Dynamic PHYSICAL THERAPY

Confidential Medical History

Name: _____ **Date of Birth** _____/_____/_____ **SS#:** _____

Address: _____ **City/State/Zip:** _____

Phone: _____ **Cell:** _____ **Marital Status (Circle):** M S D W

Occupation: _____ **Are you presently working?** Y___ N___

Employer: _____ **Employer Phone:** _____

Insurance Company: _____ **ID#:** _____

Name of Card Holder: _____ **Date of Birth** _____/_____/_____ **SS#:** _____

Have you received any of the following services during your current insurance plan year?

Occupational Therapy	Y___ N___	Massage Therapy	Y___ N___
Physical Therapy	Y___ N___	Chiropractic Services	Y___ N___
Speech Therapy	Y___ N___	Home Health Services	Y___ N___

Do you have any of the following medical conditions?

	YES	NO		YES	NO
Asthma, Bronchitis or Emphysema	_____	_____	Osteoporosis	_____	_____
Shortness of Breath or Chest Pain	_____	_____	Varicose Veins	_____	_____
Coronary Heart Disease	_____	_____	Bowel or Bladder Problems	_____	_____
Pacemaker	_____	_____	Sleeping Difficulties	_____	_____
High Blood Pressure	_____	_____	Emotional or Psychological Problems	_____	_____
Heart Attack or Surgery	_____	_____	Severe or Frequent Headaches	_____	_____
Stroke or TIA	_____	_____	Vision or Hearing Difficulties	_____	_____
Blood Clot or Emboli	_____	_____	Dizziness or Faintness	_____	_____
Epilepsy or Seizures	_____	_____	Pregnancy	_____	_____
Thyroid Trouble or Goiter	_____	_____	Arthritis or Swollen Joints	_____	_____
Cancer or Chemotherapy/Radiation	_____	_____	Gout	_____	_____
Anemia	_____	_____			
Infectious Diseases	_____	_____	Other Medical Conditions: _____		
Diabetes	_____	_____	_____		

Referring Physician: _____ **Referral Date:** _____

Chief Complaint: _____ **Date of Injury:** _____

Current Symptoms: Pain Numbness Stiffness Weakness **Other:** _____

List all medications you are currently taking: □ None _____

_____

List any known allergies: □ None _____

List any previous surgeries: □ None _____

Have you had any diagnostic imaging for this injury? □ None MRI XRAYS CT SCAN **Other:** _____

Do you smoke?	Y___ N___	**How much/often?**	_____
Do you consume alcohol?	Y___ N___	**How much/often?**	_____
Do you exercise regularly?	Y___ N___	**How much/often?**	_____

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Consent For Treatment

I hereby give my consent for medical treatment of my physical condition. I authorize the release of any medical information needed to process my claim. I understand that I am responsible to inform the office of any changes that occur with regard to my insurance policy. If I choose to file a claim through my insurance, I authorize release of payment directly to Dynamic Physical Therapy regardless of whether benefits are deemed to be in-network or out-of-network. Should I default on my financial responsibility and monetary collection is necessary, I will be responsible for collection costs that are incurred.

Patient/Parent/Guardian Signature: _____ Date: _____

Patient/Parent/Guardian Name (Please Print): _____

Receipt of Policies

I acknowledge that I have received the packet of patient policies which includes the following: HIPAA Notice of Privacy Practices, Attendance Policy, Financial Policy, and Financial Responsibilities. I understand that I may ask questions about these policies at any time.

Patient/Parent/Guardian Signature: _____ Date: _____

Contact Information

1) Please indicate any family members we may speak with regarding your care including but not limited to diagnosis, treatment plan, or prognosis.

_____ _____

_____ _____

2) May we leave a message on your answering machine/cell phone? Yes No

3) How would you like to receive appointment reminders? Phone Email Text

NOTE: By choosing one of the above options, I authorize Dynamic Physical Therapy or entities acting on behalf of Dynamic Physical Therapy (e.g. debt collection agency) to deliver messages to me using an automated dialing system and/or artificial pre-recorded voice in accordance with the FCC's Telephone Consumer Protection Act. I understand that by choosing "No" I have opted not to receive messages using an automated dialing system or pre-recorded voice.

Child/Adolescent Protection Policy (For patients under 18 years of age)

It is the policy of Dynamic Physical Therapy to release minors only to the care of the following individuals after completion of their physical therapy visit.

_____ _____

_____ _____

Patient/Parent/Guardian Signature: _____ Date: _____

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Marketing Survey

Patient Name: _____

Age:_____ Gender: □ Male □ Female

Email Address: _____

How did you hear about our clinic (check all that apply)?

- □ Referring Physician
  Did this physician refer you **specifically** to Dynamic Physical Therapy?
  □ Yes □ No
- □ Other Physician
  If yes, whom may we thank? _____
- □ Family or Friend
  If yes, whom may we thank? _____
- □ Media/Advertising
  If yes, what source?
  - □ Newspaper
  - □ Television
  - □ Radio
  - □ Brochure
  - □ Telephone book
  - □ Internet (website, google, etc)
  - □ Facebook/Twitter
  - □ Billboard (not the sign outside of our clinic)
  - □ Clinic sign/ location
  - □ Health Fair: _____
  - □ Other: _____
- □ Local Club or Group
  If yes, which one? _____
- □ I am a returning patient
- □ Other: _____

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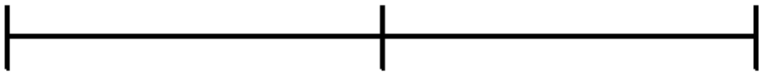
Patient Name: _____ Date: _____

Functional Assessment (OPTIMAL)

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 <u>*all*</u> of the activities you would like to do, please mark an "X" at the point on the line that best describes your <u>*overall*</u> 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.* <u>*12*</u> *2.* <u>*8*</u> *3.* <u>*13*</u>)

1.____ 2.____ 3.____

Present Total Score = _____ Previous Total Score = _____

Adapted/revised in July 2005 and August 2006 with permission of APTA from Guccione AA, Mielenz TJ, De Vellis RF, et al. Development and testing of a self-report instrument to measure actions: Outpatient Physical Therapy Improvement in Movement Assessment Log (OPTIMAL). *Phys Ther*. 2005;85:515-530.

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Medication Checklist

Please list all medications in the appropriate category below. Please include dosage and frequency. If you require more space, please ask a front desk staff member for assistance.

Prescription Medication Name	Dosage	Frequency	Route
Over-the-Counter Medication Name	**Dosage**	**Frequency**	**Route**
Herbal Supplement Name	**Dosage**	**Frequency**	**Route**
Vitamin/Mineral Supplement Name	**Dosage**	**Frequency**	**Route**

I verify the above information is correct to the best of my knowledge. □ Yes □ No

I understand Dynamic Physical Therapy strongly encourages me to communicate with my primary care physician that I am presently taking all of the medications and dosages listed above. □ Yes □ No

_____ _____

Patient or Authorized Representative Signature Date

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Attendance Policy

Dynamic Physical Therapy is committed to improving the lives of our patients by exceeding expectations in the pursuit of excellence in the field of rehabilitation. We strive to be known as the best physical therapy practice in our community by achieving excellent results with the most friendly and most efficient staff.

In order to fulfill our mission and help you achieve your goals in a timely manner your physical therapist will help you to establish a treatment dosage – that is, the number of times per week you should attend physical therapy. This dosage of physical therapy should be treated the same as if you were prescribed a dosage of medication and should not be taken haphazardly. To make the largest gains in the shortest period of time, we expect that you will make every attempt to adhere to the weekly visit frequency prescribed during your initial examination.

Except in the case of a serious emergency, it is expected that you keep all your appointments. If you need to cancel an appointment, we require 24 hours notice. Every attempt should be made to reschedule any missed appointments within the same week by contacting our office and speaking with a member of our front desk staff. **In the instance of a cancellation without 24 hours notice or a no-show to a scheduled appointment, we reserve the right to charge you a $25.00 fee.** Exceptions to this policy include inclement weather or sudden illness. However, we still request that you reschedule your missed appointment within the same week in order to maintain compliance with your prescribed dosage of physical therapy.

We also reserve the right to discharge patients who routinely cancel or miss their scheduled appointments. If 3 appointments in a row are missed or cancelled without cause (illness, hospitalization, family emergency) or if you attend fewer than 75% of your prescribed visits in a one month period, you will be discharged. If an appointment is missed and not rescheduled, we will make 2 attempts to contact you to reschedule that appointment. If our calls are not returned, then you will be discharged. Patients who are discharged in this manner will have a letter sent to their referring physician and/or case manager explaining the reason for the discharge. **We also reserve the right not to allow patients who are discharged for non-compliance with their established treatment frequency to return for future episodes of care at any of our facilities should the need arise.**

Our staff works very hard to help you meet your goals. Keeping your scheduled appointments is the key to a successful outcome. We trust that you will make every attempt to assist us in helping you and look forward to providing you with the highest quality of rehabilitation services.

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Financial Policy

Dynamic Physical Therapy is dedicated to providing you the most effective care and efficient service possible. Your understanding of our financial policy is an essential element of your care and service.

If you have insurance, we will bill your insurance carrier as a courtesy for you under the condition that we are a participating provider with your insurance plan. After your claim is processed, any remaining balance is due within thirty (30) days of the billing statement date. Any unpaid balance after ninety (90) days will be turned over to a collection agency or taken to Magistrate Court, and you will be held responsible for any costs incurred because of this action.

If you do not have insurance and choose to pay for our services out-of-pocket, payment is expected at the time of service.

Not all physical therapy services are covered by all insurance carriers. If your physical therapist feels that you require services that we know are not covered by your insurance carrier, and if you would still like to receive these services, you will be asked to pay for these services out-of-pocket and at the time the service is delivered.

Diagnoses and services are carefully documented to comply with federal law. Under no circumstances will these be changed, altered or falsified in order to obtain coverage by insurance.

It is your responsibility to make sure we have accurate insurance carrier and billing information. If a claim is denied because of flawed insurance or billing information, including fraudulent attempts to obtain services, you will be responsible for the balance unless attempts to rectify these errors result in a successful filing of your claim.

It is the policy of Dynamic Physical Therapy to provide essential physical therapy services regardless of a patient's ability to pay. Reduced fees for services are available and offered based on a sliding fee scale depending on family income and size in accordance with our Financial Assistance Program.

We will make every effort to answer any questions you have regarding our financial policy as outlined above. We will also assist you with any insurance problems that may arise during the course of your treatment to the best extent that we can accommodate.

If you have any questions regarding any aspect of our financial policy, please feel free to present your questions to our clinical director. If our clinical director is unable to completely answer your questions, a telephone appointment with our billing manager will be arranged.

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Financial Responsibilities

Dynamic Physical Therapy will apply the following policies to each patient:

1) If your insurance requires a co-payment fee, we will require you to pay this fee at each visit.

2) If your insurance carrier requires a co-insurance fee, we will strongly encourage you to pay an estimate of your co-insurance for each visit according to the following rate: 10% = $10 payment, 20% = $20 payment, 30% = $30 payment, and so on. This is only an estimate of your financial obligation to us and you may still receive a bill if there is a balance due to us once your insurance pays its portion of our fees.

3) If you have a deductible, we will require you to pay $50 each visit until the deductible is met. This is only an estimate of your financial obligation to us and you may still receive a bill if there is a balance due to us after charges for all our services have been processed through your insurance company.

4) Once our billing office generates a bill for you, if there is an outstanding balance we will require you to pay $50 each visit until your outstanding balance is paid in full. At the end of the month if a balance still remains, you will be required to pay off the remaining balance. If your physical therapist discharges you before the end of the month, any balance remaining on your bill will also be due. We will strongly encourage you to pay your bill in full on the first day the bill is received.

5) Payments for co-insurances and deductibles are estimates and any refunds will be promptly provided after all outstanding charges have been paid in full.

6) Patients who do not comply with these policies will be discharged.