Functional HOME OT LLC.
Melissa Lopez MS OTR/L ECDCP CFPS
Phone: (207) 548-5913
Fax: (207) 337-9281
Melissa.Strout@FunctionalHomeOT.com

Client Information:

Last Name:		First Name:	

DOB:		Age:	Gender	Pronoun	Preferred Name:

Address:	

City:		State:		Zip Code:	

Contact #1		Contact #2	

Date of Injury:		Problem:	

Emergency Contact Information:

First Name:		Last Name:		Relationship	

Address:	

City:		State:		Zip Code:	

Insurance Information:

Primary Insurance Company:	

Contact Number:		Name on Card:	

Policy Number:		Group Number:	

Secondary Insurance Company:	

Contact Number:		Name on Card:	

Policy Number:		Group Number:	

Referring Provider and Specialty:

Name:		Specialty:		Phone:	

Fax #:		Address:	

City:		State:		Zip Code:	

Dates of Hospitalization in the Past Year:	
Dates of Home Health, Under Medicare Part A in the Past Year:	
Prior Therapy Received in the Past Year:	

Current Medications and Medical History:

1	High Blood Pressure	☐	**18**	Bronchitis	☐
2	Diabetes	☐	**19**	Pneumonia	☐
3	Cancer	☐	**20**	Persistent Cough	☐
4	Heart Disease	☐	**21**	Tuberculosis	☐
5	Chest Discomfort	☐	**22**	Hay Fever	☐
6	Heart mummer/Valve Disease	☐	**23**	Sinusitus	☐
7	Shortness of Breath	☐	**24**	Abdominal Discomfort	☐
8	Swollen Ankles	☐	**25**	Indigestion/heartburn	☐
9	Palpitations	☐	**26**	Nausea	☐
10	Lightheadedness/Dizziness	☐	**27**	Vomiting	☐
11	Rheumatic Fever	☐	**28**	Diarrhea	☐
12	Asthma	☐	**29**	Blood in Stool	☐
13	Persistent Swollen Glands	☐	**30**	Constipation	☐
14	Bone Fractures	☐	**31**	Hearing of Vision Problems	☐
15	Anxiety/Depression	☐	**32**	Other	☐
16	History of Falls	☐	**33**	Number of falls in past year	☐

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Release of Information:

I hereby authorize the release of any information by telephone, email/fax, or in writing, including reports of diagnosis, treatment prognosis, recommendation, benefits payable, as well as any other data pertinent to my treatment, by **Functional Home OT's LLC** to the physician who referred me for therapy, to_____ and to any organization responsible for payment of my account. I also authorize the release of any information by telephone or in writing for utilization and quality review purposes.

Notice of Privacy Practices: I acknowledge receipt of the Notice of Privacy Practices from **Functional Home OT's LLC**. I understand that the Notice of Privacy Practices provides information about how **Functional Home OT's LLC** may use and disclose my protected health information. I have reviewed it and understand that the Notice of Privacy Practices is subject to change. If the Notice is changed, I may request a revised copy.

Assignment of Insurance Benefits: I hereby authorize that the payment of authorized benefits be made directly to **Functional Home OT's LLC** of any services that are reimbursable by Medicare or another insurance if applicable.

Consent for Treatment: I hereby consent to such treatment procedures and patient care which, in the judgment of my therapist and/or physician, may be considered necessary or advisable while I am a patient of **Functional Home OT's LLC.**

Guarantee of Account: I hereby guarantee payment for any and all services rendered to me which are not covered or allowable by Insurance, together with collection costs, including reasonable attorney fees. I also understand that all bills are due and payable upon invoice. I understand that the client's responsibility portion of my bill

shall be due and payable at the time of invoice. I understand that I am personally responsible for full payment of all charges including Insurance denials, deductibles, and copayment and coinsurance fees. I understand that I will be provided with an invoice for services not covered.

Medicare: I hereby certify that the information given by me in applying for payment under title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any such information needed for this or a related Medicare Claim. I request that the payment of authorized benefits be made on my behalf. I understand that I am responsible for any health insurance deductibles and co-insurance. I understand that I cannot receive Medicare Part B services in the home if I am currently on Home Health under Medicare Part A and or on Hospice Care. I understand that services must be skilled and medically necessary to be covered by Medicare Part B. I understand Medicare will pay for 80% of the allowed amount, and I am responsible for the remaining 20% if I do not have secondary insurance.

Cancellation/No-Show Policy: I understand that I will be charged a missed visit fee of $50 if I cancel less than 24 hours before my visit. This amount is my responsibility. I understand if I cancel more than 2x I will be placed on a same-day scheduling list.

Estimate of Insurance Payment/Expense:

Based on the insurance information provided to Functional Home OT LLC, the following is the best estimate of payment/expense.

Insurance Deductible Remaining: _____ Coinsurance: _____ Copay: _____
The estimated cost of a one-hour therapy session:
_____ *Evaluation sessions are higher than treatment sessions.

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Informed Consent Form

You have consulted with Functional Home OT, LLC, and have decided to receive outpatient therapy services. **It is important that you, the client, read this consent form carefully and obtain answers to any questions that you may have.**

Physical and Occupational Therapy: Physical and Occupational therapy involves several methods of evaluation and treatment. We use a variety of procedures and treatments to help us try and improve your physical and psychosocial function. As with all forms of medical treatment, there are benefits and risks involved. Patient responses to a specific form of treatment can vary widely from patient to patient, and it is not always possible to predict responses to a given form of treatment. There is a risk that your treatment may result in pain, injury, or aggravation of a previous condition.

Speech Therapy: Speech involves several methods of evaluation and treatment. We use a variety of procedures and treatments to help us try and improve your function. As with all forms of medical treatment, there are benefits and risks involved. Patient responses to a specific form of treatment can vary widely from patient to patient, and it is not always possible to predict responses to a given form of treatment. There is a risk that your treatment may result in pain, injury, or aggravation of a previous condition.

You have the right to inquire as to the form of treatment based upon your history, diagnosis, and symptoms.

You may discuss with your provider the potential risks and benefits of a specific treatment and possible alternative treatment.

You have the right to decline treatment at any time or during your treatment sessions.

Your therapist will answer questions you may have regarding a given course of treatment, type of exercise or treatment method, associated risks, and possible alternatives.

This consent form is based upon your informed decision to participate in the proposed treatment plan for therapy services. The therapist identified on this form has discussed with me in words

that I can understand, my diagnosis, conditions, reasons for and benefits of the plan of care, the reasonable likelihood of success, the possible material risks of not following the plan of care, the possible risks associated with the plan of care, and possible alternatives and risks associated with those alternatives. The therapist identified on this form and I have discussed my goals for recovery and potential problems that might arise during treatment. I have decided not to participate in alternative treatments at this time. I understand there are risks associated with therapy as described above. I am giving this consent with the understanding that any treatment or services involve some risks and hazards and that no guarantees have been made to me.

I acknowledge that services may be provided to me by another therapist other than those identified on this form.

I HEREBY CERTIFY THAT I HAVE READ THIS FORM (OR HAVE HAD IT READ TO ME) AND FULLY UNDERSTAND THE ABOVE CONSENT. I HAVE HAD THE OPPORTUNITY TO ASK QUESTIONS, AND ALL OF MY QUESTIONS HAVE BEEN ANSWERED TO MY SATISFACTION. I DO NOT DESIRE ANY FURTHER EXPLANATION AND UNDERSTAND AND ACKNOWLEDGE THAT COMPLICATIONS CAN RESULT.

Name of Provider Obtaining Consent:	

Name of Patient/Authorized Legal Guardian:		**Date:**	