PREMIER PHYSICAL THERAPY

Physical Therapy Questionnaire

Patient Name:_____.
Referring Physician:_____.
Patient Occupation:_____.
Emergency Contact Name:_____. **Phone: ( ) - .**

Date of first MD visit for this problem or injury:_____.Follow-up MD visit for this problem:_____.

Is this a work injury? Yes No Is an Attorney involved? Yes No

Date of Injury or onset of symptoms:_____.

How did your symptoms begin (gradually, suddenly, injury specifics)?_____.
_____.

Have you had surgery for this problem/Injury: Yes No Type of Surgery_____.
Date of Surgery_____.

List any medications you are currently taking_____.

Are you allergic to any medications or latex? If yes, please specify_____.

Please list symptoms you are currently having (pain, swelling, weakness, etc.)_____.
_____.

What is your main complaint?_____.

Check all the activities that you have trouble performing as a result of your present condition.

Bathing	Child Care	Dressing	Eating
Homemaking	Yard Work	Sitting	Sleeping
Standing	Walking	Working	

How long can you tolerate the following?

	Less than 30 min	1-2 hours	3-4 hours	No Problem
Walking				
Sitting				
Standing				

What treatment have you previously received for this injury/episode?

Physical Therapy	Occupational Therapy	Chiropractic Care
Surgery	Medication (list below)	
Other (specify below)		

List medications if circled above:_____.
Other:_____.

Please circle if you have had any of these test done for this injury/episode: Bone Scan X-Ray
CAT Scan EMG-NCV Myelogram Other

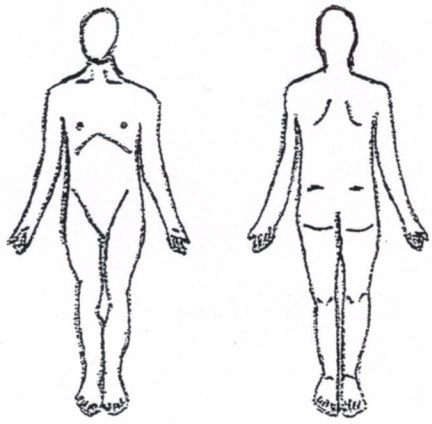
Physical Therapy Questionnaire

Have you had any of the following? **Circle** all that apply.

Asthma/ Bronchitis/Emphysema	Blood Clot/ Emboli	Any pins or metal implants	Heart Attack
Shortness of breath/chest pain	Epilepsy Seizures	Severe or frequent headaches	Bowel/ bladder problems
Coronary Heart Disease or Angina	Hernia	Vision or hearing difficulties	Sleeping Problems/ Difficulties
High Blood Pressure	Gout	Osteoporosis	Weight loss/ Energy loss
Heart Surgery	Stroke/ TIA	Weakness	Allergies
Pacemaker	Infectious Disease	Arthritis/Swollen Joints	Joint Replacement
Diabetes	Tuberculosis	Ringing in the ears	
Cancer/ receiving treatment	Anemia	Thyroid trouble/ Goiter	

Are you pregnant? YES NO Do you smoke? YES NO

Body Chart: Please mark the areas on the chart where you feel pain.



List any other information that would assist us in your care:_____.

_____.

Are you aware of what your diagnosis is? YES NO

Based on your awareness, what are your expectations/goals while in this program?_____.

_____.

Patient/Guardian Signature_____. Date_____.

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Notification of Patient Responsibility for co-payments/Co-percentages and Deductibles

Your insurance company requires PREMIER PHYSICAL THERAPY to collect your co-payments/co-percentages and any unmet deductible amount from you at the time of service. If we do not collect these amounts we could be in violation of your contract with your insurance company and risk being denied reimbursement for your treatment.

Benefits as Quoted by your insurance plan:

Co-Payment at $_____ **EACH VISIT**

Co-percentage _____ % per visit

Deductible Amount $_____ Amount Met $_____.

Out of pocket maximum $_____ Out of pocket met to date $_____.

These benefits may not include any claims that are currently pending with your insurance plan.

Physical Therapy Visit Limit _____ Maximum dollar amount $_____.

- Visit limit is per: person condition c/year Contract year Other.

ALL Medical services provided must be considered Medically Necessary by your insurance provider to be considered for payment.

Please Read:

- These quoted benefits are not a guarantee of payment.
- If you have a secondary or tertiary insurance we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- You the patient are responsible for payment of services rendered if your insurance denies payment due to exceeding your allowed visits and or dollar amount limit.
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage.

Please list your health insurance plans:

Primary _____ **Secondary** _____ **Tertiary** _____.

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

By signing below you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.

_____.

Patient Name (Printed) Signature Date

****

I hereby authorize Premier Physical Therapy to release and disclose all Medical History to:

Name: _____ Relationship to Patient: _____.

Name: _____ Relationship to Patient: _____.

I authorize Premier Physical Therapy staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers

( ) - and ( ) - .

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I also understand that I have the right to terminate this authorization at anytime in writing or verbally.

_____.

Patient Name (Printed) Signature Date

Notification of Patient Responsibility for co-payments/Co-percentages and Deductibles

Your insurance company requires PREMIER PHYSICAL THERAPY to collect your co-payments/co-percentages and any unmet deductible amount from you at the time of service. If we do not collect these amounts we could be in violation of our contract with your insurance company and risk being denied reimbursement for your treatment.

Benefits as Quoted by your insurance plan:

1. Deductible Amount **$162.00** Amount met **$_____.**
   Co-percentage **20% of Medicare-approved amount.**
2. **Maximum dollar amount per Medicare is $1,870.00 per calendar year.**
   This includes Physical Therapy and Speech Therapy.

PLEASE NOTE: Medicare has set a cap of $1,870 but services provided must be considered Medically Necessary by your insurance company for services to be covered and considered for payment.

Please Read:

- These quoted benefits are not a guarantee of payment.
- If you have a secondary or tertiary insurance we will forward the claims for payment as a courtesy to you. This does not guarantee that you will not be financially responsible for any amounts left unpaid by either insurance plan.
- You the patient are responsible for payment of services rendered if your insurance denies payment due to exceeding your Medicare cap limit. ***Exceeding your therapy cap may occur if you attend several facilities within the same year or if you attend therapy to many times within the same year.***
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that may lead to the denial of your claims.
- The patient is financially responsible for services rendered regardless of insurance coverage.

Please list your health insurance plans:

Primary _____ **Secondary** _____ **Tertiary** _____.

We highly recommend that you call your insurance to verify your Physical Therapy benefits.

Have you had any Physical Therapy or Speech Therapy this year? Yes No

If yes, how many visits? Staff Initial

By signing below you acknowledge having read this form in its entirety and fully understand your financial responsibilities as a patient.

_____.

Patient Name (Printed) Signature Date

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Patient Name_____ **Patient Date of Birth** _____

Consent for Care and Treatment

I give my consent for treatment by the staff at Premier Physical Therapy for physical therapy services and treatment considered medically necessary as prescribed by my physician.
I understand that it is my responsibility to immediately communicate any difficulties and concerns that I have regarding my therapy to the staff at Premier Physical Therapy.

Signature _____ Date _____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits be paid directly to **Premier Physical Therapy** for medical benefits to which I am entitled, including Medicare, private insurance and third party payers for services performed during the course of my treatment.
I authorize Premier Physical Therapy to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Physical Therapy staff.
Premier Physical Therapy will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other healthcare operations.

Signature_____ Date_____

Appointment/Cancellation Policy

Premier Physical Therapy requires that all appointments be cancelled and/or rescheduled within 24 hours of your schedule appointment time. If you cancel with less than 24 hours notice or fail to keep an appointment, you will be charged a $25.00 no-show/late cancellation fee which is due prior to your next scheduled appointment.

Financial Policy Statement

- We bill insurance carriers solely as a courtesy to the patient
- The patient is financially responsible for services rendered regardless of insurance coverage
- Payment is due at each visit and determined by your benefits
- If any payment is made directly to the patient for services billed by Premier Physical Therapy, the patient recognizes an obligation to promptly submit the same payment to Premier Physical Therapy
- It is the patient's responsibility to inform our staff if there is a change in insurance coverage and/or contact information to include address and contact phone numbers
- **If payment is made in the form of a check and the check is dishonored or returned for any reason there will be a processing fee of $40.00 per check plus the original amount of each check**

I have read and understand my responsibilities for the payment of my account.

Signature_____ Date_____

Premier Physical Therapy Witness_____ Date_____

- *Appointments are scheduled 1-2 weeks in advance. It is your responsibility to make sure appointments have been made.*

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PATIENTS RIGHTS AND RESPONSIBLIITIES

Patient rights and responsibilities were established with the expectation that observance of these rights will contribute to more effective patient care and greater satisfaction for the patient, family, physician, and facility caring for the patient. Patients shall have the following rights without regard to age, race, sex, national origin, religion, culture, physical handicap, personal values or belief systems.

The Patient Has The Right To:

- Receive the care necessary to help regain or maintain his or her maximum state of health and, if necessary cope with death.
- Expect personnel who care for the patient to be friendly, considerate, and respectful and qualified through education and experience and perform the services for which they are responsible with the highest quality of service.
- Expect full recognition of individuality, including privacy in treatment and care. In addition, all communications and records will be kept confidential.
- Complete information, to the extent known by the physician, regarding diagnosis, treatment and prognosis, as well as alternative treatments or procedures and the possible risks and side effects associated with treatment.
- Be fully informed of the scope of services available at the facility, provisions for after hours and emergency care and related fees for services rendered.
- Be a participant in decisions regarding the intensity and scope of treatment. If the patient is unable to participate in those decisions, the patient's designated representative or other legally designated person shall exercise the patient's rights.
- Refuse treatment to the extent permitted by law and be informed of the medical consequences of such refusal. The patient accepts responsibility for his or her actions should he or she refuse treatment or not follow the instructions of the physician or facility.
- Approve or refuse the release of medical records to any individual outside the facility, except in the case of transfer to another health facility, or as required by law or third party payment contract.
- Be informed of any human experimentation or other research/educational projects affecting his or her care or treatment and can refuse participation in such experimentation or research without compromise to the patient's usual care.
- Express grievances/complaints and suggestions at any time.
- Change primary or specialty physicians or dentist if other qualified physicians or dentists are available.
- Have and advance directive, such as a living will or healthcare proxy. A patient who has an advance directive must provide a copy to the facility and his or her physician so that his or her wishes may be known and honored. Surgery centers and diagnostic imaging centers may be exceptions to this statement and will have a facility-specific policy.
- Express those spiritual beliefs and cultural practices that do not harm others or interfere with the planned course of medical therapy for the patient.

The Patient Is Responsible For:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the facility.
- Reporting whether he or she clearly understands the planned course of treatment and what is expected of him or her.
- Keeping appointments and, when unable to do so for any reason, for notifying the facility and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in the patient's condition or any other patient health matters.
- Observing prescribed rules of the facility during his or her stay and treatment and, if instructions are not followed, forfeiting the right to care at the facility and being responsible for the outcome.
- Promptly fulfilling his/her financial obligations to the facility.

Signature:_____. **Date:**_____.

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Auto Accident Case and Worker Compensation Policy and Acknowledgement

Due to the lengthy nature of liability/compensation claims, our practice has had to devise a policy for the handling of these cases. We do not bill lawyers or other third parties.

THE FOLLOWING INFORMATION MUST BE PROVIDED PRIOR TO RECEIVING CARE:

- Claim Adjuster's Name
- Claim Number
- Billing address and billing contact phone number

Auto Accident Cases
If you carry PIP on your auto accident policy, we will bill your auto insurance company directly for our services. Your auto insurance company will pay your medical bills whether or not you are at fault. If you were the passenger in a vehicle, the driver's insurance policy will cover your medical bills. The driver's insurance company will pay your medical bills whether or not the driver was at fault. If you failed to carry PIP benefits on your policy at the time of the accident, we will either bill your health insurance or you will be required to self-pay for your visits.

Auto and Compensation Cases
We will bill your auto/compensation insurance directly and we expect to receive payments directly. Your lawyer or you should not receive payments for services provided by our facility. You should call your insurance company and ask that they pay our medical providers directly. If we do not receive payments from your insurance company within a reasonable amount of time (4-6 weeks), the bill for our services will be made your responsibility.

We appreciate your cooperation in dealing with the difficulties of billing for accident and compensation cases. We will try and help with any other questions you may have concerning billing for your physical therapy services.

Thank you from Premier Physical Therapy.

I understand the above information and agree that Premier Physical Therapy may bill my auto, compensation or health insurance. Furthermore, I agree to release all medical information from Premier Physical Therapy to my lawyer (address noted below).

Patient Signature: _____

Date: _____

Lawyer Information:

_____
_____
_____
_____