NEW EVALUATION HEALTH QUESTIONNAIRE

Date: ______________

Name: ___________________________ **DOB:** ___ / ___ / ____ **SS#** ______ - ___ - ______

Home Phone # (   ) ____-______ **Cell # (   )** _____-______ **Work# (   )** _____-______

Street: ______________________________ **City**______________ **State** ___ **Zip** ______

Email Address: (Please print neatly) ____

Do we have permission to contact you by email? Yes ____ **No** ____ Your email is for internal use only and will not be sold to third parties.

Occupation: ______________________ **Referring Physician:** ______________________

Emergency Contact's PH# (   ) _____-_______ **Relationship:** ____________________

Insurance Cardholder's Name: ____________________________ **DOB:** ___ / ___ / ____

Have you ever had or been told you had any of the following: (Check if yes)

___ Cardiovascular Disease
___ High Blood Pressure
___ Respiratory Disease
___ Cancer
___ Pelvic Floor Dysfunction (incontinence/pain)
___ Unexplained weight loss
___ Diabetes: Type I or Type II
___ Other: ___________________________
___ Gastrointestinal Disease
___ Neurological Disorder
___ Rheumatoid arthritis
___ Depression
___ Osteoarthritis
___ Allergies
___ Kidney Disease

Explain if yes:

____

____

List all hospitalizations: Operations, serious illness, injuries, etc.

____

____

Your present weight: __________ **Height:** ________

Are you pregnant? ______ **Do you currently have any illnesses?** _______

Please describe your activity level prior to this injury/condition:

____

____

List all your current medications: Prescription, over the counter, vitamin & herbal.

NAME	**DOSE**	**FREQUENCY**

What is your reason for seeking therapy at this present time?

____

____

What type of diagnostic testing have you had for this condition? Examples: x-rays, MRI, etc

____

____

____

Have you ever had therapy in the past for this injury/condition? If so, when?

____

____

Please rate your level of pain on a 0-10 scale.

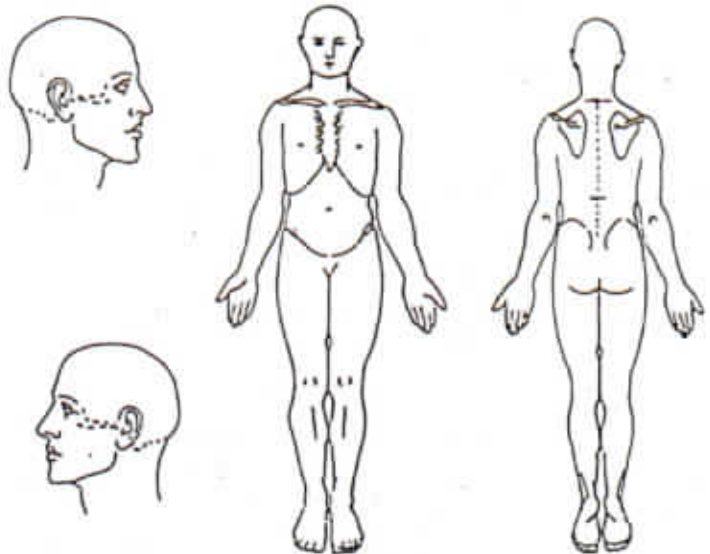
Rate your pain:

At worst: _______

At best: _______

Current: _______

Mark areas of pain on body diagram.



I certify that the above information is true and accurate to the best of my knowledge.

Signature: ______________________________ **Date:** ____________

141 HAMPTON CIRCLE
ROCHESTER HILLS, MI 48307
(248) 853-7555

BLUE CROSS BLUE SHIELD

We **accept** assignment from Blue Cross, but the insurance checks **may be made out to you and sent to you.** When you receive these checks in the mail, please bring them in along with the Explanation of Benefits (we will make a copy of the paperwork and return the original to you). You should receive the first check approximately 3-4 weeks after your first visit and then one a week until your final visit has been paid. After you have been discharged, please mail us the remaining checks along with a copy of the Explanation of Benefits.

Please sign at the bottom of this page to insure that you have been informed of this policy. Thank you for your cooperation in this very important matter.

SIGNATURE: ______________________________ **DATE:** ____________

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NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties and your rights concerning your health information. Before we begin any healthcare treatment we must require you to read and sign this consent form stating that you understand and agree with how your records will be used.

1. The patient understands and agrees to allow this physical therapy office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations and coordination of care. As an example, the patient agrees to allow this physical therapy office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for purpose of payment. Be assured that this office with limit the release of all PHI to the minimum needed for what the insurance companies require for payment.

2. We may use or disclose your health information to your attending and referring physician.

3. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.

4. Patients have the right to receive a copy of their health record in electronic format if records are stored in electronic format. The request will be processed within 30 days with a one times 30 day extension if required.

5. A patient's written consent need only be obtained one time for all subsequent care given in this office.

6. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for any care given prior to the request to revoke consent, but would apply for any treatment given after the request has been received.

7. As stated in #3 we must disclose your health information to you. We may also disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or payment for your healthcare, but only if you agree that we may do so.

8. Patients 18 years and older will be considered as an adult and will be responsible for making their own decisions.

9. We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages or letters.

10. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.

11. The patient has the right to request that information not be sent to their health plan when the patient is paying out of pocket in full for the service(s) performed.

12. Patients have the right to file a formal complaint with our privacy official about any possible violation of these policies and procedures.

13. If the patient refused to sign this consent for the purpose of treatment, payment and healthcare operations, the physical therapist has the right to refuse treatment.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

SIGNATURE: ______________________________ **DATE:** ____________

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To Our Patients Regarding

Cancellations and No-Shows

- The following are our policies regarding cancellations and no-shows. We take this subject very seriously at the clinic, because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or your therapist have prescribed a set frequency treatment. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow your therapist's instructions and we will be able to help you to achieve your goals in treatment.

- We require 24 hours' notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get in the full prescribed number of treatments that week whenever possible. (In some cases, this may not work since some forms of treatment do not work well if given two sequential days.)

- There is a $25.00 charge for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.

- For Worker's Compensation and Personal Injury patients documentation of any missed appointments is forwarded to your Case Manager and Primary Physician and this could jeopardize your claim.

- You may need to see a therapist other than the one who normally treats you if you do re-arrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands. You will return to your original therapist in the next regularly scheduled visit.

- Please understand that your pain will probably increase and decrease as your course of treatment progresses and before it is finally erased. Either condition can seem to be a reason not to come in: a) you're feeling worse and think the treatment is not working or, b) you're feeling better and it's a great day for wind-surfing. Neither of these conditions is legitimate as a reason not to come: a) if you're in pain, come in and get it fixed, b) if you're out of pain, now is the time that we can begin doing some real correction of the underlying causes of your problem and educate you so you won't re-injure yourself, etc.

When you don't show as scheduled, three people are hurt; You, because you don't get the treatment you need as prescribed by the doctor and/or PT; the therapist, who now has a space in their schedule since the time was reserved for you personally; and another patient who could have been scheduled for treatment if you had given proper notice.

Please co-operate with us in this regard. We're looking forward to working with you.

SIGNATURE: ____ **DATE:** ____________

INTERVIEWER SIGNATURE: ___________________________ **DATE:** ____________

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PAYMENT PROVISIONS AUTHORIZATION

The term "healthcare benefits" in the following paragraphs means Medicare, Medicaid, maternal and infant health benefits, BCBS, commercial health insurance benefits, health maintenance organization, preferred provider organization, or managed care plan coverage, as applicable.

I request payment on my/the patient's behalf of all health care-benefits for services provided by Neil King PT.

I assign and transfer to Neil King PT all health care benefits applicable to my/the patient's care. I authorize and direct that all such health care benefits be paid directly to Neil King PT.

I understand that my insurance benefits were verified with my insurance company at the beginning of my treatment, and the deductible amount may change based on what was verified. I am also aware that during my treatment my deductible may reset and my account will be adjusted accordingly, and I will be responsible for any and all charges that may occur.

I understand that while I am being treated by Neil King Physical Therapy, it is my responsibility to notify them of any changes in my insurance coverage. Any additional charges (deductible, co-pay, etc.) will be the patient's responsibility. If a new insurance requires pre-authorization & patient doesn't notify us, then the patient will be responsible for all the therapy sessions rejected by the insurance company.

I agree personally to pay for any physical therapy charges not covered by or collected from any applicable health care benefit program, including any deductibles and coinsurance amounts.

I certify that I have read this for and that I understand it and consent to it. If the signer is not the patient, the signer certifies that he is the patient's duly authorized representative.

SIGNATURE: ______________________________ **DATE:** ____________

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ATTENTION MEDICARE PATIENTS

If you are receiving **HOME HEALTHCARE** for any reason you must notify our office at the time of your evaluation.

If for any reason you fail to notify us charges for Physical Therapy are not covered then you will be held responsible for payment.

I certify that I have read this form and that I understand it and consent to it. If the signer is not the patient, then the signer certifies that he is the patient's duly authorized representative.

SIGNATURE: ________________________________ **DATE:** ____________