MOBILE THERAPY SPECIALISTS

Patient Registration

shaded areas for office use only

___ New Patient ___ New Diagnosis ___ New Insurance					Patient #
Are you currently receiving healthcare service through a Home Health Agency (HHA)? ___ Yes ___ No **If YES, please call us now to discuss your treatment options – *MTS 949.529.1567***					
Patient Name (Last, First, Middle Initial)					Date
Address		City/State/Zip			
Cell Phone ( )		Work Phone ( )		Home Phone ( )	
Social Security #	DOB	Driver's License #	Gender ___M ___F	Email	
Occupation		Employer		Employer Phone #	
Address		City/State/Zip			
Emergency Contact (Name)		Home Phone ( )		Work Phone ( )	
Address		City/State/Zip		Relationship to Patient	
Referring Physician	Referring NPI#		Referring Physician Phone#		Treating Therapist
Diagnosis:			**ICD-10 Code:**		

Financially Responsible Party (if other than patient)

Name (First, Middle Initial, Last)			Relationship to Patient
Address			City/State/Zip
Home Phone ( )	Work Phone ( )		Email Address
Social Security #	DOB	Gender ___M ___F	Driver's License #

I have completed the above information to the best of my knowledge. I understand that by signing below, I am openly providing this information to Mobile Therapy Specialists Inc. for new patient registration.

Patient Signature:	Date:

MOBILE THERAPY SPECIALISTS

Insurance Information

Primary Insurance In- network ▭ Out-of-network ▭				Pre-Certification ▭Yes ▭No	Visits per Year
Claims Mailing Address	City, State, Zip Code				
Subscriber Name	Date of Birth	Sex ▭M ▭F	Relationship to Patient		
ID Card # (including alpha prefix)	Group #	Authorization #			
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty $	Visits Remaining
Deductible Start Amount $	Deductible Remaining Amount $	Pre-Certification Phone # ( )			
Benefits Verified By	Date	Spoke to	Ins. Customer Service Phone # ( )		

Secondary Insurance In- network ▭ Out-of-network ▭				Pre-Certification ▭Yes ▭No	Visits per Year
Claims Mailing Address	City, State, Zip Code				
Subscriber Name	Date of Birth	Sex ▭M ▭F	Relationship to Patient		
ID Card # (including alpha prefix)	Group #	Authorization #			
Claim #	Effective Date	Coverage%	Co-Ins%	Co-Pay by Specialty $	Visits Remaining
Deductible Start Amount $	Deductible Remaining Amount $	Pre-Certification Phone # ( )			
Benefits Verified By	Date	Spoke to	Ins. Customer Service Phone # ( )		

The above description is a quote of your insurance(s) benefits. It is our experience insurance carriers do occasionally make errors. MTS assumes no liability for any errors and the patient is responsible to clarify any discrepancies in the above information and inform us immediately. We have reviewed these benefits with you and you understand and agree to pay any balance remaining after your insurance carrier(s) has paid its portion of the charges.

Patient Initials	Date

ASSIGNMENT OF INSURANCE BENEFITS

1. The undersigned agrees, whether signing as agent or patient, and it hereby individually obligated to pay for services rendered to the patient in accordance with the regular rates and terms of the company, which are not reimbursed by third parties. The undersigned further agrees to bear legal fees and collection expenses, which may be incurred by the company, in collection of payment on the amount, if that amount becomes delinquent.
2. The undersigned hereby authorizes treatment by Mobile Therapy Specialists Inc. and assigns to Mobile Therapy Specialists Inc. any and all benefits arising out of any type of insurance, which insures the patient's bill. The undersigned understands that the temporary acceptance of verified insurance coverage in lieu of payment does not release the patient from ultimate payment responsibilities.
3. The undersigned hereby authorizes Mobile Therapy Specialists Inc. to release any or all information to third parties, including but not limited to employers and insurance companies, who may be liable to the patient or Mobile Therapy Specialists Inc. for payment of charges to the patient.

Patient Signature:	Date:

MTS MOBILE THERAPY SPECIALISTS

PATIENT MEDICAL HISTORY

Name: _____ Age: _____ Today's Date: _____

Occupation: _____ How did you hear about MTS?_____

Doctor's Name: _____ Height/Weight: _____ Have you fallen in the last year? YES / NO

Where is your pain/problem? (Body Part) _____Date of Injury/Surgery: _____

Please describe your injury history or onset of this condition: _____

_____

Is your condition accident related? Is litigation (lawsuit) involved? _____

Have you had any treatment for this condition? / Where? _____

If you are experiencing pain, please rate the worst pain you've experienced on the following scale:

(None) 0 1 2 3 4 5 6 7 8 9 10 (Severe)

Describe your pain: sharp / burning / aching/ tingling / numbness / other _____

Does pain radiate into arms and/or legs? YES / NO Does rest relieve your pain? YES / NO Does pain awaken you? YES / NO

What aggravates your pain most? sitting / standing / walking / other_____

What helps to reduce your pain? _____

Please list any medications you are currently taking:

Name:	**Frequency:**	**Dosage:**
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Are you currently experiencing or have you experienced any of the following?

Diabetes	YES / NO	Kidney problems	YES / NO
High Blood Pressure	YES / NO	Nervous disorders	YES / NO
Heart Arrhythmia	YES / NO	Stroke	YES / NO
Heart Disease	YES / NO	Pregnant / IUD	YES / NO
Heart Attack	YES / NO	Allergies / Skin disorders	YES / NO
Pacemaker	YES / NO	Hernia	YES / NO
Headaches	YES / NO	Metal Implants	YES / NO
Seizures	YES / NO	Shortness of breath	YES / NO
Cancer	YES / NO	Asthma	YES / NO
Injured in a motor vehicle accident	YES / NO	Unrelated previous surgeries	YES / NO

Other _____

If yes to any of the above, please explain & give approximate dates: _____

CONSENT FOR PHYSICAL THERAPY TREATMENT

Consent for Treatment: I am suffering from a condition requiring diagnostic and/or medical treatment and I hereby voluntarily consent to care by the healthcare providers at Mobile Therapy Specialists Inc. as deemed necessary by their clinical judgment. I understand and expect that the care I receive will be consistent with physical therapy treatment standards. I also understand that medicine is not an exact science and acknowledge that diagnosis and treatment may involve risks of injury. I acknowledge that no guarantees have been made to me as a result of examination or treatment.

If I refuse treatment that is suggested for me, I will not hold Mobile Therapy Specialists Inc. or any other individual responsible for any consequences resulting from my decision.

I have read and agree with the statement above. I understand that by signing below, I am giving my consent to physical therapy treatment from Mobile Therapy Specialists Inc.

_____ _____

Patient Signature Date

Printed Name: _____

If this consent is signed by a person on behalf of the patient, please complete the following:

_____ _____

Signature of Patient Representative Date

Printed Name: _____

Relationship to Patient: _____

REFUSAL (only complete if refusing treatment)

- ☐ I have read, in its entirety, this Consent for Physical Therapy Treatment form and do, with full knowledge of my physician/healthcare provider's recommendation for my treatment, refuse to sign this consent form. I know that in doing so, I am refusing the healthcare provider recommended treatment for all physical therapy care. I have affixed my signature below to attest to this decision. I realize a copy of this refusal will be forwarded to my physician/healthcare provider.

Patient Refusal Signature: _____ Date: _____

Clinic Representative: _____ Date: _____

CANCELLATION / NO-SHOW POLICY

To our valued patients,

Our MTS therapists are traveling throughout their day and will always work diligently to be on time for each and every visit. However, there are times they will hit traffic or deal with unforeseen circumstances. If they are running more than 10' late you will receive a call to inform you. At that time, you will have the option to cancel and reschedule that appointment at no cost to you.

However, given the mobile nature of our business, we've found that a clear understanding of our cancellation/no-show policy is essential. This is particularly important as considerable time is invested in travel to provide you with the exceptional care we are known for in the convenience of your home. We ask that you please be prepared at your scheduled appointment time so we can get started immediately and maximize your treatment.

Please review this document carefully and ask any questions you may have before initialing and signing.

Please Initial:

_____ We ask for a **24 hour notice** for any appointment cancellation. If you call to cancel your appointment with less than 24 hours notice, you will accrue a **$40 fee**.

_____ **NO SHOW** appointments will be charged a **$60 travel fee**.

_____ _____

Signature Date

_____

Name (please print)

_____ _____

Signature of guardian if under 18 years of age Date

_____

Name (please print)

A. Notifier: MOBILE THERAPY SPECIALISTS Inc. (Medicare Part B Providers)

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

Advance Beneficiary Notice of Non-coverage (ABN)

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 healthcare provider have good reason to think you need. We expect Medicare may not pay for the **D. services** below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
PHYSICAL THERAPY SERVICES	**The 2022 Medicare Part B payment CAP LIMIT is $2150 .** Medicare may not pay past this limit without exception. Patients would be responsible for any services not deemed 'medically necessary' and therefore not covered by Medicare.	Cash price is: $185/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. 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 copays 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:

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