LIMITLESS
Physical Therapy & Wellness

Physical Therapy Medical Screening

DOB: ____ /____ /____ **Date:** ____ /____ /____
Name: _____

Sex: M F **Age:** _____ **Ht:** _____ **Wt:** _____
Smoker: Y N **Possibly Pregnant:** Y N
Occupation: _____
Briefly describe your regular exercise routine:

_____
_____
_____

Past Surgical History: (include dates if known)
_____
_____
_____

Current Medication: (list or provide list to copy)
_____
_____

Recent Diagnostic Imaging (MRI, XR, CT) or blood work for current symptoms:
_____
_____

Past Medical History:

(Put a line through any condition you have NEVER had, AND Circle each condition you currently have OR ever had in the past)

Cancer Diabetes I or II Stroke Blood Clot Pacemaker Depression Seizures
Ulcers High Blood Pressure Heart Disease Liver Disease Kidney Disease Lung Disease
Asthma Fibromyalgia Osteoporosis Osteoarthritis Rheumatoid Arthritis
Allergies: _____
Other(s): _____
Recent illness? (explain): _____

Recently I have been experiencing:

(please circle all that apply, AND put a line through any that do not)

Fever/Chills/Sweats Unexplained weight loss Increased pain at night/rest Difficulty swallowing
Difficulty Speaking Dizziness Poor balance/falls Vision Changes Numbness or Tingling
Nausea/vomiting Chest pain Shortness of breath Changes in appetite Pain with meals
Unusual pain with menstruation Change in (Bowel) or (Bladder) control, habits or appearance

Current Symptoms:

Where is your PRIMARY symptom located?_____
Approximately what date did this symptom begin? _____
How did your symptoms start (injury/gradual/sudden)?_____
Have you ever had this problem before? (circle one: Y N **)** If YES, please answer the next two questions:
What treatments helped?_____
What treatments failed?_____
Please indicate any barriers to learning: _____

In the past month, have you often been bothered by feeling down, depressed, or hopeless? **YES NO**
In the past month, have you often been bothered by little interest/pleasure in doing things? **YES NO**
Are these feelings something with which you would like help? **(YES today) (YES but not today) (NO)**

I certify that the above information is correct (patient/guardian signature): _____ Date:_____

Reviewed by (physical therapist signature): _____ Date:_____

PATIENT SUBJECTIVE QUESTIONNAIRE

Name _____ **D.O.B.** _____ **Date** _____

Reason for visit (low back pain, headaches, etc): _____ **Date of injury:** ----------

Please indicate how your pain started:

☐ Trauma	☐ Motor Vehicle Accident	☐ Progressive
☐ Work Accident	☐ Pregnancy Related	☐ Sports Injury
☐ Surgery	☐ Chronic Pain (unsure of cause)	

☐ Other (briefly explain)_____

Have you had Physical Therapy or Chiropractic treatments previously? ☐ YES ☐ NO

Have you had any of the following diagnostic studies?

	NO	YES	Date (year)	Where
Diagnostic X-Rays	☐	☐	_____	_____
CT Scan (computed tomography)	☐	☐	_____	_____
MRI (magnetic resonance image)	☐	☐	_____	_____
Other: _____	☐	☐	_____	_____

On the body diagrams mark and label your primary areas of concern:

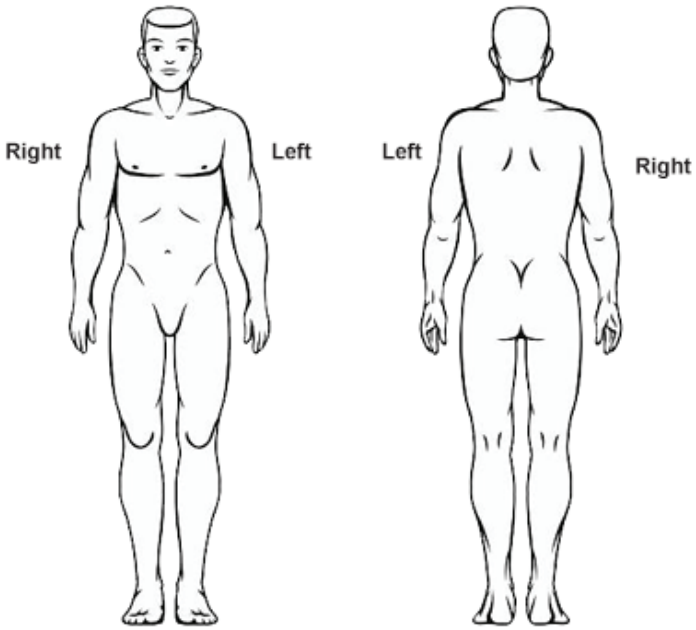
On the line below, please indicate (with an "X") the maximumand minimum amount of pain your feel on a daily basis:

No Pain----------Worst Possible Pain

0-----1-----2------3-----4-----5-----6-----7-----8-----9-----10

What activities make your pain worse? (Please check (x) all that apply to you)

☐ Lying on back	☐ Exercise (during)
☐ Bending forward	☐ Bending backwards
☐ Sitting	☐ Exercise (after)
☐ Coughing / Sneezing	☐ Standing
☐ Twisting	☐ Early Morning
☐ End of Day	☐ Walking
☐ Other _____	☐ None



Initial_____

LIMITLESS
Physical Therapy & Wellness

Consent to Treatment:

1. I have presented myself to this facility for therapy treatments and consent to the care (history, physical examination, treatment, etc.) that will be provided by my therapist.
2. I realize I have the right to refuse any treatments or procedures to the extent permitted by law. I acknowledge that the delivery of health care does not guarantee 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.
3. I hereby authorize the release of medical information necessary to process my insurance and authorize payment directly to the provider of service. I am responsible for any services not covered by this authorization. I have read and fully understand the Patient Financial Responsibilities Form.
4. Worker's Compensation - I hereby authorize Limitless Physical Therapy l to receive my records related to my work injury.

PT Benefits Provided by Your Insurance Company:

I grant to Limitless Physical Therapy and its affiliated entities, and its representatives and employees (collectively the "Company") the right to take photographs and\or videos of me in connection with my participation in physical therapy services. I authorize the Company, to copyright, use and publish the same in print and/or electronically. I agree that the Company may use such photographs of me with or without my name and for any lawful purpose, including for example such purposes as publicity, illustration, advertising, and Web content and waive any right to compensation therefore. I understand that I may revoke this authorization but only in writing delivered to the clinic office manager. I understand that if I choose to revoke this Authorization, the revocation will not be effective for any uses and/or disclosures of my protected health information that have already been made in reliance on this Authorization.

□ Agree OR □ Decline

Notice of Privacy Practices:

By signing this form, I acknowledge that Limitless Physical Therapy has made its' Privacy Notice available to me, which explains how my health information will be handled in various situations. I understand that I may discuss my concerns and/or any questions I have concern-ing this Privacy Notice with Limitless Physical Therapy representatives.

PT Benefits Provided by Your Insurance Company:

I acknowledge that my physical therapy benefits have been explained to me to my satisfaction. I understand that I am ultimately responsible for any copays, deductible(s), and/or co-insurance. I acknowledge that I should contact a representative of Limitless Physical Therapy if I do not understand my benefits, have ques-tions regarding payment due, or if I am unable to provide payment for my services prior to receiving treatment. **I understand that the information provided regarding my insurance is an estimate and a quote of benefits and may not reflect the exact balance owed. I acknowledge that I am responsible for any balance not covered by my insurance and that I have the right and responsibility to follow-up with my insurance for specific questions regarding my individual policy.**

Communication:

I consent to receive information (such as appointment reminders, patient surveys, and other information relating to the physical therapy services provided to you) via the communication channels for which you provided the contact information including via phone, text, and email.

Release of Information:

I authorize the following individuals to receive information regarding my diagnosis, treatment, and billing.

Name	Relationship

Authorization:

I acknowledge, as indicated by my signature below, that I have read and fully understand this consent form. By signing this form, I am acknowledging my understanding of the "Notice of Privacy Practices" and authorizing persons listed on the Information Release to receive my health information.

Patient Name (please print):

_____

Patient or Guardian Signature:

_____

Limitless PT Employee Signature:

_____

Date of Authorization: _____

LIMITLESS
Physical Therapy & Wellness

Limitless Physical Therapy & Wellness
101 Uhland Rd. Suite 115
San Marcos, TX 78666
Phone: 512-878-0351 | Fax: 512-878-0356

Notifier(s):

Medicare Financial Limitation Notification Form:

Effective January 1, 2018 the Center for Medicare and Medicaid Services (CMS) implemented a Financial Limitation, (or Cap), totaling $2,010.00 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 on $2,010.00 financial limitation (Cap) for both therapies combined.**
- **Occupational Therapy services will have separate $2,010.00 financial limitation.**
- **These financial limitations will be effective until December 31, 2018 unless otherwise changed or suspended by CMS.**

These limits are based on the Medicare fee schedule allowed amount after your $183.00 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 $2,010.00 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 $2,010.00 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.

The $2,010.00 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 Scheduling Coordinator of any physical, occupational or speech therapy services you have received between January 1, 2018 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.

_____ _____

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 $2,010.00.

LIMITLESS
Physical Therapy & Wellness

Patient Name: _____

1. Do you receive Veteran's benefits? **Yes** **No**

2. Are you receiving benefits under the Black Lung Program? **Yes** **No**

If yes, date benefits began _____

If yes, are the services you will be receiving related to a non-black lung condition? **Yes** **No**

3. Was this injury/illness due to a work related accident/condition? **Yes** **No**

If yes, date of injury/illness _____

4. Was this injury/illness related to an automobile accident? **Yes** **No**

If yes, date of accident _____

5. Was this injury/illness related to an accident which you intend to file a liability suit or litigation is pending? **Yes** **No**

Attorney Name: _____

Address: _____

Phone: _____

6. Are you entitled to Medicare based on:

□ Age (65 & over) – go to question 7

□ Disability – go to question 7

□ End Stage Renal Disease

Do you have group health plan (GHP) coverage? **Yes** **No**

Are you within the 30-month coordination period? **Yes** **No**

7. Are you currently employed? **Yes** **No** Date of retirement: _____

a) Is your spouse currently employed? **Yes** **No** Date of retirement: _____

b) Do you have a group health plan (GHP) as primary coverage based on your own or a spouse's current or former employment? **Yes** **No**

c) Does the employer that sponsors your GHP employ 20 or more employees? **Yes** **No**

If you answered Yes to questions #3, #4 or #7 above, please complete the following information:

Insurance Company:	*Address:*
Policy/Cert. #:	*Group Name and #:*

_____ _____

Patient Signature Date

Responsible Party: _____ Relationship: _____