Circuit Physical Therapy

2210 Robb Street
Trinity TX 75862

Tel / Fax: 936.594.9224
Cell: 318.243.9196 | 318.243.9319

PATIENT INTAKE QUESTIONNAIRE FOR REHABILITATION CLINIC

Name: ____
(First) *(Last)*

Why are you seeking therapy? ____

____

____

Describe your injury. How and When it started? ____

____

____

Employment: ☐ Full Time ☐ Part Time ☐ Student ☐ Retire ☐ Disabled ☐ Other ________

Occupation: ________________ Employer: ________________ Length of Employment: ________

Are you currently working? ☐ Yes ☐ No

HOME STATUS / FUNCTIONAL LEVEL:

Live with ☐ Alone ☐ Spouse / Partner ☐ Family ________ ☐ Friends ☐ Other ________

Home ☐ 1-story with/without basement ☐ 2-story home with/without basement

☐ Apartment with/without elevator ☐ Mobile home ☐ Other ________

Maximum number of stairs to walk at any one time in home ____ Are there any handrails? ☐ Yes ☐ No

HEALTH HISTORY

Currently receiving any home health services: ☐ Yes ☐ No

Previous therapy for this injury or ailment: ☐ Yes ☐ No If yes, how many visits? _______ When? ______

Number of falls in the last month: ________________ In the last year? ________________

Do you? Smoke ☐ Yes ☐ No if yes, how much ________________

Drink Alcohol ☐ Yes ☐ No if yes, how much ________________

Caffeine ☐ Yes ☐ No if yes, how much ________________

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Check each condition that relates to you:

- ☐ Pacemaker/Defibrillator
- ☐ Heart Disease/Attack
- ☐ Skin Disease
- ☐ Circulation Problems
- ☐ Osteoporosis/Osteopenia
- ☐ Stomach Disorders
- ☐ HIV (+)
- ☐ Blood Clots
- ☐ Arthritis (OA, RA)
- ☐ Liver Disorder
- ☐ Mental Health Issues
- ☐ Metal Implants ______
- ☐ Bleeding tendencies
- ☐ Kidney Disease
- ☐ Lung Disease/Asthma
- ☐ Stroke
- ☐ Cancer (____________)
- ☐ Bowel/Bladder Issue
- ☐ Seizure Disorder
- ☐ Pregnant (#of Mos) ______
- ☐ High Blood Pressure
- ☐ Thyroid Disease
- ☐ Unexplained weight
- ☐ Neurological Disorder
- ☐ Diabetes (Type __________)
- ☐ Allergies ___________________
- ☐ Unexpected weight gain/loss
- ☐ Frequent Nausea / Vomiting
- ☐ Tape / Latex Allergy
- ☐ Other: ______________________

ADAPTIVE / ASSISTIVE EQUIPMENT OWNED

None	Crutches	Wheeled walker	Transfer tub bench	Bedside Commode	Hospital Bed
Cane	Walker	Wheelchair	Grab bars	Lift Chair	Other ______________

List any surgeries that may be associated with your condition (include date):

____

____

List all current medications including over the counter types (If you have a list, we will photocopy it)

____

____

How frequently are you using pain medications for this condition?

Every 3-4hours   Daily   Weekly   Intermittently / As needed   Do Not Use

What are you using for pain? ____

Rate your pain on a scale of 0-10 (0=No Pain, 10=Worst Pain)

Area/s of Pain   Current ______________ At Best ______________ At Worst ______________

____

____

____

____

Are your symptoms getting? ☐ Better ☐ Worse

Are your symptoms generally? (Check box and circle word)

- ☐ Better / Worse in the morning
- ☐ Better / Worse in the afternoon
- ☐ Better/Worse While Sleeping
- ☐ Better then worsens as the day goes on

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Area/s of Numbness/Tingling

____
____
____
____

Pain Behavior:
- ☐ Constant
- ☐ Intermittent
- ☐ Dull
- ☐ Burning
- ☐ Stabbing
- ☐ Throbbing
- ☐ Aching
- ☐ Sharp
- ☐ Radiating ______________

Have you had any of the following for this condition? If yes, state results

None		CT scan	______	EMG	______
X-ray	______	Bone scan	______	Diagnostic / Arthroscopy	______
MRI	______	Arthrogram	______	Doppler/Ultrasound	______

Previous treatment(s) for this condition: Check all that apply. (Circle helpful treatments)

- ☐ None
- ☐ Massage Therapy
- ☐ TENS Unit
- ☐ Bracing
- ☐ Medication:
- ☐ Exercise
- ☐ Traction
- ☐ Pain Clinic
- ☐ PT/OT
- ☐ Injections
- ☐ Surgery
- ☐ Other ______________
- ☐ Chiropractic
- ☐ Acupuncture
- ☐ Splinting / Taping

Functional Limitations: Place a check to each activity that causes you pain or difficulty.

- ☐ Sitting
- ☐ Laying on back / side / stomach
- ☐ Putting on socks / shoes
- ☐ Reaching to floor
- ☐ Standing
- ☐ Bathing Tasks
- ☐ Going Up / Down stairs
- ☐ Lifting to waist level
- ☐ Walking
- ☐ Grooming Tasks
- ☐ Open / Close Doors
- ☐ Reaching Overhead
- ☐ Sleeping
- ☐ Dressing Tasks
- ☐ Carrying items while walking ______________

What are your goals for therapy? ______________________________

____
____
____

PLEASE RETURN TO THE FRONT DESK WHEN COMPLETED. THANK YOU

PATIENT EMERGENCY CONTACT SHEET

Name: ____

(First) (Last)

Relationship: ___________________________ Phone Number:___________________________

Address: ____

(Apt./ Street)

____

(City) (State) (Zip Code)

Name: ____

(First) (Last)

Relationship: ____

Address: ____

(Apt./ Street)

____

(City) (State) (Zip Code)

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Patient Statement of Financial Responsibility

1. Appointment Attendance Agreement: I understand the importance of attending therapy consistently and arriving promptly for my appointment. I acknowledge that I may be rescheduled if I arrive more than 15-minute late for my scheduled appointment. I understand the importance of scheduling appointments in advance and acknowledge that appointment times given one week do not automatically follow through the subsequent weeks. I agree to provide at least a 24-hour notice when I need to cancel an appointment.
   _______ (Initial)

2. Financial Policy: A medical insurance policy is a contract between you and your insurance company. Coverage depends on your insurance company and the specific plan you have chosen. CIRCUIT PHYSICAL THERAPY is contracted with major insurance companies and as service to our patients, we agree to submit your claims directly to them. We need a copy of your insurance card and a current physician's prescription/referral for your therapy services for us to submit your claim. Any questions you have regarding insurance coverage or benefits should be directed to your insurance plan. _______ (Initial)

   All patients cost shares (co-payments, co-insurances and deductibles) are due at the time of the treatment. For patients with co-insurance and deductibles, we will be asking for a good-faith payment. A good-faith payment is an estimate of what you will owe. Once the insurance carrier adjudicates the claim, we may have to bill the remaining balance. ________(Initial)

   Medicare Patients: You must be discharged from any home health services or agency prior to initiating outpatient therapy as Medicare will not pay for both home health and outpatient care simultaneously. _______(Initial)

   Cash-Pay Policy: We offer a prompt pay rate for services paid in full at the time of treatment. This discount is based on the administrative savings to our practice when receiving payments up front, rather than billing for services. We will not bill your insurance company for services under this agreement. No forms will be produced now or in the future for you to submit claims for insurance billing. _____(Initial)

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Rebilling Policy: It is the patient's responsibility to provide us with correct billing information. If correct billing information is provided, but it is after the timely deadlines of the Payer, then you will be responsible for the bill. ______(Initial)

3. Insurance Benefits: As a courtesy, Circuit Physical Therapy will attempt to verify the patient's benefits, file the claims for services provided with the insurance carrier, and notify the responsible party of their financial responsibility. Circuit Physical Therapy understands that at times insurance carriers may not provide accurate benefit information, so we strongly encourage Circuit Physical Therapy clients to take responsibility in understanding their own insurance benefits. The responsible party understands that the verification of benefits and authorization is done as a courtesy and not a guarantee of payment, and that he/she is responsible for all changes not paid by the insurance company. ________(Initial)
4. Assignment of Benefits: I hereby authorize direct payment of my medical benefits to Circuit Physical Therapy on my behalf for any services furnished to me by the providers. _________(Initial)

5. Insurance Request for Payment: I request payment of authorized insurance benefits to Circuit Physical Therapy. I authorize any holder of medical or other information about me to release to insurance and its agents any information needed to determine these benefits or benefits of related services. _______(Initial)

6. Authorization to Release Records: I hereby authorize Circuit Physical Therapy to release my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination rendered to me needed substantiate payment for such medical services, as well as information required for pre-certification, authorization or referral to other medical provider/s.

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By my signature below, I certify that I have read, understand, and fully agree to each of the statements in this document and sign below freely and voluntarily.

____ ___________________
Signature of Patient or Legally responsible Person Date

____
Printed Name of Above

CONSENT TO PHYSICAL THERAPY EVALUATION AND TREATMENT

I hereby consent and/or treatment of my condition by a licensed physical therapist and treatment by a licensed physical therapy assistant by or under contract with Circuit Physical Therapy.

The physical therapist has fully explained to me the nature and purpose of the procedure, evaluation and course of treatment, and has witnessed my signature of this consent of his/her presence. The physical therapist has informed me of expected benefits and possible complications and discomfort, which may result from skilled physical therapy care. In addition, the physical therapist has explained to me the risks of receiving no treatment.

The physical therapist has explained that in some cases, physical therapy treatment may not improve my condition and although unlikely, it can cause additional pain or aggravation of my condition. The physical therapist has given me an opportunity to ask questions pertaining to different kinds of intervention, prognosis, expectations and plan of care and was able to answer my questions to my satisfaction.

I attest that I have fully read and understood this consent form.

Patient/ Guardian Signature ____

Date: ___________________ ____

(Relationship, if signed by person other than client)

24-Hour Cancellation/ No Show Policy

Circuit Physical Therapy is committed to providing you with the highest quality of care and in order to maintain that level of excellence we ask that you provide at least 24-hour notice of a cancellation.

We do realize that things come up like illness, transportation issues, hazardous driving conditions, or family emergencies that make it impossible to keep your scheduled appointment. Cancellations without 24-hour notice will be accepted in these circumstances on a one-time basis only. Any additional instances will be subject to a $25.00 charge and must be paid at your next scheduled visit.

Not showing for your appointment (no show) is unacceptable and a fee of $25.00 will be charged in every instance. This fee will be expected to be paid at your next scheduled visit.

This fee is not covered by your insurance and it will be your responsibility to pay no matter what type of coverage you have. If the fee is not paid, you will be billed and this balance is subject to collections.

Three consecutive missed appointments (for whatever reason) will be treated as an administrative discharge. A new doctors' referral will be needed for future physical therapy services.

Appointment times are set in order to provide all patients the allotted time needed for services. If you are 15 more minutes late for your appointment time, your appointment will be considered missed and a $25.00 missed appointment fee will be assessed.

Please be considerate of other patients and our staff and call as soon as possible if you are unable to attend your scheduled physical therapy visit.

These Policies Will Be Enforced.

Thank you for your support and understanding.

Circuit Physical Therapy Management,

________________________________ ________________

Patient Signature Date

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL AND PERSONAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND SHOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THE FORM CAREFULLY.
OUR LEGAL DUTY
CIRCUIT PHYSICAL THERAPY (CPT), is required by law to protect the privacy of your personal health and information, provide notice about our information management practices, and follow the information protocols described below.

USES AND DISCLOSURE OF HEALTH INFORMATION

CIRCUIT PHYSICAL THERAPY, uses your personal and health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and assessing the quality of care we are proud to provide. We use your personal information to contact you to arrange an appointment with us and to properly bill your insurance carrier for the services we provide you with. In addition, we may time to time, disclose your health information without prior authorization for public health purposes, auditing tracking, and research studies. In any other situation, CPT will obtain your written permission and authorization to release your information for any reason, you may later revoke that authorization to cease future disclosure any time. When changes are made in our privacy and confidentiality policies, a new Notice of Information Practices will be posted in the same area for public view. Our HIPAA Compliance Officer is Catherine Mallari. She can be reached at the office by calling 936-594-9224.

PATIENT’S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct inaccurate or incomplete information in your records. You also have the right to request a list of insurances where we disclosed your personal health information for reason other than for treatment, payment, or other related administrative purposes, except when specifically authorized by you, when required, or in an emergency. CPT will consider all such requests on a case-by-case basis. The company is not legally required to accept the request.

CONCERNS AND COMPLAINTS

If you are concerned that CPT may have violated your privacy rights or if you disagree with any decisions we have made regarding across or disclosures pf your personal health information, please contact our HIPAA Compliance Officer, Catherine Mallari, at the office address and phone number listed below. You may also send a written complaint to the U.S. Department of Health and Human Services.

2210 S. Robb St. Trinity, TX 75862 936-594-9224 ______ (Initials)