Pace Physical Therapy Inc.

Welcome to Pace Physical Therapy.

Please take a few minutes to read and fill up the following registration forms prior to coming to your appointment. This will allow your physical therapist more time to attend to your physical therapy needs.

Please initial after each paragraph where indicated.

Your first visit will consist of a thorough Initial Evaluation. This is an important component of your physical therapy treatment (in addition to being required by law) and it will ensure that you receive the most appropriate care for your condition. A thorough Initial Evaluation will be performed on your first visit regardless of how many evaluations you have received in the past by other physical therapists or health professionals. Once the Initial Evaluation is completed, the remaining of your session (if any) will be dedicated to treating your condition.

Our office is located at 3306 Ponce de Leon Blvd. Suite 200, Coral Gables Florida, 33134

For your first visit, please bring a pair of shorts and/or a sport bra if appropriate.

Please bring with you your medical prescription for physical therapy.

There are **parking meters** all around the clinic, but if you drive one or two blocks east on Ponce towards Bird Rd you can avoid them.

If you have any questions, don't hesitate to call us or email us at jpacept@gmail.com

Thank you kindly,

M. Julia Pace MA, MSPT, PPRC, CFMT, GAFT

Pace Physical Therapy

Medicare Billing Agreement

Pace Physical Therapy operates as a **NON-PARTICIPANT (NON-PAR)** Medicare Provider, and **DOES NOT** accept Medicare Assignment
Please Initial:_____

The cost of physical therapy is based on the treatment(s) rendered and on the total treatment time, according to a Medicare Fee Schedule. The Limiting Charge for NON-PAR providers is 115% of the fee schedule.
Please Initial: _____

You will be responsible for covering the full cost of the treatment at the time of the visit.
Please Initial: _____

Pace Physical Therapy will bill Medicare and your secondary insurance (if available) in your behalf. In turn, Medicare, and your secondary insurance (if available), will reimburse you directly of the Non-par fee schedule. Medicare will reimburse 80% of the non-par fee schedule (and, if available, your secondary insurance will reimburse you 20% of the fee schedule). The remainder will be your out-of-pocket expense (15% if you have a secondary insurance, 35% if you don't).
(Login to MyMedicare.gov to track your claims for therapy services).
Please Initial: _____

MEDICARE has a limit $1,940 per patient per year for physical therapy (PT) and speech-language pathology (SLP) services combined. The $ 1,940.00 limit is based on incurred expenses and includes your annual deductible ($147.00) and co-insurance (20%).
(http://www.medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html)
Please Initial: _____

This MEDICARE benefit limit is effective January 1st, 2015.
Please Initial: _____

Have you had Home Health Therapy recently____ If yes, have you been discharged? _____

Have you received any Physical Therapy treatments this year? _____Where?_____
Are you involved in a litigation involving your present physical complain?_____

I have read, understand and agreed to the MEDICARE BILLING AGREEMENT of Pace Physical Therapy. Please Initial: _____

Patient Name_____Signature:_____
Initials: _____ Date: _____

3306 Ponce de Leon Blvd #200, Coral Gables, FL, 33134 Ph: 786 514-6316 Fax:786 221-4970

Pace Physical Therapy

Cancellation and Attendance Policy

Appointments are made at designated time slot. If you are **late**, you will be seen for the remaining of your designated time slot. The rate for the late visit will remain the same as that of the originally designated time slot.
Please Initial_____

Please call the office within 24hrs of the scheduled appointment if you need to change or cancel it. Monday appointments should be cancelled by leaving a message on the office phone no later than Sunday afternoon. This allows other patients in need of physical therapy to be accommodated. You are allowed two late-cancellations (less than 24hrs notice) without incurring penalties**. A U$ 50.00 penalty for each late-cancellation thereafter will be charged directly to you**. Payment is due on your next scheduled visit Please Initial_____

Please be advised that **<u>any</u> No-Shows (missing an appointment without notifying Pace Physical Therapy) are immediately charged directly to you to at the rate of U$ 150.00 per missed appointment.** Payment is due on you next scheduled visit Please Initial_____

Release of Medical Records

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of medical information, by any means of communication, to Pace Physical Therapy Inc, for the purpose of my physical therapy treatment. Please Initial_____

Copying Policy

There is no charge for copying up to 10 pages. There is a U$ 10.00 for copying your medical records, Copying will be U$ 0.50 per page after the minimum fee. You agree to pay this fee should you need copies of your medical records for any purpose. You may also request a professional medical photocopy service to obtain copies of your chart at you own cost. If your file is in storage, there will be a minimum of U$ 25.00 for retrieval. Please Initial_____

Consent to Treatment

I understand that I have been referred for rehabilitation treatment to Pace Physical Therapy Inc.. Pace PT will design for me my individual treatment plan and I understand that I have the right to ask and have any questions answered prior to receiving treatment. This includes any risks or alternatives to the treatment plan that has been prescribed for me. By signing, I consent to have Pace PT provide treatment under the direction prescribed by my referring physician, dentist, podiatrist and/or by my therapist. This consent is intended as a waiver of liability for such treatment except for acts of negligence. Please Initial_____

Patient Name_____Signature:_____
Initials: _____ Date: _____

3306 Ponce de Leon Blvd #200, Coral Gables, FL, 33134 Ph: 786 514-6316 Fax:786 221-4970

Pace Physical Therapy

Medicare Billing Agreement

PATIENT'S COPY- RETAIN FOR YOUR RECORDS

Pace Physical Therapy operates as a **NON-PARTICIPANT (NON-PAR)** Medicare Provider, and **DOES NOT** accept Medicare Assignment

The cost of physical therapy is based on the treatment(s) rendered and on the total treatment time, according to a Medicare Fee Schedule. The Limiting Charge for NON-PAR providers is 115% of the fee schedule.

You will be responsible for covering the full cost of the treatment at the time of the visit.

Pace Physical Therapy will bill Medicare and your secondary insurance (if available) in your behalf. In turn, Medicare, and your secondary insurance (if available) will reimburse you directly for 100% of the Non-par fee schedule. The remainder 15% will be your out-of-pocket expense. (Login to MyMedicare.gov to track your claims for therapy services).

MEDICARE has a limit $1,940 per patient per year for physical therapy (PT) and speech-language pathology (SLP) services combined. The $ 1,940.00 limit is based on incurred expenses and includes your annual deductible ($147.00) and co-insurance (20%).
(http://www.medicare.gov/coverage/pt-and-ot-and-speech-language-pathology.html)

This MEDICARE benefit limit is effective January 1st, 2015.

Have you had Home Health Therapy recently____ If yes, have you been discharged? _____

Have you received any Physical Therapy treatments this year? _____Where?_____
Are you involved in a litigation involving your present physical complain?_____

I have read, understand and agreed to the MEDICARE BILLING AGREEMENT of Pace Physical Therapy. Please Initial: _____

Patient Name_____Signature:_____

Initials: _____ Date: _____

3306 Ponce de Leon Blvd #200, Coral Gables, FL, 33134 Ph: 786 514-6316 Fax:786 221-4970

Pace Physical Therapy

Cancellation and Attendance Policy

PATIENT'S COPY- RETAIN FOR YOUR RECORDS

Appointments are made at designated time slot. If you are **late**, you will be seen for the remaining of your designated time slot. The rate for the late visit will remain the same as that of the originally designated time slot.

Please call the office within 24hrs of the scheduled appointment if you need to change or cancel it. Monday appointments should be cancelled by leaving a message on the office phone no later than Sunday afternoon. This allows other patients in need of physical therapy to be accommodated. You are allowed two late-cancellations (less than 24hrs notice) without incurring penalties**. A U$ 50.00 penalty for each late-cancellation thereafter will be charged directly to you**. Payment is due on your next scheduled visit

Please be advised that **any No-Shows (missing an appointment without notifying Pace Physical Therapy) are immediately charged directly to you to at the rate of U$ 150.00 per missed appointment.** Payment is due on you next scheduled visit

Release of Medical Records

I hereby authorize any prior or present treating physician, hospital or other health institution, to release all of medical information, by any means of communication, to Pace Physical Therapy Inc, for the purpose of my physical therapy treatment.

Copying Policy

There is no charge for copying up to 10 pages. There is a U$ 10.00 for copying your medical records, Copying will be U$ 0.50 per page after the minimum fee. You agree to pay this fee should you need copies of your medical records for any purpose. You may also request a professional medical photocopy service to obtain copies of your chart at you own cost. If your file is in storage, there will be a minimum of U$ 25.00 for retrieval.

Consent to Treatment

I understand that I have been referred for rehabilitation treatment to Pace Physical Therapy Inc.. Pace PT will design for me my individual treatment plan and I understand that I have the right to ask and have any questions answered prior to receiving treatment. This includes any risks or alternatives to the treatment plan that has been prescribed for me. By signing, I consent to have Pace PT provide treatment under the direction prescribed by my referring physician, dentist, podiatrist and/or by my therapist. This consent is intended as a waiver of liability for such treatment except for acts of negligence.

Patient Name_____Signature:_____

Initials: _____ Date: _____

3306 Ponce de Leon Blvd #200, Coral Gables, FL, 33134 Ph: 786 514-6316 Fax:786 221-4970

Pace Physical Therapy

PATIENT INFORMATION

Patient FULL Name:_____ Date of Birth: _____ Sex: M F

Address: _____

_____

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Fax: _____

Email Address: _____

Occupation; _____ Employer: _____

REFERRING PHYSICIAN

Medicare requires your doctor's signature on you physical therapy plan of care. Without your doctor's signature on your plan of care, Medicare will not pay for your treatment. We will fax your plan of care to your physician requesting his/her signature. Please provide us with the following information:

Referring Physician: _____ Phone #_____

Fax Number: _____

EMERGENCY CONTACT:

Name: _____ Relation: _____

Cell #: _____ Home # : _____

Address: _____

MEDICARE

Medicare Number: _____

SUPPLEMENTAL (SECONDARY) HEALTH INSURANCE:

(please present insurance and personal ID card at the time of service)

Name of ins: _____ ID# _____Group#: _____

3306 Ponce de Leon Blvd #200, Coral Gables, FL, 33134 Ph: 786 514-6316 Fax:786 221-4970

Medical History Form

Please be as detailed as possible

Name: _____ Age: _____ Height: _____ Weight: _____

Date of onset, injury, or surgery: _____

Is this injury the result of a fall? _____ How many falls have you had during the last year? _____

Please describe all areas of symptoms, and describe symptoms: _____
_____
_____
_____

Have you had treatment for this condition before? Please explain: _____
_____
_____
_____

Are you experiencing: Loss of Bladder control? ___ Loss of Bowel control? ___ Dizziness /Faintness/Vertigo?____

Any known results of recent X-rays, MRI, CAT Scan or other tests: _____
_____
_____

List Surgeries and dates: _____
_____
_____

List any injuries and/or accidents you have had in the past and when: _____
_____
_____
_____

PLEASE FILL OUT THE FOLLOWING INFORMATION IN DETAIL: List any medications you are taking AND dosage. Please be detailed, you may use the back of this form or print a list of your own if more space is needed:

Name: _____ Dosage_____ Reason: _____ Orally/inject/cream?: _____
Name: _____ Dosage_____ Reason: _____ Orally/inject/cream?: _____
Name: _____ Dosage_____ Reason: _____ Orally/inject/cream?: _____
Name: _____ Dosage_____ Reason: _____ Orally/inject/cream?: _____
Name: _____ Dosage_____ Reason: _____ Orally/inject/cream?: _____

Do you have or had any of the following?

Allergies_____	Depression_____	Multiple Sclerosis_____
Anemia _____	Diabetes_____	Osteoporosis_____
Anxiety_____	Dizzy Spells_____	Parkinsons_____
Arthritis_____	Emphysema/Bronchitis_____	Rheumatoid Arthritis_____
Asthma_____	Fractures_____	Seizures_____
Cancer_____	Gallbladder Problems_____	Speech Problems_____
Cardiac Conditions_____	Hepatitis_____	Strokes_____
Cardiac Pacemaker_____	High Blood Pressure_____	Thyroid Disease_____
Chemical Dependency_____	Incontinence_____	Tuberculosis_____
Circulation Problems_____	Kidney Problems_____	Vision Problems_____
Currently Pregnant_____	Metal Implants_____	

How would you rate your level of pain?

Current: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

At its best: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

At its worst: 0 1 2 3 4 5 6 7 8 9 10
No pain Moderate pain Severe pain

Please describe your pain(s) (i.e. dull, stabbing, burning, sharp, etc) _____
_____

What activities or positions make your symptoms worse? _____
_____

What makes your symptoms better? _____
_____

Anything else you think we should know about you? _____
_____
_____

Patient Signature_____Date: _____

Pace Physical Therapy

Are you presently receiving Home Health physical Therapy under Medicare A coverage? _____
_____
_____

Are you presently receiving physical therapy at another location? _____
_____
_____

Are you presently involved in a litigation involving the injury/condition you are presently seeking treatment for at Pace Physical Therapy? _____
_____
_____

Have you received physical therapy for this or other complains this year? _____
If yes, when? _____ Where? _____
For what condition? _____

HIPAA Contact Information/ Limited Authorization And Release Form

May we leave a message regarding your appointment, and/or billing (please circle the answer)

Answering Machine	Yes	No
Cell voice mail:	Yes	No
Email	Yes	No
Cell Phone message	Yes	No
Text	Yes	No

May we leave a message discussing medical information: (please circle one)

Answering Machine	Yes	No
Cell voice mail:	Yes	No
Email	Yes	No
Cell Phone message	Yes	No
Text	Yes	No

Please list any other parties that can have access to your health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

In signing this HIPAA Patient Acknowledgement Form you acknowledge and authorize that this office may recommend products or services to promote you improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under HIPAA Omnibus Rule provide you this information with your knowledge and consent.

Signature_____ Date_____

Please be advised that Pace Physical Therapy is a Non-Participant Medicare Provider.

What Is A Non-Participating Provider?

http://www.wpsmedicare.com/beneficiary/general_faq.shtml#gen04

A **non-participating provider** is a health care provider who does not agree to accept assignment on all Medicare claims.

A non-participating provider who does not accept assignment on a claim **may charge up to 115% of the Allowed Fee Schedule for Non-Par providers** (or 109.25% of the Allowed Fee Schedule for participant providers).

A non-participating provider is allowed collect full payment directly from the patient at the time of service. The provider will then submit a claim to Medicare for any Medicare-covered services provided, at no cost to the beneficiary**.**

Medicare will directly reimburse the beneficiary 80% of the Medicare Allowed Fee Schedule (and, if available, your secondary insurance will cover the remaining 20% of the Allowed Fee Schedule)*.

*Please be aware that you might **not** be reimbursed the **total** amount of your expenses. Once Medicare reimburses you 80%, your secondary insurance (IF AVAILABLE) will cover another 20%, and the remaining 15% will be your responsibility. However, if no secondary insurance is available, your financial share will be 35% instead (see table below for more details)

The table below shows the differences between the different types of providers, when considering a service for which the Medicare fee schedule is $100

Payment Arrangement	Total Payment Rate	Payment Amount from Medicare	Payment Amount from Patient
PAR physician	100% Medicare fee schedule = $100	$80 (80%) MAC direct to physician	$20 (20%) paid by patient or supplemental insurance
Non-PAR/ assigned claim	95% Medicare fee schedule = $95	$76 (80%) MAC direct to physician	$19 (20%) paid by patient or supplemental insurance
Non-PAR/ unassigned claim (**PACE PT**)	Limiting charge = $ 100 + 9.25% @ 95% Medicare PAR fee schedule = $109.25**	$0	$76 (80%) paid by MAC to patient + $19 (20%) paid by patient or supplemental insurance + $14.25 balance (patient's responsibility)

***Medicare limiting charge for Non-Par Providers is 115% of the Medicare Allowed Fee Schedule, but because Medicare approved amounts for non-PAR physicians are 95% of the rates for PAR physicians, the 15% limiting charge is effectively only 9.25% above the PAR approved amounts for the services.*

How Much Should I be Expected To Pay Pace Physical Therapy For My Treatment?

Based on the 2015 Medicare Allowed Fee Schedule and on the 2015 Non-Par Medicare limiting charge you should expect to pay approximately between $120 and $140 per 1 hr-treatment session, depending on the services provided.

For sessions during which an Initial Evaluation or a Re-Evaluation must to be performed, expect to pay up to $170.00.

How Long Should I Wait Before Contacting Medicare To Check On The Status Of A Claim?

Medicare processes most claims within 30 days of receipt: however, if they need additional information from you or your provider, it may take longer.

To check the status of a claim at any time, please call

Contact Center Operations at

1-800-633-4227 (1-800-MEDICARE).

For more information please go to http://www.medicare.gov/your-medicare-costs/part-a-costs/assignment/costs-and-assignment.html or contact your local Medicare Organization. 1-800-MEDICARE.

Pace
Physical Therapy Inc.

"The definition of insanity is doing the same thing over and over and expecting different results"
A. Einstein

Do you know the joke that asks how many psychotherapists are needed to change a light bulb? The answer is: only one, but the light bulb needs to want the change.

Now, how many physical therapists are needed to help a single patient? It depends on whether the patient wants to change or not. No amount of therapists or physical therapy will help a patient who wants to feel better but is unwilling to change.

Physical Therapy is a partnership between the patient and the therapist. If you want results from your physical therapy treatment, it would be wise of you to understand your responsibilities as they relate to achieving the results you want.

Many, if not most, of our physical dysfunctions are not the result of an acute traumatic injury, but are consequence of many years of "misusing" our body. Poor postural habits, improper lifting techniques, overuse injuries, overtraining/improper training, pushing ourselves beyond our limits of comfort… these are, among many others, all examples of "bad habits" we tend to acquire in the course of our life. Do they sound familiar to you? If sitting at a desk in front of a computer invariably hurts you neck, is your neck really the problem? Perhaps the problem is in the way you sit in front of that computer, and/or the amount of time you do it for. If you were able to feel discomfort before it turned into pain, and were able to change you position/posture, or improve your support, it's very likely that your neck would not feel like a problem at the end of your day.

If you knew that changing a few habits would prevent you from having pain, would you change them? Careful not to answer this question too quickly, it is not that simple. What if I tell you that most of my patients come to me expecting me to "fix" them? They come to me expecting a passive process of recovery in which the patient is merely the recipient of healing, and not a active participant in the process. Would you identify with them? (If you answered "yes", you are an honest person. You, like most of my patients, have learned to expect that 3 sessions of physical therapy per week should "do the trick", regardless of what you do on your own during the remaining 165 hours of the week. Although it sounds REALLY good, it also sounds a bit improbable, doesn't it?).

Let me make a disclaimer right off the bat: **I can't fix you**. People fix cars, and blenders, and refrigerators. You, on the other hand, are not a refrigerator, and you are not broken. Misused and battered perhaps, but definitely not broken. In need of a helping hand, but not without your own resources.

So… at least in this clinic, physical therapy is indeed a partnership between therapist and patient. One in which I enter into an agreement with you: I will do my best to support and guide you through your own path to recovery, respect your goals and preferences, and listen to your concerns and suggestions. On the other hand, in this partnership, you must enter into an agreement with **yourself**. You must accept that you will have to be pro-active in your own recovery. That "getting better" is not a passive process, that it requires change, and that ultimately it is you yourself who will define the final results of your rehabilitation.

Change is seldom an easy thing to accept or achieve, but always worth the effort when attained. If you are open to the process, it will be my pleasure **NOT** to fix you, but to help you instead.

Ok, let's get to work…

M. Julia Pace MA, MSPT, PPRC, CFMT, GCFP

"If you know what you do, you can do what you want."
M. Feldenkrais

Pace Physical Therapy, 2510 Lincoln Ave, Miami, FL, 33133, Phone: (786) 514-6316, Fax: (786) 221-4970, Jpacept@gmail.com