ACHIEVEMENT kidS PEDIATRIC THERAPY PERFORMANCE PHYSICAL THERAPY

Patient Registration

Previous Patient ___Yes ___No

_____ _____ _____ _____ _____
Last Name First Name Age Male Female

_____ _____ _____ _____
Street Address City State Zip

_____ _____ _____ _____
Mailing Address (If different from above) City State Zip

(_____) _____ (_____)_____ _____
Home Phone Cellular Phone E-Mail Address

_____ (_____)_____ _____
Emergency Contact Person Phone If Minor, Parent/Legal Guardian Name

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____ ____Single ____Married

Referring Physician _____ Primary Care Physician _____

Primary Insurance Name and ID Number: _____

Secondary Insurance Name and ID Number: _____

Have you received therapy in the past year either through another facility or through home healthcare? ____Yes _____No
If yes, please explain: _____

For Achievement Rehabilitation Pediatric patients, if applicable:

Child was placed in your home for foster care at the age of ____ on ____/____/_____. Number of previous placements?_____

Formally adopted at the age of ___ on ____/____/____. Name(s) the child had prior to adoption: _____.

Informed Consent

By signing below, you are hereby granting Achievement Rehabilitation Through Therapeutic Intervention, Inc (ARTTI) staff to perform therapeutic services. It is your right to accept or refuse any treatment offered. I understand that this care may include an evaluation and continuing treatment, based on the Plan of Care set by your evaluating therapist.

I understand the purpose of physical/speech/occupational therapy is to maximize my health potential through natural means and promote my ability to perform work, leisure/play and sports activities through increased strength, flexibility, agility, language, sensory-motor and movement strategies. It is not possible to predict the results or the outcome of treatment(s). Sometimes benefits are realized immediately and sometimes more gradual over time.

It is up to the patient/guardian/caregiver to inform the therapist/staff about any health problems or allergies the patient may have. Patient/guardian/caregiver must also tell the therapist/staff about any medications being taken as well as any medical conditions and/or surgeries. I understand that by signing this form, records of a confidential nature will only be released to the entities providing financial assistance or regarding authorization for my health care.

If the patient is a minor (under the age of 18), the parent or legal guardian is responsible for all charges and decisions made by the minor. We do not assume any liability for the minor while on premises or not, and it is the responsibility of the parent or guardian to supervise the minor before, during and after treatments.

If the patient is a minor, I hereby authorize Achievement Rehabilitation Through Therapeutic Intervention, Inc (ARTTI) staff to secure medical treatment necessary for my child's welfare.

In addition, I give ARTTI permission to screen for other therapies, such as Behavioral, Occupational, Speech or Physical therapy.

_____ _____ _____
Patient's Signature Legal Guardian's Signature Date

Patient Summary Form

Please complete ths form to the best of your ability. Completion will assist us in delivering the best services possible and will assist us in gaining authorization from your insurance company.

Patient Information

Patient name: Last | First | MI — ◉ Female ○ Male — Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form): Achievement Rehabilitaton Through Therapeutic Intervention
2. Federal tax ID(TIN) of entity in box #1: 270991521

3. Name and credentials of the individual performing the service(s): 1 MD/DO | 2 DC | 3 PT | 4 OT | 5 Both PT and OT | 6 Home Care | 7 ATC | 8 MT | 9 Other ____

4. Alternate name (if any) of entity in box #1
5. NPI of entity in box #1: 1275869513
6. 352-419-6570

7. Address of the billing provider or facility indicated in box #1
8. City
9. State: FL

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

1. Traumatic
2. Unspecified
3. Repetitive
4. Post-surgical →
5. Work related
6. Motor vehicle

Date of Surgery

Type of Surgery

1. ACL Reconstruction
2. Rotator Cuff/Labral Repair
3. Tendon Repair
4. Spinal Fusion
5. Joint Replacement
6. Other _____

Diagnosis (ICD codes)
Please ensure all digits are entered accurately

1°
2°
3°
4°

Patient Type

1. New to your office
2. Est'd, new injury
3. Est'd, new episode
4. Est'd, continuing care

Nature of Condition

1. Initial onset (within last 3 months)
2. Recurrent (multiple episodes of < 3 months)
3. Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942 ○ 98941 ○ 98943

Current Functional Measure Score

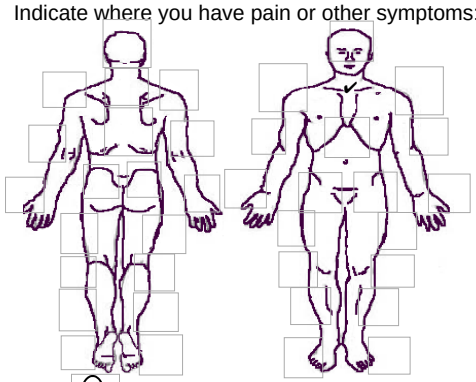
Neck Index | DASH | (other FOM)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain/symptom intensity:

Last 24 hours: Scale of 1 (minimal) to 10, with 10 being the worst:

Past week: Scale of 1 (minimal) to 10, with 10 being the worst:

4. How often do you experience your symptoms?

1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

6. How is your condition changing, since care began at *this* facility?

0 **N/A — This is the initial visit** 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

7. In general, would you say your overall health right now is...

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Patient Signature: X _____ **Date:** _____

ACHIEVEMENT kidS PEDIATRIC THERAPY PERFORMANCE PHYSICAL THERAPY

Informed Company Policies for a Successful Relationship

To Our Patients, Regarding Cancellations and No Call/No Shows:

The following are our policies regarding cancellations and no call/no shows. We take your treatment very seriously, as it can make a difference between whether or not you succeed in your treatment. Your referring physician or therapist prescribed a frequency of treatment and maintaining your scheduled visits is your highest priority.

We REQUIRE a minimum of 24 hours notice, in the event of a cancellation. It is your responsibility, when you call, to call during regular business hours and have an alternate time in mind that will ensure you attend the entire number of prescribed treatments each week.

For medicaid, workers' compensation and personal injury patients, documentation of any missed appointments will be communicated to your insurance, case manager and/or referring/primary care physician. This can jeopardize your claims and/or ability to get future authorizations for therapeutic services.

In an instance of a cancellation without 24 hours notice or no-call / no-show to a scheduled appointment, we charge a $50 cancellation fee, which must be paid prior to attending future appointments.

Patients who have multiple same-day cancellations or no-shows will be removed from the active schedule and placed on our day-to-day list to avoid future last minute cancellations that keep other patients from care.

When you do not attend as scheduled, three people are hurt by your action:

1. *You* did not receive your treatment as prescribed.
2. *The Therapist*, who has scheduled the time for you and your treatment.
3. *Another patient* who could have been scheduled if proper notice was given.

Late Policy (Fifteen Minutes)

We need you to call as soon as you know you are running late. We will begin your scheduled appointments on time. Being late by more than 15 minutes will require you to either reschedule or wait for the next available appointment. There are no guarantees since openings due to cancellations are unpredictable. We do not allow appointment overlap as this undeservedly compromises the care of another patient.

Other Important Information:

1. **Cell phones must be turned off, or on silent while in our buildings.**
2. Children requiring supervision are NOT allowed to attend sessions with you.
3. Unless you are walking to/from the restroom, you are not allowed in the gym area unless escorted by a member of the ARTTI staff. Please remain in the reception area until a member of our staff is able to escort you.

You will review a more detailed copy of this policy with our Patient Care Coordinator and will receive a copy. This policy is also posted at all reception desks..

_____	_____	_____
Patient's Signature	Legal Guardian's Signature	Date

We look forward to working with you! Your cooperation with our policies is greatly appreciated and will benefit us all.

Achievement Rehabilitation Through Therapeutic Intervention Health Information Privacy Protection Act

WE ARE COMMITTED TO YOUR PRIVACY - Our practice is dedicated to maintaining the privacy of your individual and identifiable information. During the course of your business with us, it will be necessary for us to share aspects of your care and health insurance with specific parties. Federal law prohibits us from doing this without your consent. We are required by law to maintain the confidentiality (of health insurance information that identifies you) from parties other than yourself and your insurance company. We are also required by law to inform you of the parties who may have access to your medical information. This process may include the collection of such information as: your full legal name, home / mailing address, date of birth, social security number, insurance identification numbers, treatment for other related and previous conditions, etc. Please trust that this information will be treated in the safest of manners and will not be shared or disclosed unless as otherwise noted below. This information is never shared with any party outside our facility without your written consent except as noted below and will only be accessed by our staff in order to facilitate your care and or payment for our services.

WE WILL COLLECT INFORMATION FOR MANY PURPOSES - Each time you visit our practice, a record will be maintained of specific information regarding the particulars of that session. This information may include (but is not limited to): medical record maintenance, treatment that was provided, subjective information you provided us regarding your state of being and the state of the condition, assessment information related to the progression of your condition, billing information, communication with insurance companies etc. When communication is made with your insurance company we will maintain a record of these communications either in your medical record or billing record.

HOW MAY WE USE AND DISCLOSE YOUR HEALTH INFORMATION

FOR TREATMENT - We will collect subjective and objective data about you that will be used for your treatment. As part of your care, we may disclose information about your treatment to your referring provider, your insurance company, or anyone else who is directly connected with the treatment of this condition. This information may be provided in verbal and / or written format. It will only be provided in the event that these parties can identify you with three specific criteria.

FOR PAYMENT - We may disclose information about your treatment and services to bill and collect from you, your insurance company or a third party payer related to your insurance company (i.e.: payment management company or a Health Savings Reimbursement Account) or your attorney. This may involve our disclosing information about past and expected future services that have been or will be provided by our facility for this current condition.

FOR HEALTH CARE OPERATIONS AND PERFORMANCE IMPROVEMENT - We may use information in your record to help us improve your care as well as the care of other individuals with similar conditions. This may also include the training of new staff within our facility. In this case, no specific information regarding your identity will be utilized.

INDIVIDUALS INVOLVED IN YOUR CARE - We may disclose information about you to friends and family members who are involved in your medical care or who help to pay for care. In these cases the information released is restricted to those individuals who provide proof of their ability to obtain said information.

I hereby give ARTTI staff permission to release my medical information to the following person/persons and understand this release will remain until the end of my treatment time with ARTTI, unless I specify otherwise. I understand a full version of this notice is available on our website, at https://achieve-rehab.com/.

Name	**Relationship to You**
_____	_____
_____	_____

_____	_____	_____
Patient's Signature	Legal Guardian's Signature	Date

Assignment of Benefits

I, _____ (policyholder name) hereby instruct and direct _____ (insurance company) to pay Achievement Rehabilitation Through Therapeutic Intervention. I assign Achievement Rehabilitation Through Therapeutic Intervention any and all rights, claims, benefits and causes of action for personal injury protection benefits and medical payment benefits available to me under the policy affording coverage to me for any and all treatment, services and medical claims resulting from this injury/illness. In the event that I do not have insurance coverage, I understand I remain personally responsible for payment of services including all costs of collection, including attorney's fees and costs.

I authorize release of any medical or other information pertinent to my case to any insurance company, adjuster or attorney involved in this case for the purpose of processing claims and securing payment of benefits.

I understand that I am financially responsible for all charges whether or not they are paid by insurance and that I am responsible for knowing my benefits and insurance coverage.

I understand that verification of benefits is not a guarantee of payment and my financial responsibility is subject to change.

_____ _____ _____

Patient's Signature | Legal Guardian's Signature | Date

Copay/Deductible Collection Policy

Payment is due before services are rendered, unless your insurance requires a percentage copay of services rendered, in which case you must pay before leaving. *No exceptions*.

We are required by law to collect the copay / coinsurance set by your individual health insurance plan and/or determined by federal guidelines. At no point in time during the patient's course of treatment will the copay and/or deductible amount to be collected from the patient decrease, unless the patient provides us with documentation regarding the change to his/her individual health care plan. In the event that the patient's health insurance provider pays for the full amount of services or pays an amount that is in excess of the patient's copay and/or deductible amount during the patient's prescribed course of treatment, the patient will receive a refund subsequent to the following conditions being met. (1) Completion of the patient's prescribed course of treatment or (2) cessation of treatment services provided by the therapist to the patient and, (3) a formal audit of the patient's balance has been conducted.

Medicare Patients

If you do NOT have supplemental insurance, you will be responsible for the twenty percent (20%) co-insurance portion not paid by Medicare as well as any deductible amounts not yet met. It is your responsibility to keep track of therapy cost totals for the purpose of not exceeding the therapy cap (unless your diagnosis is exempt from the cap).

Medical Necessity

All treatments must be justified and medically necessary in order for us to treat and bill your insurance. Some of the factors that determine whether or not treatment is medically necessary are: 1) Does your condition interfere with the quality of your life? 2) Does your condition interfere with your ability to perform work or daily activities? 3) Are you motivated and able to participate in your treatment program and follow home and self-care instructions? 4) Is there potential for your condition to improve and/or resolve? If not, is there potential for your function or ability to perform daily activities to improve through modified movement, assistive devices, etc? 5) Are there specific goals set that are measurable? If the above criteria are not met, you are welcome to participate in our elective services such as group fitness/exercise training, one on one training performed by a therapist or assistant. These services are payable out-of-pocket by cash, check or credit card.

_____ _____ _____

Patient's Signature | Legal Guardian's Signature | Date