



KORT New Patient Information

Patient Name: _____ E-Mail Address: _____ Age: _____ Sex: _____

Social Security Number: _____ - _____ - _____ Date of Birth: ____/____/____ Marital Status: _____ Phone: _____

Address: _____ City/State/Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____ Work Phone Number: _____

Spouse (or parent, if minor): _____ Social Security Number: _____ - _____ - _____

Spouse or Parent Employer: _____ Address: _____

Contact Person Outside Home: _____ Phone No.: _____

Referring Physician: _____ Primary Care Physician: _____

Onset Date (injury, accident, surgery date or recent date symptoms started): : ____/____/____
(For workers compensation or auto accident we must have the date of injury.)

Billing Information *(Please present insurance card)*

Workers Comp Auto Accident Medicare Anthem Humana Aetna Group Health Other: _____

If you want us to bill under workers comp or for an auto accident, we will do so but we ask that you present us with your personal health insurance information as back up.

Primary Insurance: _____ Address: _____ City/State/Zip: _____

Phone No: _____ Subscriber No. or Claim No: _____ Subscriber's Date of Birth: _____

Precertification or Referral No: _____ Adjuster/Case Manager: _____

Secondary Insurance: _____ Address: _____ Phone: _____

Subscriber No. or Claim No.: _____ Adjuster/Case Manager: _____

CONSENT TO TREATMENT

- 1 I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of services and fully understand that I am financially responsible for any services not covered by this authorization.
- 2 I have presented myself to this facility for treatments and consent to diagnostic procedures and care provided by my attending therapist.
- 3 I realize I have the right to refuse any drugs, treatments, and procedures to the extent permitted by law. I acknowledge that medicine is not an exact science, no guarantees or warranties can be made to me regarding the results of any treatments at this facility. I understand that information from any medical record(s) kept by this facility may be used for educational administrative, and/or facility approved purposes when my personal identity will not be revealed.
- 4 ****NOTE TO WORKERS COMP**** I hereby authorize my rehab consultant to receive my records related to my work injury. This information may be faxed or mailed.
- 5 I understand if I do not attend therapy for two weeks or miss three consecutive appointments that I am subject to discharge. Once I have been discharged, I understand that I will need a new physician's order/referral for any further treatment and will be receiving a new evaluation. This is in compliance with State Law.

I HAVE READ AND FULLY UNDERSTAND THE ABOVE GENERAL CONSENT FORM AND ANY QUESTIONS I MAY HAVE HAD, HAVE BEEN ANSWERED TO MY SATISFACTION.

_____ DATE: _____

SIGNATURE OF PATIENT (if the patient is a minor - under 18 yrs of age - parent must sign)

_____ DATE: _____

SIGNATURE OF WITNESS



BILLING DISCLOSURES TO INDIVIDUALS INVOLVED IN PATIENT'S CARE

There may be times when it is necessary for an individual directly involved in your care to call the facility to inquire about your personal health information or billing information. Please take a few moments to complete this form.

I authorize KORT to disclose my health information that is directly related to my current treatment at KORT to the individual(s) listed below for purposes of their role in my treatment or payment for the health services that I have received.

Such persons involved in your care may include spouses, children, blood relatives, roommates, boyfriends or girlfriends, domestic partners, neighbors and colleagues.

NAME	RELATIONSHIP

I do not wish to have my health information disclosed to the individuals below even though involved in my care.

NAME	RELATIONSHIP

Signature of Patient (or Patient's Representative)

Date:

Signature of Witness

Date:

If you are the representative of a patient, check the scope of your authority to act on the patient's behalf:

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Power of Attorney | <input type="checkbox"/> Guardian | <input type="checkbox"/> Surrogate Decision-Maker |
| <input type="checkbox"/> Executor of Legal Rep. | <input type="checkbox"/> Parent | <input type="checkbox"/> Other (please specify) _____ |

Provide documentation or explanation of your authority to act for the patient



Medical Screening Form

Name: _____ Date: _____

Please circle YES or NO

Do You Have A History Of:	SELF	FAMILY
Diabetes?	Yes...No	Yes...No
High Blood Pressure?	Yes...No	Yes...No
Heart Attack?	Yes...No	Yes...No
Heart Disease?	Yes...No	Yes...No
High Blood Cholesterol?	Yes...No	Yes...No
Smoking?	Yes...No	Yes...No
Chest Pain?	Yes...No	Yes...No
Dizziness/Fainting?	Yes...No	
Shortness of Breath?	Yes...No	
Ankle Swelling?	Yes...No	
Night Coughing?	Yes...No	
Stroke?	Yes...No	Yes...No
Cancer?	Yes...No	Yes...No
Osteoporosis?	Yes...No	Yes...No
Osteoarthritis?	Yes...No	Yes...No
Rheumatoid Arthritis?	Yes...No	Yes...No
Rheumatic Disease?	Yes...No	Yes...No
Alcohol Use?	Yes...No	
↳ Current number drinks/week?	_____	
Allergies?	Yes...No	
↳ Type?	_____	
Asthma?	Yes...No	
↳ Always have inhaler with you?	Yes...No	
Childhood Diseases?	Yes...No	
Falling?	Yes...No	
↳ Number of times in last year?	_____	
Headaches?	Yes...No	
Kidney Disease?	Yes...No	
Lung Disease?	Yes...No	
STDs?	Yes...No	
Seizures?	Yes...No	
Pacemaker/Defibrillator?	Yes...No	
Assistive Device (e.g. cane)?	Yes...No	

In the Past 3 Months, Have You Experienced:

Unexplained change in your health?	Yes...No
↳ If yes, please describe:	_____
Explained illness or injury?	Yes...No
↳ If yes, please describe:	_____
Unexplained weight change?	Yes...No
Night sweats?	Yes...No
Numbness or tingling?	Yes...No
Changes in bowel/bladder?	Yes...No

In the past month, have you frequently been bothered by feeling down, depressed or hopeless? Yes ... No

In the past month, have you frequently been bothered by having little interest in things or have you lost pleasure in doing things? Yes ... No

Do you have a problem with ... (check all that apply)

- Hearing Speech
 Vision Communication

Do you regularly exercise? Yes ... No

Number of days per week? _____

Number of minutes per session? _____

What is your body weight? _____ height? _____

Please list any medicine allergies you may have:

Please list or provide a copy of the medications you are currently taking: (Dosages not necessary)

Please list any major surgeries in your past:

Other:

Women:

Are you or could you be pregnant? Yes ... No

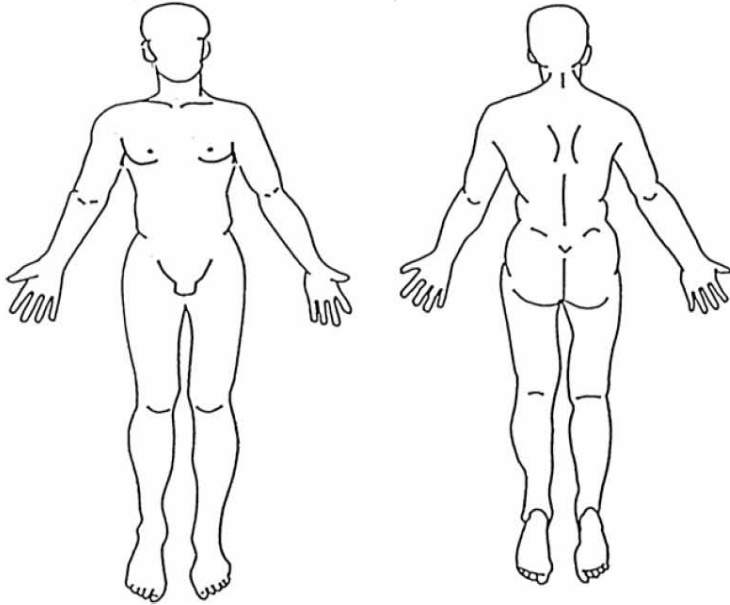
Patient/Representative Signature: _____ Therapist Signature: _____

Name: _____ Date: _____

Please use the diagram below to indicate where you feel symptoms right now.

Use the key below to indicate the different types of symptoms:

KEY: Pins & Needles = 0000000 Stabbing = ///////////////
Burning = XXXXXXX Deep Ache = ZZZZZZZ



Please mark your **current** level of pain on the following line:

0 1 2 3 4 5 6 7 8 9 10
(0 = No Pain → 10 = Worst Pain Imaginable)

Please mark your **worst** level of pain in the past 24 hours on the following line:

0 1 2 3 4 5 6 7 8 9 10
(0 = No Pain → 10 = Worst Pain Imaginable)

What makes your pain worse? _____

What makes your pain better? _____

Are your symptoms: (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine Moderate Difficulty Only with Medication

Do you have pain at night? Yes...No

When (date) did your problem begin? _____

Patient Specific Functional Scale

Please list three (3) activities that you are having difficulty performing. Please rate your ability on the line next to each activity.

(0 = Can Perform Normally → 10 = Unable to perform)

1. _____ | _____

2. _____ | _____

3. _____ | _____

Other Information:

Patient or Representative Signature: _____ Date: _____

Reviewer Signature/Initials: _____ Date: _____



Medicare Secondary Payor (MSP) Questionnaire – Page 1

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Office Use Only

Patient Name: _____

Clinic Name: _____

Medicare Number: _____

Patient Acct#: _____

(exactly as appears – Red-White-Blue Government Medicare Card)

Database: _____

1. Have you received Home Health Care of any kind in the past 60 days or currently are residing in a Skilled Nursing Facility? Yes No

Agency Name/Facility Name: _____

Phone: _____

If in a Skilled Nursing Facility: **Are you on/in the “Medicare Unit”?**..... Yes No

2. Are you entitled to benefits under the Black Lung Program, Dept. of Veteran Affairs or other government program? Yes No

If yes, Program Name: _____ Phone: _____

Address, City, State, ZIP: _____

NOTE: The government program listed in question #2 will be primary to Medicare.

3. Was this injury/illness due to any of the following?

Work-related? **If yes,** date of accident/injury: _____ / _____ / _____ **Yes No**

Auto accident? **If yes,** date of accident: _____ / _____ / _____ **Yes No**

Accident on Property? (other than your own)(Example: store, restaurant, etc.) **Yes No**

If yes, date of accident: _____ / _____ / _____

If yes, please give details of the accident:

If yes, please provide the following information about the **liability insurance:** Insurance

Name: _____ Phone: _____

Address, City, State, ZIP: _____

Contact Person/Adjustor's Name: _____

Claim Number: _____ **(required)**

NOTE: Medicare regulations require us to file with the above liability insurance first, even if they will not pay directly or immediately. We must comply with this regulation before filing with Medicare. Your understanding and cooperation is appreciated.

4. Do you feel you have a right to be compensated by a party who may have caused the injury or illness? Yes No

If yes, do you intend to file a liability claim or lawsuit in connection with this injury or illness? **Yes No**

If yes, Attorney's Name: _____

Law Firm Name: _____

Address: _____

Phone number: _____



Medicare Secondary Payor (MSP) Questionnaire – Page 2

IMPORTANT NOTICE TO PATIENT: Please fill out this form in its entirety. Failure to do so may result in a delay in obtaining your Medicare benefits.

Patient Name:

Medicare Number:

(exactly as displayed on Red-White-Blue Government Medicare Card)

Clinic Name:

Patient Acct#:

Database:

5. Have you received a kidney transplant or are currently receiving dialysis for End Stage Renal Disease (ESRD)? Yes No

If **yes**, please provide the date of the transplant or start of dialysis: ____/____/____

If the date is less than 30 months ago:

Are you currently covered under group insurance provided by your or a family member's employer?Yes No

If **yes** – the group insurance will be primary If **no** – Medicare will be primary

6. Are you currently employed?..... Yes No

If yes, Does your employer employ more than 20 employees?Yes No

If no, Date of retirement:____/____/____ or check Not employed

Is your spouse currently employed?..... Yes No

If yes, Does his/her employer employ more than 20 employees?..... Yes No

If no, Date of retirement:____/____/____ or check Not employed

(NOTE: If both are not currently employed, then Medicare is primary.)

7. If you've answered No to questions 1 – 6 AND your Medicare coverage is due to age or disability:

Do you have a group insurance plan through another family member's current employer?

..... Yes No

If **yes** – the group insurance will be primary If **no** – Medicare will be primary

Do you have any benefits through TriCare (formerly Champus)? Yes No

8. If you answered YES to questions 6 or 7, please complete the following group insurance information for the proper billing of your account:

Insurance Co. Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____

Employer Name: _____

Insured's Name: _____

Policy Identification #: _____

(Sometimes referred to as the health insurance benefit package number)

Group Identification #: _____

Patient Signature

Date

Appointed Representative Signature

Relationship



Date of Evaluation: _____

Medicare Financial Limitation Notification Form

Effective January 1, 2012, the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling \$1,880.00 for Medicare Part B outpatient services for Physical, Occupation and Speech therapy services.

The purpose of this notice is to help you make an informed choice about whether or not you wish to continue to receive outpatient physical, occupational or speech therapy after the Medicare Financial limitation has been met, knowing you will be financially responsible for these services.

CMS's financial limitation (Cap) will be applied in the following manner for your outpatient rehabilitation services:

- **Physical and Speech Therapy will share one \$1,880.00 financial limitation (Cap) for both therapies combined.**
- **Occupational Therapy services will have a separate \$1,880.00 financial limitation.**
- **These financial limitations will be effective until December 31, 2012 unless otherwise changed or suspended by CMS.**

Medicare will subtract your co-insurance from the \$1,880.00 cap and pay \$1,504.00 or 80%. The 20% co-insurance, or \$376.00, will be paid by you or a supplemental insurance you may have. These limits are based off the Medicare fee schedule allowed amount after your \$140.00 deductible has been met. The cap will be based on services paid by Medicare at the allowable rate, not the provider's charges.

As Medicare providers, we are obligated to inform you of this financial limitation and Medicare's determination that once the \$1,880.00 financial limitation for Physical, Occupational and/or Speech therapy benefit is met as described above, you will be financially responsible for any services provided, unless you qualify for a Cap exception as outlined below. As a courtesy, we will track the services you receive from us and notify you when the amount is close to meeting Medicare's \$1,880.00 financial limit. This will allow you to make an informed consumer decision regarding whether or not you want to continue therapy services and accept financial responsibility for the cost of any appropriate medically necessary continued care provided. Medically necessary therapy services you receive beyond the cap may be continued at a Hospital Outpatient Rehabilitation department and billed to Medicare, as this type of facility is exempt from the financial limitation imposed by Medicare.

The \$1,880.00 financial limitation is your annual Medicare insurance benefit, regardless of which non-hospital based therapy providers deliver the service. If you received physical, occupational or speech therapy prior to attending therapy at our center, please be aware that those services will be included in your financial limitation total. **Please assist us in ensuring you stay within the cap limits by informing our Patient Service Specialist of any physical, occupational or speech therapy services you have received between January 1, 2012 and today.** We will be sure to include any self-reported amount in your beginning balance and notify you when you have reached the cap at our facility so you may make an informed decision about continuing care that is medically necessary beyond the financial limitation.

Medicare Therapy Cap Exceptions

Congress has made provisions for exceptions to the Medicare Cap for which you may qualify when therapy services beyond the financial limitation (cap) are medically necessary. Your therapist will discuss your status with you as you near the cap. If you have already exceeded your financial limit (cap) for the 2012 calendar year, your therapist will discuss your ability to qualify for further treatment under an exception after your evaluation or re-evaluation. If you do not qualify for an exception, you will be financially responsible for continued care beyond the limitation. Ask our staff what the estimated cost of items and services will be in the event that you do not qualify for an exception.

Patient Signature

Date

This notice was adapted from CMS's "Notice of Exclusion from Medicare Benefits" form and is not an all-inclusive list of excluded Medicare benefits. This notice pertains to Medicare's financial limitation and excluded benefits beyond \$1,880.00.

KORT'S NOTICE OF PRIVACY PRACTICES Effective April 14, 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices apply Select Medical Corporation and each of its subsidiaries, affiliates, and entities managed or controlled by Select Medical, including the corporate office and its employees. All of the entities will share personal health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to personal health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make a new Notice effective for all personal health information maintained by Select Medical Corporation. We are also required to inform you that there may be a provision of State law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act. A copy of any revised Notice of Privacy Practices or information pertaining to a specific State law may be obtained by mailing a request to the Privacy Officer, Select Medical Corporation, 4716 Old Gettysburg Road, Mechanicsburg, PA 17055.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Authorization and Consent: Except as outlined below, we will not use or disclose your personal health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Uses and Disclosures for Treatment: With your agreement, we will make uses and disclosures of your personal health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history etc.

Uses and Disclosures for Payment: With your agreement, we will make uses and disclosures of your personal health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations: With your agreement, we will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which may include clinical improvement, professional peer review, business management, accreditation and licensing, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and patient care.

Individuals Involved In Your Care: With your written agreement we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with involved individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates: Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, outcomes data collection, legal services, etc. At times it may be necessary for us to provide your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Appointments and Services: We may contact you to provide appointment reminders or information about your treatment or other health-related benefits and services that may be of interest to you. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You also have the right to request that we not send you any future marketing materials and we will use our best efforts to honor such request. You may make your requests by sending your name and address to Privacy Officer, P.O. Box 2034, Mechanicsburg, PA 17055.

Research: In limited circumstances, we may use and disclose your personal health information for research purposes. In all cases where your specific authorization is not obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional review board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

Other Uses and Disclosures:

We are permitted and/or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization for the following:

- any purpose required by law.
- public health activities, such as required reporting of disease, injury, birth and death, or required public health investigations.
- if we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect, or domestic violence.
- to the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls.
- to your employer when we have provided health care to you at the request of your employer;
- to a government oversight agency conducting audits, investigations, or civil or criminal proceedings.
- court or administrative ordered subpoena or discovery request;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- if you are a member of the military; we may also release your personal health information for national security or intelligence activities; and
- to workers' compensation agencies for workers' compensation benefit determination.

RIGHTS THAT YOU HAVE REGARDING YOUR PERSONAL HEALTH INFORMATION:

Access to Your Personal Health Information

You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your legal representative. You may obtain a "Patient Access to Health Information Form" from the front office person.

Amendments to Your Personal Health Information

You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, must be in writing, signed by you or your legal representative, and must state the reasons for the amendment/correction request. If an amendment or correction request is made, we may notify others who work with us if we believe that such notification is necessary. You may obtain an "Amendment Request Form" from the front office person or individual responsible for medical records.

Accounting for Disclosures of Your Personal Health Information

You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your legal representative. "Accounting Request Forms" are available from the front office person or individual responsible for medical records. The first accounting in any 12-month period is free; you will be charged a fee for each subsequent accounting you request within the same 12-month period. You will be notified of the fee at the time of your request.

Restrictions on Use and Disclosure of Your Personal Health Information: You have the right to request restrictions on uses and disclosures of your personal health information for treatment, payment, or health care operations. We are not required to agree to your restriction request, but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction by sending such termination notice to the individual responsible for medical records.

Complaints: If you believe your privacy rights have been violated, you can file a complaint in writing with the Privacy Officer, Select Medical Corporation, P.O. Box 2034, Mechanicsburg, PA 17055. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

FOR FURTHER INFORMATION: If you have questions or need further assistance regarding this Notice, you may contact the Privacy Officer, Select Medical Corporation, P.O. Box 2034, Mechanicsburg, PA 17055.

Patient Signature

Date

Witness Signature

Date