Oncology Rehab and Wellness Resources, LLC

REGISTRATION FORM

Patient Information

Last: _____ First: _____ MI: _____ Age: _____
Street Address: _____ Apt: _____
City: _____State: _____ Zip: _____ DOB: ____/____/____ SS# _____
Primary Phone: _____ Alternate Phone(s): _____
Email address: _____ Preferred method/# of contact (circle): Phone/email
Emergency Contact: _____Relationship: _____
Phone: _____ Alternate Phone(s): _____

Insurance Information

Primary Insurance: _____ ID #_____ Group # _____
Primary Holder of Insurance:_____ DOB: __/____/___

Secondary Insurance _____ ID #_____ Group # _____
Primary Holder of Insurance:_____ DOB: __/____/___

Physician Information

Ordering MD: _____ Phone: _____ Fax: _____
Surgeon/Plastic Surgeon: _____ Phone: _____ Fax: _____
Oncologist: _____ Phone: _____ Fax: _____
Primary Care MD: _____ Phone: _____ Fax: _____

Prior/Current Therapy Services: Are you currently receiving **any type of home health care**, including physical therapy, occupational therapy, speech therapy or nursing care? (circle) Y / N

Have you received any physical therapy, occupational therapy or speech therapy for any condition this year? (circle) Y / N If yes, please indicate the condition and duration of care: _____

_____

For office use only

☐ Insurance Verification:
Date of verification: _____By whom: _____ (attach copy of insurance verification info or complete below):
Coverage eff. Date:_____ Specific Plan name: _____ IN network? Y/N
Deductible: $_____ Met? Y / N Amt. of ded. met: $_____ Co-pay amt: $_____ PT benefit or visit limit: _____
Is authorization needed? Y/N – How to get authorization (form/PCP): _____
Name of representative: _____ Auth/Ref #:_____
☐ Insurance Verification information entered to database Date: _____/_____/_____ Entered by: _____

☐ Intake information entered to database Date: _____/_____/_____ Entered by: _____

PRE-EXAM FORM: *In order to evaluate your condition fully, please be as accurate as possible. Thank you.*

PATIENT NAME:_____ AGE:_____ GENDER: ❑ Female ❑ Male

DIAGNOSIS:_____ ARE YOU CURRENTLY IN TREATMENT FOR CANCER? ❑ Yes ❑ No

HAVE YOU / ARE YOU RECEIVING RADIATION? ❑ Yes ❑ Currently ❑ No CHEMOTHERAPY? ❑ Yes ❑ Currently ❑ No

CHEMO MEDS YOU ARE RECEIVING OR HAVE RECEIVED: _____

OCCUPATION:_____ ARE YOU WORKING NOW? ❑ Yes ❑ No ❑ Part-time ❑ Full-time

1.	Why is your doctor sending you to see us / Why are you seeking care from us?	❑ Weakness/fatigue ❑ Difficulty walking ❑ Losing my balance ❑ Recently completed chemo ❑ Pain ❑ Swelling in my (circle) Arm / Leg / Other ❑ Recently had surgery ❑ Numbness/tingling in my (circle) Hands / Feet ❑ Recently completed radiation ❑ Having difficulty completing day to day activities ❑ To learn about safe exercise/activity while undergoing cancer treatment ❑ To receive a screening for any problems that you may be able to help with ❑ Other :	
2.	What caused your pain/problem?	❑ Unsure or does not apply	
3.	Approximately when did it start?	❑ Unsure or does not apply	
4.	List ONE ACTIVITY you are unable to do, that you absolutely want to be able to do again:		
5.	Have you ever had this same (or similar) pain/problem before?	❑ Yes (If yes, when and describe) ❑ No	
6.	In your understanding, what do you think will make it better?		
7.	How optimistic are you that physical therapy, if indicated, can help you get better? (circle one)	Not at all.....Mildly optimistic.....Fairly.....Very optimistic.....Extremely OR.....I don't think I need Physical Therapy	
8.	What are some potential obstacles to you getting better?		
9.	Over the next 30-days, how many hours per week can/will you commit to getting better if referred for physical therapy treatment?	_____ hours per week	
10.	On the scale, circle your worst **fatigue level** in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
11.	On the scale, circle your worst **pain level** in the past couple of days:	*Mild* *Moderate* *Severe* 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10	
12.	List all past surgeries with dates / year:		
13.	List all medical conditions you have (or were told you have): * you may attach a separate sheet/copy if desired		
14.	List all medications you are currently taking * you may attach a separate sheet/copy if desired		

MEDICATIONS - please list any medications you are currently taking, including prescription, over the counter and herbal medications, Vitamins / mineral / dietary / nutritional supplements. *** This information is required by some insurance companies.

If your doctor has this information, please ask him/her to fax this to us at 703-634-7368 OR you may attach separate list.

Name of medication or supplement	How taken (by mouth, inhaled, injection, infusion patch, etc.)	Dose	Frequency	Comments

GENERAL HEALTH AND ACTIVITY

	Prior to your illness (circle)	**Currently (circle)**
General Health	Excellent Good Average Fair Poor	Excellent Good Average Fair Poor
Activity/Exercise	None 1-2 days/wk 3-4 days/wk 5+ days/wk	None 1-2 days/wk 3-4 days/wk 5+ days/wk
Has your doctor advised you on any activity or work restrictions?	No / Yes: (indicate restrictions below)	No / Yes: (indicate restrictions below)

❑ **Does not apply to me**

FOR LYMPHEDEMA EVALUATIONS ONLY:

Please check all of the conditions below that apply to you:

❑ Congestive Heart Failure / Cardiac Edema

❑ Impaired kidney function

❑ Acute (current) infection of any type

❑ History of infection(s) in my (circle): ARM LEG

❑ Known active cancer – location(s): _____

❑ Lack of sensation in my (circle): ARM LEG HAND FOOT

❑ Diabetic neuropathy

❑ Peripheral artery disease

❑ Have you recently been examined to rule out a deep vein thrombosis (DVT)? ❑ Yes (If yes, when and describe below) ❑ No

_____

❑ Do you or have you ever had a deep vein thrombosis (DVT) ❑ Yes (If yes, when and describe below) ❑ No

_____

I understand that my candidacy for a rehabilitation/lymphedema program will be dependent upon my willingness to improve. I have answered the questions above honestly and accurately to the best of my ability. The doctor/therapist will determine whether or not I am a viable candidate for a rehabilitation/lymphedema program and that my approval into their program is not guaranteed. I understand that I also have the right to refuse such services if deemed a viable candidate, even if it may be against medical advice.

Patient Signature (or guardian):_____ Date: _____

Oncology Rehab and Wellness Resources, LLC

FINANCIAL AGREEMENT and SERVICES POLICY

Patient's Name: _____ Date: _____

I understand that my insurance company will be sent an itemized bill for each session, in accordance to reasonable and customary charges. I agree to assign benefits directly to **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered by **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC**.

*** It is understood that the **insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility.**

I*** I agree to pay for all services rendered should my insurance company deny payment for services, and **I will be responsible for any deductible, co-insurance or co-payment, to be paid at the time of my visit or when billed by ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC.**

Note: Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered," you will be responsible for those charges.

*** While **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** will complete an initial verification of benefits as a courtesy to our patients, **it is the patients' responsibility to know their therapy benefits. Therefore patients will need to check with their insurer to verify coverage if they want to be sure.**

PATIENT NOTIFICATION OF CANCELLATION PROCEDURES

Your appointment time is reserved for you. This office requires 24 hours advance notice for cancellations. **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** reserves the right to determine penalty for failure to abide by above cancellation policy. Fees are as follows:

** **$30** for cancellations with less than 24 hours notice and **$50** for no show/not home for visit.

*** Fees are not covered by insurance and therefore cannot be submitted for reimbursement. You are fully responsible for payment of all fees as stated.*

TARDINESS: Please call if you are running late. Physical therapy treatments may need to be abbreviated for patients arriving late. We reserve the right to reschedule your appointment. We will deliver the same respect for your time. If we are running late, the session will be completed in its entirety.

PATIENT NOTIFICATION OF SCHEDULING AND DISCONTINUANCE PROCEDURES

Should you miss three consecutive visits/visits in excess as determined by your therapist, you may be moved to "same day scheduling" and will be offered times available for that day. Should you miss visits in excess it will be considered that you are not in adherence or compliance with your plan of care, and may be discharged from this office. Your primary/referring physician will be notified. Your therapist may, at their discretion, modify this policy.

BILLING AND COLLECTIONS FOR SERVICES RENDERED

Balances after insurance are due within 30 days of receipt of statement unless other satisfactory payment arrangements have been made with our office. **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** reserves the right to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment.

NOTE: In such an occurrence, you will be responsible for all legal or other collection fees charged by lawyers, courts or collection agencies in addition to the amount due to our office.

I HAVE READ AND UNDERSTOOD **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

> Patient / Responsible Party Signature:_____ Date: _____/_____/_____

OTHER SERVICES :

As a convenience to our patients, we offer Credit Card On File (CCOF) services. Your credit card will be securely stored in our database for use at each visit for any copayments, equipment/supply purchases or balances due. You will not be charged unless authorized each session/prior to charging.

□ Yes, I would like ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC to maintain my credit card on file

□ No, I wish to defer the utilization Credit Card on File services

> Patient / Responsible Party Signature:_____ Date: _____/_____/_____

OTHER EQUIPMENT /SUPPLIES NOT COVERED BY INSURANCE :

Other equipment/supplies, including lymphedema bandaging and/or garments if not covered by insurance

Please be advised that some exercise equipment/supplies/adaptive equipment/assistive devices that may be recommended by your therapist may not be covered by insurance and you will be responsible for payment to receive these supplies for home/personal use. Fees will be discussed with you and payment is expected at time of provision of such supplies. Commonly used supplies: * Iontophoresis pad/patch (standard) $8.00/$10.00 OR * Iontophoresis patch (ActivaPatch 2.5hr) $12.00 * Electrical Stimulation pads $8.00 (one-time charge) * Theraband – 6 ft - $6.00 *Lower extremity lymphedema bandaging kit $213 * Upper extremity bandaging kit $95

□ Yes, I accept such charges if they apply to me/my therapist recommends any treatment supplies as above

□ No, I wish to defer such treatments even if recommended by my therapist

> Patient / Responsible Party Signature:_____ Date: _____/_____/____

Oncology Rehab and Wellness Resources, LLC

NOTICE OF PATIENT INFORMATION/PRIVACY PRACTICES AND CONSENT

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your personal health information may be used by **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** for treatment, obtaining payment, during an audit, in emergencies, or when required by law. You will be asked for written authorization to use your personal medical information for any other reason than those listed above. You have the right to review your personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of their health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer for **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC at 703-789-0367**

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's Notice of Patient Information/Privacy Practices. In doing so, I hereby release **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

I have read and agreed to the above policies and procedures.

Patient or Responsible Party Signature: _____Date: _____