



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

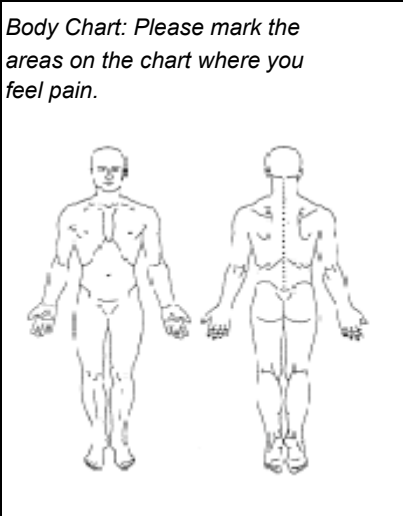
Date of Injury or onset of symptoms
How did your symptoms begin (gradually, suddenly, injury specifics)?

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?

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

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



## 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 of 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.
- 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.

X

Signature

Date

THANK YOU FOR CHOOSING



**Consent for Care and Treatment**

I the undersigned do hereby agree and give my consent for PREMIER REHAB to furnish medical care and treatment to \_\_\_\_\_ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**Benefit Assignment/Release of Information**

I hereby assign all medical benefits to which I am entitled, including Medicare, Medicaid, private insurance, and third party payers to PREMIER REHAB. I hereby authorize said assignee to release all information necessary including medical records to secure payment.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

**Financial Policy Statement**

We bill your insurance carrier solely as a courtesy for you. You are responsible for the entire bill when services are rendered. We require that arrangements for payment of your estimated share be made today. If any payment is made directly to you for your services billed by us, you recognize an obligation to promptly submit the same to PREMIER REHAB.

The above may not apply for those patients who are considered workers compensation. However, be advised if you claim workers compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

If you pay with a check and your check is dishonored or returned for any reason there will be a processing fee of \$40.00 per check plus the original amount of the check.

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.*

I understand my responsibilities for the payment of my account.

Patient/Guardian/Responsible Party \_\_\_\_\_ Date \_\_\_\_\_

PREMIER REHAB representative/witness \_\_\_\_\_ Date \_\_\_\_\_

**Please note**

***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.

**These are your benefits as quoted by your insurance plan to us by phone verification. Please note that these benefits are not a guarantee of benefits as specified by your insurance company. Your insurance will confirm benefits upon processing of claims submitted by Premier Rehab.**

**Please feel free to call your insurance company for more information.**

Co-payment \$ \_\_\_\_\_ at **EACH VISIT** Co-percentage \_\_\_\_\_ % per visit  
Deductible Amount \$ \_\_\_\_\_ Amount Met \$ \_\_\_\_\_  
Out of pocket maximum \$ \_\_\_\_\_  
( the amount we collect at each visit will be applied to your co-percentage responsibility)

**Please read and initial**

Maximum visits/days \_\_\_\_\_ per person/condition/year/lifetime \_\_\_\_\_

Maximum dollar amount \$ \_\_\_\_\_ (If no limit services must be medically necessary)

**PLEASE NOTE:** Visit limitations set by your insurance company are not a guarantee of benefits.

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

*Exceeding your limitations may occur if you attend several facilities within the same year or if you attend therapy more than the allowed amount, both are determined by your insurance plan once your claims are processed.*

- You the patient are responsible for payment of services if your insurance denies payment due to exceeding your allowed visits and or dollar amount limit. **Initial** \_\_\_\_\_
- You the patient are responsible for payment of services if you fail to respond to insurance requests for additional information that lead to the denial of your claims. **Initial** \_\_\_\_\_

Patient Name (Printed)	Signature	Date
*****		

Due to the importance of scheduled appointments we ask that you call our office to cancel appointments with at least 24 hours notice.

**Unfortunately due to the large amount of cancels and no-shows there is a \$25 fee that will be charged to you if you fail to give us at least 24 hours notice to cancel your appointment(s).**

We are *not* able to bill this to your insurance therefore it will be your responsibility.  
This charge will be due prior to your next scheduled appointment.

- This charge applies to the following appointments.**
- **Appointments scheduled at either 4:00pm, 5:00pm or 6:00pm**
  - **Any pool appointments**

I have read and understand that I am subject to a \$25 fee if I fail to give 24-hours notice to cancel or reschedule my appointment if I am scheduled

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Signature	Date
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