MSP SCREENING FORM

Medicare requires all patients with Medicare or a Medicare supplement policy to answer all questions listed below.

Provider: Louisiana Physical Therapy Centers of Pineville, LLC

Patient's Name:____

Medicare Number: ____

Admission Date: ____

A provider may be held liable if an overpayment occurs and Medicare finds that the provider furnished erroneous information or failed to disclose facts, if known it may be relevant to payment. If the patient responds "yes" to any questions, answer the other applicable questions in this section.

1. Is the illness or injury due to any kind of accident?

☐ No If no, proceed to question # 2 on the next page.

☐ Yes If yes: Medicare may be secondary. Check the appropriate type of accident below.

☐ Motor Vehicle: name of patient's automobile insurer: ____
____ Policy No. __________________________
Obtain copy of Insurance Card. Call to verify Auto Insurance if primary: we bill them.

☐ Motor Vehicle: name of third party's liability Insurer: ____
____ Policy No. __________________________
Liability may be primary. Bill Medicare (unless patient's automobile insurer can pay first) and attach copies of all documentation.

☐ Work Related: name of Worker's Compensation Insurer ______________________________________
____ Group No. __________________________
Patient's Account No.____
Worker's Compensation Insurance is primary: we bill them.

☐ Slip and fall: explain where fall occurred
If fall occurred at place other than patient's home, determine if liability
Claim or suit will be filed or if any kind of compensation can be made. ☐ Yes ☐ No
If yes: Name of third
Party/Insurer/Attorney: ____ Policy No. ________________
Obtain a copy of insurance card. Call to verify.
Bill Medicare and attach copies of all documentation.

COVERAGE THROUGH OTHER GOVERNMENTAL ENTITY

2. Does the patient have coverage through the VA, the Department of Labor's Black Lung Program, or some other federal or state agency program other than Medicare?

☐No If no, proceed to question #3

☐Yes If yes: Name of Program ____________________________ Policy/Claim No. ______________________

Obtain a copy of Insurance card. Call to verify.

The entity the patient has coverage with must be billed primary to Medicare. Medicare may reject the claim unless the entity pays as primary or submits a denial of charges.

A patient with Veterans Administrations (VA) coverage may choose to receive treatment under either the VA or Medicare. However, Medicare cannot pay for services received from VA hospitals or other VA facilities except for emergency hospital services that the patient receives in a non - VA hospital or from a non - VA physician

EMPLOYER GROUP COVERAGE FOR THOSE 65 AND OVER

3. Is the patient 65 or above and employed at the time of this service?

☐No If no, proceed to question #4

☐Yes If yes, enter patient's date of birth (MM/DD/YY) ____

Name of patient's company/employer ____

☐Full Time ☐Part Time

Does the employer employ 20 or more employees? ☐ Yes ☐ No

Does the patient have and Employer Group Health Plan (EGHP) through his/her current employer? ☐ Yes ☐ No. if yes, enter name of EGHP: _____________________________________ Policy/Group# _______________ Obtain copy of insurance card. Call to verify.

If the patient is aged 65 or above and has answered yes to both questions, the EGHP show is primary and should be billed.

Medicare is secondary.

4. Does the patient have a spouse who is employed at the time of this service?

☐No If no, proceed to question #5

☐Yes If yes, enter patient's date of birth (MM/DD/YY) ____

Name of spouse's company/employer ____

☐Full Time ☐Part Time

Does the employer employ 20 or more employees? ☐ Yes ☐ No

Does the spouse have an Employer Group Health Plan (EGHP) by reason of his/her current employment which covers patient? ☐ Yes ☐ No. if yes, enter name of EGHP: ____
Policy/Group# ______________ Obtain copy of insurance card. Call to verify.

If patient is 65 or over and has answered yes to both questions, the EGHP shown is primary and should be billed before medicare. If patient also has an EGHP (see#3). Medicare will be billed third.

EMPLOYER GROUP COVERAGE FOR THOSE LLC. TITLED TO MEDICARE SOLELY DUE TO END STAG RENAL DISEASE

5. Is the patient entitled to Medicare solely because of End Renal Disease (ESRD/kidney failure) and in the first 18 months of ESRD Medicare entitlement.

☐ No If no, proceed to question #6

☐ Yes If yes, enter the patients date of entitlement as shown on the Medicare card. __________ (MM/YY)

Does the patient have coverage through his/her, his/her spouse's, a parent's, or a guardian's Employer Group Health Plan (EGHP)? ☐ Yes ☐ No If yes, enter Name of employer__________________________________

Name of EGHP ______________________________________ Policy/Group No ________________________

Obtain copy of insurance card. Call to verify.

If the patient answers yes, to both questions, the EGHP is primary and should be billed. Medicare is secondary.

EMPLOYER GROUP COVERAGE FOR THOSE ENTITLED TO MEDICARE SOLELY BECAUSE OF DISABILITY

6. Is the patient under the age of 65 and entitled to Medicare solely (does not have/has not had ESRD) because of disability.

☐ No If no, proceed to question #7

☐ Yes If yes, enter patient's date of birth (MM/DD/YY) ____

Does the patient have coverage through his/her, his/her spouse's, a parent, or a guardian's Employer Group Health Plan (EGHP)? ☐ No ☐ Yes. If yes, enter: Name of each insured whose policy covers the patient

A) ____ B) ____

Name of corresponding employer(s) A) __________________________ B) _____________________________

Name of corresponding EGHP(s) ____

Obtain copy(s) of insurance card(s). Call to verify.

If the patient answers yes to both questions, the EGHP(s) is/are primary and should be billed. Medicare is secondary (or third)

7. Is the patient enrolled in an HMO (Medicare Replacement Policy) that has Medicare benefits assigned?

☐ No If no, proceed to question #8

☐ Yes Name of HMO ________________________________ Policy/Group No. ______________________

If yes: contact HMO to obtain authorization and obtain copy of HMO card.

HMO is primary. Medicare is not billed at all.

8. Has the patient elected Hospice benefits instead of Medicare Part A and Part B benefits?

☐ No

☐ Yes If yes, Hospice is primary and should be billed, unless diagnosis is not Hospice related.

I hereby certify, to the best of my knowledge, the above information is true.

Patient/Guardian signature:____

Date: ____

(Adapted from HCFA Pub. HIM 10. Section 326)

Louisiana Physical Therapy Centers of Pineville, LLC
1135 Expressway Drive, Suite 200A
Pineville, LA 71360
(318) 487-6525 Fax: (318) 487-6527

Patient Information:

Name: ____

First Middle Last

Address: ____

City: ______________________ State: _______________________ Zip: _____________________

Phone: _____________________________ Other Contact: ________________________________

Email: ____

Social Security # _____________________________ Dob: ________________________________

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single

Place of Employment: ____

Name of School If Student: ____

Referring Dr: ____

Next Dr. Appt: ____

Are You Currently Receiving Home Health? ☐ Yes ☐ No

Do You Have an Attorney Related to This Injury? ☐ Yes ☐ No

If Yes, Name: _____________________________________ Phone# ________________________

How Did You Hear About Our Clinic? ____

Primary Insurance: ____

Policy Holders Name: ____

Date of Birth: _________________________ Social Security# ______________________________

Secondary Insurance: ____

Policy Holders Name: ____

Date of Birth: _________________________ Social Security# ______________________________

Please List Medications on The Next Page That is Provided.

Louisiana Physical Therapy Centers
of Pineville, LLC

	Name of Drug\Supplement	Dosage	Morning, Noon and/or Night	Route of Administration	Reason for Usage
Ex:	XXXX/xxxxxxxxxxx	20mg	Morning & Night	Taken Orally	High Blood Pressure
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					

Louisiana Physical Therapy Centers
of Pineville, LLC

Patient Name: ____

Date of Injury: (If Known) ____

Check Which Apply to Your Symptoms (If Known)

☐ Work Related Injury ☐ Recurrence of Previous Injury

☐ Motor Vehicle Accident ☐ Injury Related to Lifting

☐ Athletic Injury ☐ Cause Unknown

Have You Had Any Related Surgery to This Injury? ☐ Yes ☐ No

If Yes, Explain and Give Approximate Date: ____

Select Any of The Following Condition/ Complaints That You Have Had in The Last 6 Months?

☐ Pregnant ☐ Hernia ☐ Diabetes

☐ High Blood Pressure ☐ Headaches ☐ Osteoarthritis

☐ Chest Pain Angina ☐ Seizures ☐ Skin Abnormalities

☐ Ringing in Ears ☐ Cancer ☐ Recent Fractures

☐ Arthritis ☐ Nausea ☐ Rheumatoid

☐ Pacemaker ☐ Heart Disease ☐ Dizziness

☐ Metal Implants ☐ Other: ____________________________

Please Carefully Complete This Drawing Using the Symbols Listed Below to Help us Better Understand Your Pain and Current Complaints.

/// DULL/ACHING/THROBBING

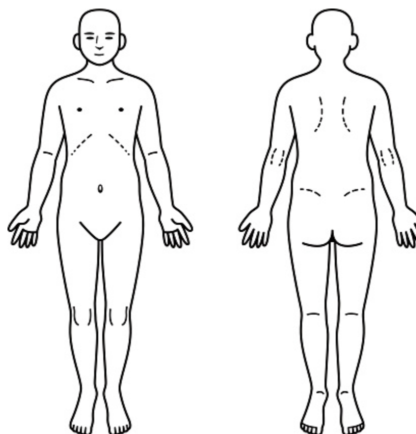
XX SHARP/STABBING

BB BURNING

== NUMBNESS

::: TINGLING

SSS CRAMPING



I Acknowledge That the Information I Have Provided Is True and Correct.

Relation to Patient ____

Signature ______________________________ Date ____________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Louisiana Physical Therapy Centers of Pineville to use and disclosure protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Louisiana Physical Therapy Centers of Pineville's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Louisiana Physical Therapy Centers of Pineville reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Louisiana Physical Therapy Centers of Pineville's Privacy Officer at 1135 Expressway Drive, Suite 200A, Pineville, LA 71360.

With this consent, Louisiana Physical Therapy Centers of Pineville may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TIP, such as appointment reminders, insurance items, and any calls pertaining to my clinical care, including laboratory results among others. Louisiana Physical Therapy Centers of Pineville may also contact me at my home or other alternate location and leave a voice mail or in person concerning my account.

With this consent, Louisiana Physical Therapy Centers of Pineville restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Louisiana Physical Therapy Centers of Pineville's use and disclosure of my PHI to carry out my TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Louisiana Physical Therapy Centers of Pineville may decline to provide treatment to me.

I also give my consent to be treated in the gym in front of other patient's that may be attending therapy.

____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN

____ ________________________
PATIENT'S NAME DATE

PATIENT'S EXTENDED SIGNATURE AUTHORIZATION

*I acknowledge that the information I have provided is true and correct. I also understand that LAPT will make every reasonable effort to collect on this account: however, if my account must be turned over for collection, I will be responsible for any fees associated with the collection process.

*I realize that my participation in the Louisiana Athletic Club facility could involve risk of injury. I hereby expressly assume all the delineated risk of injury and all other possible risk of injury which occur by reason of my participation.

*We file your insurance as a courtesy to you. Your insurance is intimately a contract between you and your insurance company. If, for some reason, whether it be pre-existing or they did not receive the claims, etc. and they do not pay the claim, it is necessary that you understand that you are responsible for payment to our office. (If your insurance company does not pay, you are responsible.)

*I authorize payment of medical benefits to undersigned physician or supplier for physical therapy services described below. (You are authorizing your insurance company to pay LAPT and not the patient.

*I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. (You are authorizing the release of any information to the insurance company to get the claims paid.)

____ ________________________

SIGNATURE DATE

LOUISIANA PHYSICAL THERAPY CENTERS OF PINEVILLE

All insurance companies placed a limit on the amount they pay for outpatient physical therapy, speech therapy & home health services combined.

Louisiana Physical Therapy Centers of Pineville will not compromise your care in any manner; we will assist you in tracking your visit and limits. If you reach your limit, we will work with you on a self-pay basis to continue your care so that your functional outcome will be maximized. Upon reaching your allowable limit, you will also have the option of receiving covered services in a hospital outpatient therapy setting.

To assist us in tracking your available benefits, please answer the following questions:

1. Have you received any Home Health since 1/1/2017? ☐ Yes ☐ No

   If yes, select the location in which the treatment was received and the date the Home Health ended.

   ☐ Hospital ☐ Home Heath ☐ Outpatient Clinic ☐ Rehab Facility ☐ Doctor's Office

   Date ended ______________________

2. Have you received any Physical Therapy since 1/1/2017? ☐ Yes ☐ No

   If yes, select the location in which the treatment was received.

   ☐ Hospital ☐ Home Heath ☐ Outpatient Clinic ☐ Rehab Facility ☐ Doctor's Office

3. Have you received any Speech Therapy since 1/1/2017? ☐ Yes ☐ No

   If yes, select the location in which the treatment was received.

   ☐ Hospital ☐ Home Heath ☐ Outpatient Clinic ☐ Rehab Facility ☐ Doctor's Office

If you are unsure about the above question, please ask a staff member for assistance.

I have read and understand the above information.

____ _________________________

SIGNATURE DATE