



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

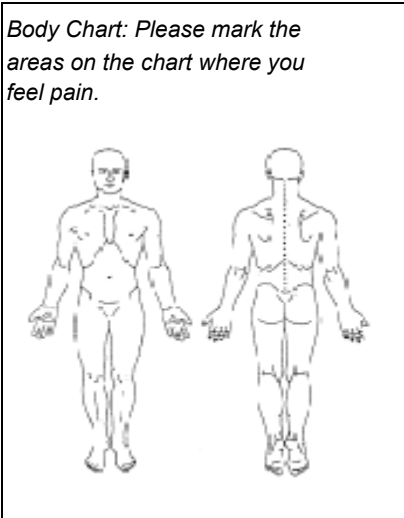
Date of Injury or onset of symptoms
How did your symptoms begin (gradually, suddenly, injury specifics)?

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)



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

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?

Table with 5 columns: Activity, Less than 30 min, 1-2 hours, 3-4 hours, No problems. Rows: Walking, Sitting, Standing.

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

- Physical Therapy, Occupational Therapy, Chiropractic Care, Surgery, Medications, Other

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

Do you have or have you had any of the following?

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

Are you Pregnant? Yes No

Do you smoke? Yes No

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

Premier REHAB

PATIENT NAME _____ Patient Date of Birth _____

Consent for Care and Treatment

I give my consent for treatment by the staff at PREMIER REHAB for physical therapy services and necessary 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 REHAB.

Signature _____ Date _____

Benefit Assignment/Release of Information

I hereby authorize assignment of my insurance benefits to be paid directly to **PREMIER REHAB** 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 Rehab to release all information necessary including medical records to secure payment for Physical Therapy services provided by Premier Rehab staff.

PREMIER REHAB will use and disclose your personal health information to treat you, to receive payment for the care we provide and for other healthcare operations. *Healthcare operations generally include those activities we perform to improve quality of care.*

Signature _____ Date _____

Appointment/Cancellation Policy

Premier Rehab requires that all appointments be cancelled and/or rescheduled within 24 hours of your scheduled appointment time. If you cancel with less than 24 hours notice or fail to keep an appointment, you will be charged a \$25 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 as determined by your benefits
- If any payment is made directly to the patient for services billed by PREMIER REHAB, the patient recognizes an obligation to promptly submit the same payment to PREMIER REHAB.
- It is the patients' 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 a 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 REHAB representative/witness _____ Date _____

- Appointments are scheduled 1-2 weeks in advance. It is your responsibility to make sure appointments have been made. Also please be sure to specify land or pool when making your appointments.



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

Your insurance company requires PREMIER REHAB 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:

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 Rehab to release and disclose all Medical History to:

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

I authorize Premier Rehab staff to leave any voice messages regarding appointments and or medical information when medically necessary to the following phone numbers (____) _____ - _____ and (____) _____ - _____

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

Patient Name (Printed) Signature Date



PATIENT RIGHTS AND RESPONSIBILITIES

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, 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 an 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.
- Be fully informed before any transfer to another facility or organization.
- 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 _____