**PRIVATE THERAPY PAYMENT INFORMATION SHEET DATE:\_\_\_\_\_**

Please return to THERAPY IN YOUR HOME – OT, PT, ST

147 Vista Del Monte, Los Gatos, CA 95030-6335 Phone: 408-358-0201

Fax 877-334-0714 or email [JulieGroves@TherapyInYourHome.net](mailto:JulieGroves@TherapyInYourHome.net)

**NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alt #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email addresses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Communication directives**: fax\_\_, email\_\_, note in home\_\_, phone\_\_, mail\_\_

* Health Care Advocate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Advance Directive? Y / N; POLST? Y/N; Special requests: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Who we should NOT be included in communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Others involved in your care who we should talk with?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Insurance options** so we can guide you to the best reimbursement for therapy:

- Prior Therapy: # out patient visits for each OT\_\_, PT\_\_, ST\_\_; Where\_\_\_\_\_\_\_\_

- Home Health: When, which company, why discontinued?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

- Medicare: Straight, PPO, HMO, Secondary; A, B or Both?

* Kaiser
* Long Term Care Insurance
* Workers’Comp
* Medi-Cal
* Hospice

**Referring MD and specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_; Street and town of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Primary MD and specialty:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**PHONE #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX #: \_\_\_\_\_\_\_\_\_\_\_; Street and town of physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What we need from you: send to address above**

1. Prior therapy this year: # Out Patient visits: PT\_\_\_\_\_; OT\_\_\_\_\_\_; ST\_\_\_\_\_
   1. Who provided the therapy? Why was it discontinued?
2. Dates of Home Health Agency care\_\_\_\_\_\_\_\_\_\_\_\_\_, company\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Prescription: Please ask your doctor to fax a RX to 877-334-0714.
4. Medication list and please keep us updated regarding changes
5. ABN, if needed, stating why Medicare will not cover services

***I agree to the Rights and Responsibilities, HIPPA document on website, and to pay for services:***

***Signed:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Printed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

New Client Documents July 2014