FISCHER PHYSICAL THERAPY

For staff use only:
Height:in
Weight:lb
Gait Speed:sec

Patient Intake Questionnaire

Name _____
Date _____

1. How did you hear about Fischer Physical Therapy? (circle one) Physician Friend Yellow Pages Newspaper
2. Is an attorney involved with this case? No_____ Yes, please list attorney name and phone number_____

GENERAL HEALTH STATUS

3. At the present time, would you say that your health is excellent, very good, fair, or poor?_____
4. Please rate your average level of stress (circle) Low Moderate High Very High
5. Have you had any major life changes during the past year? No_____ Yes, please explain_____
6. Have you sought PT in the last 12 months? No_____ Yes_____

SOCIAL/HEALTH HABITS

7. How many glasses of water do you drink per day? _____
8. Do you take any prescription **or** nonprescription medications? No _____ Yes, please list _____

_____

9. Do you take supplements? No _____ Yes, please list _____

_____

CURRENT CONDITION/CHIEF COMPLAINT(S)

10. What is your pain level *today*?

(low) 1 2 3 4 5 6 7 8 9 10 (high)

11. What is your pain level *on average*?

(low) 1 2 3 4 5 6 7 8 9 10 (high)

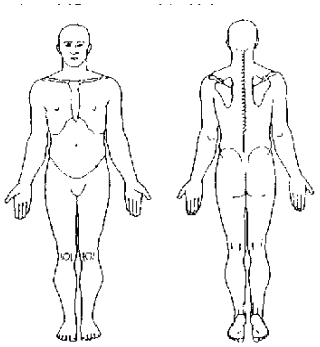
12. Please describe the problem(s) for which you seek physical therapy _____

_____

13. What makes the problem(s) better?_____
14. What makes the problem(s) worse? _____
15. What are your goals for physical therapy?_____

_____

Please mark the location of your symptoms on the diagram below.



16. Please check if you have ever had the following:

- ❑ Arthritis
- ❑ Broken bones/fractures
- ❑ Seizures/epilepsy
- ❑ Osteoporosis
- ❑ Neurological disorder (MS, ALS)
- ❑ Cancer
- ❑ Ulcers/stomach problems
- ❑ Depression or anxiety
- ❑ Circulation/Vascular problems
- ❑ Heart problems
- ❑ High blood pressure
- ❑ Lung problems
- ❑ Thyroid problems
- ❑ Diabetes or low blood sugar
- ❑ Head injury
- ❑ Infectious disease (TB, hepatitis)
- ❑ Joint pain or swelling
- ❑ Pain at night
- ❑ Headaches
- ❑ Weakness in arms or legs
- ❑ Loss of balance
- ❑ Difficulty walking
- ❑ Difficulty sleeping
- ❑ Chest pain
- ❑ Bowel or bladder problems
- ❑ Shortness of breath
- ❑ Dizziness or blackouts
- ❑ Weight loss or gain
- ❑ Cough
- ❑ Hearing problems
- ❑ Traumatic Event(s)
- ❑ Other_____

For Men:

- ❑ Prostate disease

For Women:

- ❑ Pelvic or reproductive problems or disease

Are you or could you be pregnant? No___ Yes___

MEDICAL/SURGICAL HISTORY

17. Have you ever had surgery? _____ No _____ Yes See attached □

If yes, please describe, including dates _____

PATIENT INFORMATION

NAME: Last First M.I.

ADDRESS:

CITY: STATE: ZIP:

PHONE: Home Work Cell

E-MAIL:

SEX: M F MARITAL STATUS: (circle) Married Single Widowed

EMPLOYER/OCCUPATION: /

DATE OF BIRTH:

REFERRING PHYSICIAN:

PRIMARY CARE PHYSICIAN:

EMERGENCY CONTACT/PHONE: /

SPOUSE NAME:

SPOUSE EMPLOYER/WORK PHONE: /

RESPONSIBLE PARTY INFORMATION

RELATION TO PATIENT: (circle) Self Spouse Parent Other

NAME: Last First M.I. DATE OF BIRTH:

ADDRESS:

PHONE: Home Work

EMPLOYER:

EMPLOYER ADDRESS:

INSURANCE INFORMATION (please omit if insurance card is on file or a copy has been made)

PRIMARY INSURANCE NAME: _____

Policy Group Name: _____ Policy Group #: _____

Policy ID #: _____

SECONDARY INSURANCE NAME: _____

Policy Group Name: _____Policy Group #: _____

Policy ID #: _____

FINANCIAL AGREEMENT

Welcome to Fischer Physical Therapy. We hope to make your healing process with us a successful and comfortable one.

Billing

As a courtesy, we will be assisting with the task of processing insurance claims. However, **it should be understood that it is your responsibility to pay for any amounts not covered by your insurance company.** We can work with you in setting up a payment schedule if necessary.

We appreciate payment of your **co-pay** portion at the time of the visit in order to keep our record keeping as accurate and current as possible. We will provide you with a monthly statement showing the amount of adjustments and payments made by you and your insurance company and any outstanding balance due.

Worker's Compensation and Motor Vehicle Accident Claims

If we are billing an insurance company for a worker's compensation claim, or motor vehicle accident, we request all information be supplied to us prior to your first appointment so we can assure authorization. In the event your claim is denied, we require your personal information for our files.

Past Due Accounts

A 15% interest rate will apply to all accounts 60 days past due. In the event an account becomes more than 90 days past due, with no indication of a payment plan, we will turn the account over to a collection agency and/or pursue small claims court. If legal action is necessary to resolve any outstanding account balances, any legal fees we pay will be added to your account and future treatment at Fischer Physical Therapy will be terminated.

_____ (Please initial)

Cancellation Policy

We reserve your appointment time exclusively for you to best meet your schedule and ours. Therefore, we require a 24-hour notice for non-emergency cancellations. Failure to provide a 24-hour notice of cancellation may result in a $20 or $30 no-show fee. These charges cannot be billed to your insurance company so these charges will become your responsibility. *In the event of two no-shows or frequent cancellations, the physical therapist has the right to terminate all future sessions.*

_____ (Please initial)

If you have any questions, please don't hesitate to ask. We look forward to providing you with a positive, caring atmosphere to facilitate your healing and physical restoration.

I have read and understand this letter and agree to the terms stated above.

Signature:_____ Date: _____

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS

I consent to the use or disclosure of my protected health information by Fischer Physical Therapy, PC, for the purpose of providing treatment to me, obtaining payment for my health care bills, or to conduct health care operations of Fischer Physical Therapy, PC. I understand that treatment of me by my physical therapist may be conditioned upon my consent as evidenced by my signature on this document.

I understand that I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment, or other healthcare operations of the facility. Fischer Physical Therapy is not required to agree to the restrictions that I may request. However, if Fischer Physical Therapy agrees to a restriction that I request, the restriction is binding on Fischer Physical Therapy and my physical therapist.

I have the right to revoke this consent, in writing, at any time, except to the extent that my physical therapist and Fischer Physical Therapy has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physical therapist, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Fischer Physical Therapy's Notice of Privacy Practices prior to signing this document. The Fischer Physical Therapy Notice of Privacy Practices has been made available to me for review. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of health care operations of Fischer Physical Therapy. The Notice of Privacy Practices for Fischer Physical Therapy is provided to each new patient and is also available in the waiting room area. This Notice of Privacy Practices also describes my rights and Fischer Physical Therapy's duties with respect to my protected health care information.

Fischer Physical Therapy reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

Signature of Patient_____ Date: _____
(or Personal Representative)

Name of Patient: (please print) _____

For our Medicare Patients:

As of January 1, 2018, Medicare has implemented an outpatient rehabilitation cap of $2010.00 per beneficiary for the year. This cap covers any and all physical therapy services and speech-language pathology services you receive during the year. Medicare patients are also responsible for a $183.00 deductible.

New Medicare guidelines also dictate that patients no longer need a physician's referral for physical therapy. However, it is recommended that you have a primary care physician with whom you have recently discussed your current status so that this physician will be able to review and sign your physical therapy plan of care. This being the case, the policy of Fischer Physical Therapy is as follows:

Generally, you will be seen for up to 30 days. Following the initial evaluation, the physical therapist will write a Medicare Plan of Care indicating the problems, goals, and the frequency of which a patient will be seen and send it to your primary care physician for signature/approval. While waiting for this signature, you may continue physical therapy and Medicare will be responsible for their part of the bill. If the plan of care is not signed, we will discontinue care. Medicare will still be responsible for their part of the bill for all previous visits. By the end of the 30 days another assessment will be completed to determine discharge of plans to a home program or further skilled care, with this information provided to your physician.

Signature: _____ Date: _____