SMART Therapy
SPORTS MEDICINE & REHABILITATIVE THERAPY

Medical History

Name: _____ Date: _____

Medical History:

General Health (Circle One): Excellent Good Fair Poor

Have you had any **medical problems** or hospitalizing in the past year (circle): **YES** **NO**
If yes, please specify:

_____

_____

_____

_____

Surgical History:

Date:	**Procedure:**

Are you currently receiving Home Health Care or Hospice: YES NO
If so, please provide the name and address of company:

_____

Prescription Medications (Including over the counter medications):

_____

_____

_____

_____

Past Injury/Problem History

Date:	**Injury/Problem:**	**Treatment:**

Present Injuries/Complaints

Date of Injury:	Body Part:	Symptoms at the time of onset:

Present/Past Medical Conditions (Circle applicable):

Asthma	Y	N	Heart Attack	Y	N
Arthritis	Y	N	Heart Disease	Y	N
Cancer	Y	N	Hernia	Y	N
Chemical Dependency	Y	N	High Blood Pressure	Y	N
Circulator Disease	Y	N	Kidney Disease	Y	N
Depression	Y	N	Metal/Implant	Y	N
Diabetes	Y	N	Multiple Sclerosis	Y	N
Dizziness	Y	N	Nervous Disorder	Y	N
Eating Disorder	Y	N	Numbness	Y	N
Emphysema	Y	N	Osteoporosis	Y	N
Epilepsy	Y	N	Pregnancy	Y	N
Fainting	Y	N	Stroke	Y	N
Headaches	Y	N	Thyroid Problems	Y	N
Hepatitis	Y	N	Tuberculosis	Y	N
Weakness	Y	N	Night Pain	Y	N
Dyspnea	Y	N	Seizure Disorder	Y	N

Other:

_____

_____

Please circle the word (s) that best describe your pain which brought you to therapy:

pain sharp dull aching throbbing burning stinging piercing

I have filled out the above questionnaire to the best of my ability and give my consent to SMARTherapy for therapy treatment and to align a plan of care.

_____ _____

Patient or Guardian Signature **Date**

SMART Therapy
SPORTS MEDICINE & REHABILITATIVE THERAPY

5454 Wisconsin Avenue
Suite 1555
Chevy Chase, MD 20815
Phone: 301.951.8593
Fax: 301.951.8598

2021 K Street, NW
Suite 610
Washington, DC 20006
Phone: 202.540.5999
Fax: 202.540.5690

5215 Loughboro Road, NW
Suite 200
Washington, DC 20016
Phone: 202.787.5620
Fax: 202.787.5606

SMARTherapy Cancellation Policy

We understand that unforeseeable events may occur that require rescheduling of your appointment. At SMARTherapy we require at least a **24 business hour** notification if you are unable to keep your scheduled appointment. This courtesy will allow us to maximize available time with our therapists to accommodate our patients. We do realize that emergencies arise, however we must enforce this policy due to excessive no-shows. If you would like to request special consideration for a no-show or less than 24 hour cancellation, please contact the site supervisor at your therapy location.

Cancellation of appointments:

- **Failure to give a 24 hour** notice to cancel or reschedule an appointment for the ***first*** time will result in a **$25 fee**.
- **Subsequent cancellations** of less than 24 hour notice will result in a **$95 fee** for **each occurrence**.

No-show/late appointments:

- All patients who **fail to show** for a scheduled appointment (no-show) will be assessed a **$95 fee** for each occurrence.
- The therapist schedules are curbed so each patient may be seen at their requested time. If you are over 15 minutes late for your appointment, you may be asked to reschedule.

Patients with excessive no-shows may be asked to provide a credit card prior to booking future appointments.

As a courtesy to our SMARTherapy patients, we will attempt a reminder call 24-48 hours prior to the scheduled appointment. Please provide current contact information to our front desk staff.

Signature:_____ **Date**:_____

Int._____ Date: ____/____/____ - Service Rendered

Int._____ Date: ____/____/____ - Service Rendered

Int._____ Date: ____/____/____ - Service Rendered

Int._____ Date: ____/____/____ - Service Rendered

SMARTherapy Consent Waiver

Patient Name:_____ **Date of Birth**:_____

Present Injury/Complaint:_____ **Date of Injury**:_____

Rate your pain from 1-10 (10 being the worst): at worst _____ at best _____ right now _____

Consent to Treat

I give my consent to SMARTherapy for therapy treatment and to align a plan of care.

_____ _____

Signature Date

I acknowledge that I have been presented with a copy of the Notice of Privacy Practices for SMARTherapy.

_____ _____

Signature Date

Consent to Leave Phone Messages and Access to Medical Records

I understand that as part of my health care and treatment, SMARTherapy may need to reach me by phone.

☐ **I DO** authorize SMARTherapy to leave a message on my voice mail/answering machine(s) regarding communication of my health care/treatment such as appointment confirmation calls, clinical and/or billing needs, etc.. (check all that apply)

☐ Home Phone ☐ Cell Phone ☐ Work Phone Preferred Contact Number:_____

☐ **I DO NOT** authorize SMARTherapy to leave a message on my home, cell, or work phone regarding communication of my health care/treatment such as appointment confirmation calls, clinical and/or billing needs, etc.. **I understand that selecting this option may result in delayed communication of pertinent treatment information such as appointment confirmations, billing communications or clinical call backs. I understand that I will be responsible to make appointments to obtain this information.**

List below any person(s)/family member(s) whom you authorize access to your medical records and authorize us to leave a detailed message with regarding all aspects of your medical chart, health condition, medications, and financial history.

Name: _____ Contact Number:_____ Relationship:_____

Name: _____ Contact Number:_____ Relationship:_____

Patient or Legal Guardian Signature:_____

SMARTherapy **Today's Date: _____/_____/_____**

Patient Name:_____DOB:_____/_____/_____

Height: _____ft. **_____**in. **Weight: _____**lbs. **BMI: _____**

Smoking Status (circle): Current Smoker Never Smoker Former Smoker

LIST OF CURRENT MEDICATIONS: List all tablets, patches, drops, ointments, injections, etc. Include prescription, over-the-counter, herbal, vitamin, and diet supplement products. Also list any medicine you take only on occasion (Viagra, Albuterol, Nitroglycerin, etc.)

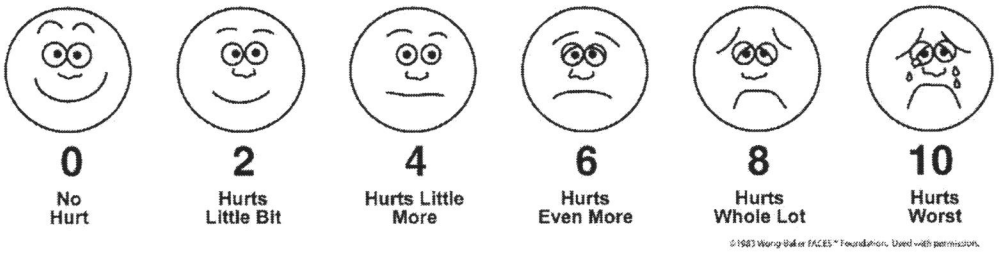
Medication	**Dose**	**Manner taken (oral, topical, injected, etc.) & Frequency**

- **In the past year, which of the following have you experienced: Please circle one**

No Falls **One Fall – No Injury** **Two or more Falls** **Fall with Injury**

- **How would you rate your pain today with 10 being the worst? Please circle one**

Wong-Baker FACES™ Pain Rating Scale



Signature: _____ **Date: _____**

A. Notifier: SMARTHERAPY– 5454 Wisconsin Ave., Suite 1555, Chevy Chase, MD 20815 (301-657-1996)

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

Advance Beneficiary Notice of Non-coverage (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
Codes listed but not limited to others not listed: 97001-97004 Evaluation and Re-evaluation 97750 Performance Muscle Test 97110 Theraputic Exercises 97112 Neuro-Re-Education and balance 97760Orthotic Management and training 97140 Manual Therapy 97530 Theraputic activities direct 97016 Vasopneumatic therapy 97012 Traction 97014/G0283 E-Stim No Show Appointments $25/$95 Canceled Appointments $25/$95	**Medicare allows $1980 for Physical and Speech Therapy combined for the calendar year.** **Medicare allows $1980 for Occupational Therapy for the calendar year.**	**No more than the Medicare allowable for each visit.**

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 below about whether to receive the **D.** _____ 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.** _____ 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.** _____ 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.** _____ 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:

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Medicare Assignment of Benefits

SMARTherapy does participate with Medicare Part B. By signing this waiver I certify and confirm the medical insurance information I have provided to SMARTherapy is correct. I authorize the release of any necessary information, including medical information for this or any related claim, to Medicare. This authorization will be used in place of an original authorization, if already on file, and may be revoked in writing by myself or the insurance company at any time.

Patient Name:_____

Signature:_____ **Date:**_____

Secondary to Medicare
Out-of-Network Insurance Waiver

I, _____, understand that I am choosing to seek treatment at SMARTherapy. SMARTherapy does participate with Medicare Part B, but is outside of my **secondary** insurance plan's network. Claims for my treatment will be submitted on my behalf to both Medicare and my secondary insurance. I understand that I may be billed for any deductible, co-insurance, and/or co-pay amounts not paid in full by my secondary insurance policy.

Signature:_____ **Date:**_____

Commercial Primary/Medicare Secondary
Out-of-Network Insurance Waiver

I, _____, understand that I am choosing to seek treatment at SMARTherapy. SMARTherapy does participate with Medicare Part B, but is outside of my **commercial** insurance plan's network. Claims for my treatment will be submitted on my behalf to both my commercial insurance and Medicare. I understand that I may be billed for any deductible, co-insurance, and/or co-pay amounts not paid in full by my insurance policies.

Signature:_____ **Date:**_____