COMMERCIAL INSURANCE AND SELF PAY INFORMATION FORM

***All** Patients or Patients' Legal Representative, please complete all Sections*

(1) Patient: (Full Legal Name or as on Insurance Card)

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _______-_________ (_____) _______-_________ (_____) _______-_________ (_____) _______-_________
Home Mobile Work Emergency

(2) Patient

Sex: M F

Birth date: _____/_____/______

Social Security # ______/______/_______

Legal Photo ID # _______________________

Please Circle One: Married, Single, Other

(Driver's License or Other State/Federal Photo ID)

(3) Payor Information:

Primary Insurance Company:

Ins. Co. Name: ____________________________________

Policy/Plan #: ______________ _________________

Group #: _____________________________________

Secondary/Supplemental Insurance Company:

Ins. Co. Name: ____________________________________

Policy/Plan #:____________________________________

Group #: ______________________________________

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(4) Payment Authorization: *(Initials required for all 5 statements)*

__________ **Assignment of Insurance Benefits**

Initials

I authorize that the payment of my insurance benefits be made directly to TheraSpecialists, Inc for all services delivered; if I am paid directly I will promptly pay TheraSpecialists, Inc all monies paid to me.

__________ **Guarantee of Payment**

Initials

I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility' by my insurer by the statement due date.

__________ **Certification of Information**

Initials

I certify that the information I have provided TheraSpecialists, Inc for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

__________ **Medical Records Release**

Initials

I authorize the release of medical information necessary to request reimbursement from my insurance company (s). This authorization will remain in effect until revoked by me in writing.

__________ **Treatment Consent**

Initials

I hereby give consent for physical therapy to be administered to me or minor patient by persons in this office in acceptable, professional standards.

(5) Signature/ Date:

____ ____________________

Patient or Legal Representative's Signature **Today's Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below indicates that I have been given the Notice of Privacy Practices for TheraSpecialists, Inc. I recognize that outside of purposes for treatment, for payment, for certain healthcare operations or as permitted or required by law I must give my written authorization to TheraSpecialists to release any of my protected healthcare information.

____
Printed Name of Patient or Authorized Representative

____
Signature of Patient or Authorized Representative

____
Date

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24 HOUR APPOINTMENT CANCELLATION POLICY

TheraSpecialists, Inc. has a 24 hour cancellation / rescheduling policy

If you miss your appointment, cancel or change your appointment with less than 24 hours notice you will be subject to a $20 charge.

This policy is in place out of respect for our physical therapists and our patients. Cancellations with less than 24 hours notice are difficult to fill. By giving last minute notice or no notice at all you prevent someone else from being able to schedule in that time slot.

By signing & dating below, you acknowledge that you have read and understand the 24 Hour Cancellation Policy for TheraSpecialists, Inc.

Thank you for your understanding and cooperation.

____________________________ __________________
Signature Date

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HEALTH QUESTIONNAIRE

Print Your Name:____**Age**____________

Please circle : Are you right-handed or left-handed?
Please circle: English understood/ Interpreter needed/ Language you speak most often?_________________________
Highest grade completed (*circle one*) 1 2 3 4 5 6 7 8 9 10 11 12 some college / college graduate / graduate school / advanced degree

CURRENT CONDITION(S) / CHIEF COMPLAINT(S)

Describe the problem for which you seek physical therapy:____

____

Is the current problem the result of (*please circle*): **Work Accident / Auto Accident / Other Accident / Unknown / Other**

When did the problem(s) begin (Date)?____

What happened?____

Have you ever had the problem(s) before? YES or NO If yes, what did you do for the problem (s)? ___________________________

____

Did the problem(s) get better? YES or NO

How are you taking care of the problem(s) now?____

What makes the problem(s) better?____

What makes the problem(s) worse? ____

What are your goals for physical therapy? ____

Name of Doctor prescribing physical therapy?__________________________________ Date of next MD appt?__________________

Have you had Physical Therapy or are you seeing anyone else for the problem(s)? (chiropractor, etc):__________________________

Are you currently receiving **HOME HEALTH**? Or have you had **HOME HEALTH** recently? Yes or No ________
(is any healthcare worker, nurse or aide or provider coming to your home?) If Yes, Whom?________________________________

CLINICAL TESTS have you had any of the following test(s) recently? *Please circle all that apply*

Arthroscopy	X-rays	Stress test (treadmill, bicycle)
NCV (nerve conduction velocity)	Doppler Ultrasound	Myelogram
EKG (electrocardiogram)	Bone Scan	MRI
EMG (electromyogram)	CT Scan	Other ___________________

MEDICATIONS:
Separate list Provided? YES or NO If NO please list ALL medications with dosage & frequency below
this includes prescription, over the counter drugs, herbal and nutritional supplements you take routinely and/or on an as needed basis.

Medication /Drug Name	Dosage	Number of Times per Day & Route

MEDICAL/SURGICAL HISTORY *please circle if you have ever had or currently have-*

PACEMAKER/DEFIBRILLATOR		Lung problems	Parkinson disease
Broken bones/fractures	Stroke	Seizures/epilepsy	Skin diseases
Osteoporosis	Diabetes/high blood sugar	Developmental/growth problems	Depression
Arthritis	Low blood sugar/hypoglycemia	Thyroid problems	Cancer
Circulation/vascular problems	Blood disorders	Infectious disease (eg.TB,hepatitis)	Head injury
Heart problems	Multiple Sclerosis	Kidney problems	Ulcer/stomach problems
High blood pressure	Muscular dystrophy	Repeated infections	Other _________

Within the past year, have you had any of the following symptoms?
Please circle all that apply

Chest pain	Coordination problems	Difficulty sleeping	Urinary problems
Heart palpitations	Weakness in arms or legs	Loss of appetite	Fever/chills/sweats
Cough	Loss of balance / Falls	Nausea/vomiting	Headaches
Hoarseness	Difficulty walking	Difficulty swallowing	Hearing problems
Shortness of breath	Joint pain or swelling	Bowel problems	Vision problems
Dizziness or blackouts	Pain at night	Weight loss/gain	Other_________________

Have you ever had surgery? If yes, please describe and include dates:____

____

Do you have any known allergies? *Please circle* Yes or No, *If Yes please list*:____

For women only-Are you pregnant or think you might be? *Please circle* Yes or No

GENERAL HEALTH STATUS

Please rate your health by *circling one answer*: Excellent / Good / Fair / Poor
Have you had any major life changes during the past year? (eg. new baby, job change, death of a family member)_________________

HEALTH HABITS

Do you currently use tobacco products? *Please circle* Yes or No
If yes what type and how much per day?____

FUNCTIONAL STATUS/ACTIVITY LEVEL *Please check all that apply*

___Difficulty with locomotion/movement
___Difficulty with self-care (such as bathing, dressing, eating, toileting)
___Difficulty with home management (such as household chores, shopping, driving/transportation, care of dependants
___Difficulty with community and work activities
___work/school ___recreation or play activity

Do you exercise beyond your normal daily activities and chores? *Please circle* Yes or No
If yes describe the exercise____
On average, how many days per week do you exercise or do physical activity?_____________
For how many minutes, on an average day?________________

SOCIAL HISTORY

With whom do you live? ___________________________Where do you live? (eg home, assisted living)________________________
Does your home have: *please circle*

Stairs, no railing	Ramps	Uneven terrain	Any obstacles________________________
Stairs, railing	Elevators	Assistive devices________________	

Do you use: *please circle*

Cane	Manual wheelchair	Crutches	Glasses	Other:
Walker	Motorized wheelchair	Hearing aids	Contacts	_______________

Employment: *please circle*

Working full-time outside the home	Working part-time outside the home	Homemaker	Retired
Working full-time from home	Working part-time from home	Student	Unemployed

Occupation (description of type of work you perform)____

Signature of Patient or Legal Representative____ **Date**_________________

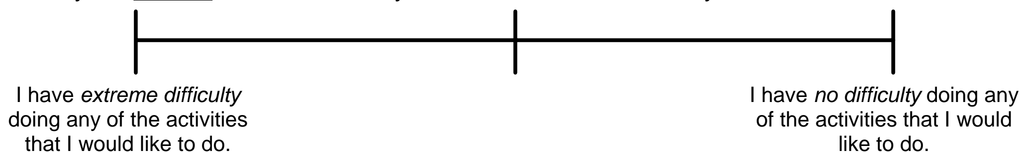
(For office use only: reviewed &verified by PT ____ *Date*_________________

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	**Able to do without any difficulty**	**Able to do with little difficulty**	**Able to do with moderate difficulty**	**Able to do with much difficulty**	**Unable to do**	**Not applicable**
1. Lying flat	1	2	3	4	5	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about *all* of the activities you would like to do, please mark an "X" at the point on the line that best describes your *overall* level of difficulty with these activities today.



I have *extreme difficulty* doing any of the activities that I would like to do.

I have *no difficulty* doing any of the activities that I would like to do.

23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: *1. 12 2. 8 3. 13)*

1.____ 2.____ 3.____

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