

Medicare Patient & Payor 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, Passport, Other State/Federal Photo ID)

| | |
|-------------------------------------|---|
| Primary Insurance Company: Medicare | Secondary/Supplemental Insurance Company: |
| Patient ID# | Ins. Co. Name: |
| Regular Medicare: Yes No | Policy ID #: |
| Rail Road Medicare: Yes No | Group #: |

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

Initials **Assignment of Insurance Benefits**
I authorize that the payment of my insurance benefits be made directly to TheraSpecialists, Inc for any services that by Medicare or my any other insurance company, if I have one.

Initials **Guarantee of Payment**
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 the billing statement due date.

Initials **Certification of Information**
I certify that the information I have provided TheraSpecialists, Inc for payment under the Social Security Act. (Medicare) including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

Initials **Medical Records Release**
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.

Initials **Treatment Consent**
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) _____
Patient or Legal Representative's Signature **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

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

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

Broken bones/fractures

Osteoporosis

Arthritis

Circulation/vascular problems

Heart problems

High blood pressure

Within the past year, have you had any of the following symptoms?

Please circle all that apply

Chest pain

Heart palpitations

Cough

Hoarseness

Shortness of breath

Dizziness or blackouts

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

Stroke

Diabetes/high blood sugar

Low blood sugar/hypoglycemia

Blood disorders

Multiple Sclerosis

Muscular dystrophy

Coordination problems

Weakness in arms or legs

Loss of balance / Falls

Difficulty walking

Joint pain or swelling

Pain at night

Lung problems

Seizures/epilepsy

Developmental/growth problems

Thyroid problems

Infectious disease (eg.TB,hepatitis)

Kidney problems

Repeated infections

Difficulty sleeping

Loss of appetite

Nausea/vomiting

Difficulty swallowing

Bowel problems

Weight loss/gain

Parkinson disease

Skin diseases

Depression

Cancer

Head injury

Ulcer/stomach problems

Other _____

Urinary problems

Fever/chills/sweats

Headaches

Hearing problems

Vision problems

Other _____

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** _____

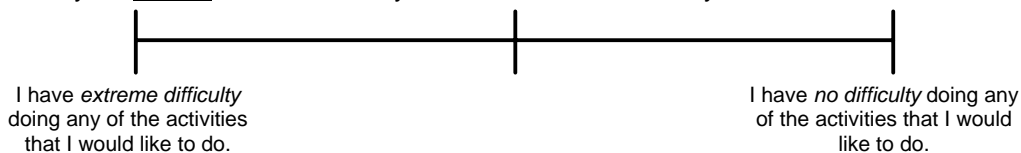
(For office use only: reviewed & verified by PT _____ *Date* _____

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.



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. ____