
___Loss of appetite
___Unusual lumps or growths
___Fatigue
___Diabetes
___Frequent or severe abdominal pain
___Frequent heartburn or indigestion
___Frequent nausea and vomiting
___Change or problems with bladder
___Change or problem bowel function
___Unusual menstrual irregularities
___Use tobacco
___Fallen twice in the past year
___High/low blood pressure
___Changes in hearing
___Frequent or severe headaches
___Problems w/swallowing
___Changes in vision (blurred or loss)
___Problem with balance or falling
___Problems with coordination
___Fainting spells
___Sudden weakness
___Fever/night sweats
___Recent severe emotional disturbances
___Swelling or redness in any joints
___Pregnant
___Stroke
___HIV
___Pain or heaviness in your chest
___Surgery
___Broken bones
___Cancer
___Feel downhearted or worthless
___Feel unsafe where you live
___Injured from a fall in the past year

ARE YOU CURRENTLY TAKING MEDICATION? ___Yes ___No
(if yes please list below or include an additional page)

_____
_____
_____
_____
_____

708 South Race Street Suite C, Port Angeles, WA 98362 Phone (360) 417-0703 Fax (360) 417-2007

Strait Occupational & Hand Therapy appreciates the opportunity to serve you. We pledge to provide you with the very best rehabilitation services.

LATE CANCELLATIONS AND NO SHOWS _____ **initial**

Cancellations or schedule changes must be made by 12:00 noon the day prior to your scheduled appointment or a charge of $50.00 will be assessed. Patients are responsible for paying this fee at the time of their next appointment. SOHT collects these fees based on Medicare/Medicaid guidelines, outlined in Pub 100-04 Medicare Claims Processing; Centers for Medicare & Medicaid Services; Transmittal 1279. If a patient fails to show for two (2) scheduled appointments or cancels an excessive number of times, occupational therapy will be discontinued and their physician will be notified.

TIMELINESS _____**initial**

We value your time and don't want to keep you waiting. Occasionally, we are delayed by an unexpected event with another patient, but please be assured that the quality of your treatment will not suffer. If you arrive late, your treatment will end at its scheduled time in order to not keep the next person waiting.

FINANCIAL POLICY _____**initial**

As a courtesy, we will bill the primary insurance company for our patients if we are provided with the necessary information. Secondary insurance plans will be billed upon request. Your insurance coverage is a contract between you and/or your employer, and the insurance company. Therefore, it is the **patient's responsibility** to determine occupational therapy benefits, authorizations, referrals, co-pays, etc. It is also the **patient's responsibility** to follow up with their insurance company on all unpaid visits. If it is necessary to set up a payment plan, please contact our office at 360-417-0703. Questions regarding billing should be directed to Marci Pohle at **(509) 443-4630**. Unpaid medical bills can adversely affect your credit score. Payment of **co-pay, co-insurance,** and **outstanding patient balances will be collected at time of check-in.** Please be prepared and have payment method ready. We accept cash, check, credit cards, and money orders. Balances 90 days or longer past due will be accessed 5% interest on the outstanding balance, and may be subject to collections.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS _____**initial**

I authorize Strait Occupational & Hand Therapy to release any necessary medical information such as diagnosis, test results, photographs, records, and/or reports requested by my insurance carrier, Primary Care Provider, or Referring Physician. We follow HIPAA guidelines for release of medical records.

PATIENT CONSENT

I hereby consent to treatment by the occupational therapist. I acknowledge that I have read and understand the financial policy and the cancel/no show policy stated above.

_____ _____

Patient's signature (If patient is a minor, Parent/Guardian signature) **Date**

Name _____ Date _____

Health and Activities of Daily Living

The following questions are about general physical activities you might do during a typical day. How able are you to accomplish these activities?

Activity	Easily	With Difficulty	Not at all
1. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	1	2	3
2. Moderate activities, such as moving a table, pushing a vacuum cleaner	1	2	3
3. Lifting or carrying groceries	1	2	3
4. Climbing several flights of stairs	1	2	3
5. Climbing one flight of stairs	1	2	3
6. Bending, kneeling, or stooping	1	2	3
7. Walking more that a mile	1	2	3
8. Walking several blocks	1	2	3
9. Walking one block	1	2	3
10. Bathing and dressing yourself	1	2	3
11. Sitting	1	2	3
12. Standing	1	2	3

Bathing

Do you need a cast protector?	Yes	No

Can you manage?	Easily	With Difficulty	Not at All
Clipping finger or toes nails			
Turning faucets on/off tub and sink			
Using razor			
Washing hands			
Washing feet			
Washing back			
Washing underarms			
Brushing teeth			
Shaving			
Combing or brushing hair			

Dressing, Can you manage?	Easily	With Difficulty	Not at All
Zippers			
Buttons			
Hook and Eye			
Belts and Buckles			
Snaps			
Bras			
Putting on and tying shoes			
Putting on socks			
Putting on splints/braces			

Food Preparation, Can you manage?	Easily	With Difficulty	Not at All
Opening jars, cans, bottles			
Peeling or slicing			
Opening packages			
Lifting pots and pans			

Eating, Can you manage?	Easily	With Difficulty	Not at All
Using a spoon or fork			
Drinking from a cup or glass			
Cutting food			
Household, Can you manage?	**Easily**	**With Difficulty**	**Not at All**
Laundry			
Vacuuming			
Washing dishes			
Reaching shelves at head level			

Other, Can you manage?	Easily	With Difficulty	Not at All
Using scissors			
Managing medicine bottles			
Opening doors with knobs			
Handling coins			
Holding a book			
Writing			
Using a telephone			

Office Use Only	(# X 4.2)	(# X 2.08)	(# X 0)	Total

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January 1, 2019

Dear Patients,

As of January 1, 2019, Medicare reintroduced a limit on the amount of coverage available for beneficiaries receiving outpatient therapy services. Two distinct caps were placed on therapy services: one for Physical Therapy and Speech-Language Pathology combined, and the other for Occupational Therapy (OT).

What does this mean to you? Medicare will pay its share for therapy services until the total amounts paid by both you and Medicare reaches either one of the therapy cap limits. Amounts paid by you may include costs like the deductible (Medicare Part B is $185) and coinsurance. If you have already met your deductible (what you must pay before your secondary will pay) then Medicare will pay 80% up to $2040. Medicare beneficiaries are responsible for 20% of their fees for services. If you have a secondary insurance you may be billed coinsurance (the amount you may be required to pay as your share of the cost for services after you pay any deductible usually around 20 percent).

What if a Medicare beneficiary exceeds the therapy cap? If you exceed the therapy cap of $2040, you may be responsible to pay for the services out of pocket if therapy is not deemed "reasonable and necessary". If you have secondary coverage, you may also ask us to bill them. It is your responsibility to verify coverage of services and inform our office of your wishes.

Can I apply for an exception? Yes, if you meet the exceptions process called "thresholds". The threshold limits for 2019 is $3700 for OT. If you are post-surgical or facing surgery, you may want to consider secondary insurance to cover this 'gap.' As long as OT is medically necessary, we will bill Medicare Part B.

For additional information regarding this process, talk to our office, your therapist, or call Medicare directly at 1-800-MEDICARE or visit Medicare.gov/contacts.

Thank you for understanding Medicare's implementation of reimbursement policies in your rehabilitation process. We look forward to working with you in your healing process.

Warm regards,

Lynda G. Williamson, OTR/L, CHT, CEAS, PBP

I have received the above statement regarding the Medicare Therapy Cap. I am aware that services may not be rendered beyond the therapy cap limit if I do not qualify for the automatic exception process.

Should you choose to pay out of pocket for Occupational Therapy services, please sign option 1 of the ABN on reverse side of this notice.

Patient signature Date

A. Notifier:

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

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____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.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost

WHAT YOU NEED TO DO

- Read this notice, so your care.
- Ask us any questior g.
- Choose an option b _____listed above.

Note: If you choose y other insurance that you migl do this.

Don't worry about this side :)

G. OPTIONS: Check o for you.
☐ **OPTION 1.** I want the I sk to be paid now, but I also want Medicare billed s sent to me on a Medicare Summary Notice (MSN). I am responsible for payment, but **I can appea** n the MSN. If Medicare does pay, you will refund or deductibles. ☐ **OPTION 2.** I want the t bill Medicare. You may ask to be paid now as I am responsible for payment. **al if Medicare is not billed.** ☐ **OPTION 3.** I don't want the **D.**_____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.

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Acknowledgement of Receipt of Privacy Practices

Strait Occupational & Hand Therapy
Office Manager (360) 417-0703

We must make a good faith effort to obtain a written acknowledgement that we gave you a copy of our Notice of Privacy Practices no than the date of the first service delivery. If we are unable to obtain your acknowledgement we must document why.

If there is an emergency, providing our Notice of Privacy Practices may be delayed until reasonably practicable after the emergency situation is resolved.

I hereby acknowledge that I have received a copy of this medical practice's Notice of Privacy Practices.

Yes No (circle one) I would like to receive a copy of any amended Notices of Privacy Practices.

by email at _____

Signed: _____ Date _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate:
Relationship:
- Parent of Guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: _____

For Office Use Only:

Signed form received by _____ Date_____

Acknowledgement refused:

Efforts to obtain: _____

_____

Reason for refusal (circle one): Patient refused. Patient did not follow instructions Didn't mail back form
Incapacity (circle one): Medical Literacy Emergency Other _____

C:\Documents and Settings\Any User\Front Office\NewPatientForms\Receipt of Privacy Practices.doc