



PATIENT HEALTH QUESTIONNAIRE

Is this condition due to an accident or injury? Yes No Date of accident/injury: \_\_\_\_/\_\_\_\_/\_\_\_\_

Have you recently received Home Health Services? Yes No If yes, when \_\_\_\_\_

Please describe your symptoms: \_\_\_\_\_

When did your symptoms start? \_\_\_\_\_

How did your symptoms begin? \_\_\_\_\_

Are your symptoms (Circle one) Getting Better Getting Worse Not Changing

How are you able to sleep at night? (Circle one) Fine Moderate Difficulty Only with Medication

Affected Side (Circle all that apply) Right Left Both Hand Dominance: Right Left Both

Location of your pain: \_\_\_\_\_

Who have you seen for your symptoms? (Circle all that apply)

No One Medical Doctor Physical Therapist Occupational Therapist Chiropractor Other

What treatment (if any) did you receive and when? \_\_\_\_\_

What tests have you received for your symptoms? (Circle all that apply)

X-Rays CT Scan MRI Injection Other \_\_\_\_\_

Did you have surgery for this condition? Yes No If yes, date of surgery? \_\_\_\_/\_\_\_\_/\_\_\_\_

Please list your previous surgeries and year: \_\_\_\_\_

Please list current medications or provide office with a photocopy:

Do you currently smoke tobacco? Yes No If yes, how many packs per day? \_\_\_\_\_

Have you smoked in the past? Yes No If yes, what year did you quit? \_\_\_\_\_

Do you have a pacemaker? Yes No

Have you ever been told that you have any of the following? Do you have a history of any of the following?

Table with 2 columns: Condition and Yes/No response. Conditions include Cancer, Diabetes, Autoimmune Deficiency, High Blood Pressure, Heart Disease, Angina/Chest Pain, Stroke, Osteoarthritis, Rheumatoid Arthritis, Hepatitis, Sexually Transmitted Disease, Allergies/Asthma, Headaches, Seizures, Adhesive Allergy.

In the past 3 months have you had or experienced any of the following:

Table with 2 columns: Symptom and Yes/No response. Symptoms include Numbness or Tingling, Weakness or Fatigue, Shortness of Breath, Dizziness, Leg/Ankle Swelling, Unexplained Weight Loss, Changes in Bowel Function, Changes in Bladder Function.

Are you currently or could you be pregnant? Yes No
Are you currently or could you be depressed? Yes No

\_\_\_\_\_  
Patient's Name

## PHYSICAL THERAPY & SPORTS REHAB OF HASTINGS (PTSR) FINANCIAL AGREEMENT

ALL ACCOUNTS FOR SERVICES RENDERED ARE DUE AND PAYABLE AT THE TIME OF SERVICE UNLESS OTHERWISE NOTED IN THE FINANCIAL AGREEMENT FORM. ALL ACCOUNTS WILL BE CONSIDERED DELINQUENT IF NOT PAID WITHIN 30 DAYS FROM NOTIFICATION.

### PAYMENT AGREEMENT

**PLEASE CHOOSE THE APPROPRIATE COVERAGE(S) AND INITIAL:**

#### HEALTH INSURANCE

\_\_\_\_\_ (Initial)

I am covered by a HEALTH INSURANCE plan and I understand all payments on this claim will go directly to PTSR. I agree to pay the amount my insurance plan indicates that I am responsible for at the time of service. I will also handle any discrepancies directly with my insurance company. I understand that not all health coverage plans cover supplies; therefore, I will pay for any supplies at the time it is dispensed.

- *Since coverage is unique to each policy, I am responsible to verify my therapy benefits regarding specific provisions (i.e. need for a physician's referral, pre-authorization, number of allowed visits, co-payment amounts, etc.).*

#### MEDICARE

\_\_\_\_\_ (Initial)

I am a MEDICARE recipient, and understand that PTSR will file my claim to Medicare. I also understand that payment for services will go directly to PTSR. Once my deductible has been met, Medicare will cover my claim at 80%. I will then be responsible for the remaining 20% unless I have furnished a secondary insurance. I understand that I may be responsible for any balance due depending upon my secondary insurance coverage. I understand that Medicare does not pay for supplies and if I wish to purchase any supply it will not be submitted to Medicare and I am expected to pay at the time it is dispensed. Medicare also has one combined cap limit on Physical and Speech Therapy of \$1840 per year and a separate cap for Occupational Therapy services with a limit of \$1840 per year. After the cap is met by Medicare, I will be responsible for the remaining balance.

#### MEDICAID

\_\_\_\_\_ (Initial)

I am covered by MEDICAID and will produce my current Medicaid card each month I am receiving therapy for the purpose of verification of coverage by PTSR. I understand that payment for services will go directly to PTSR. I understand that if I am an adult (age 21 & older) I will have an annual limit of 60 visits per fiscal year (July 1 – June 30). This limit is for a combination of physical/speech and occupational therapy. Supplies are not covered by Medicaid from PTSR and should I need supplies I must purchase them from a Medicaid Approved Supplier. Should my Medicaid plan have a co-pay requirement, I agree to pay my co-pay at the time of service.

#### WORKERS COMPENSATION

\_\_\_\_\_ (Initial)

I have a work related injury and have notified my employer. Upon authorization, PTSR will bill my employer for the services rendered and payment will be made directly to PTSR. In the event of a dispute or denial with my employer about the work injury, I accept full responsibility for payment on my account. At that time, I understand that I then have the option to send claims through by health insurance plan.

#### NO INSURANCE

\_\_\_\_\_ (Initial)

I have no insurance coverage, and I will pay at the time services are rendered.

#### LIABILITY INSURANCE (Med Pay)

\_\_\_\_\_ (Initial)

I have been involved in an accident and have verified medical payment coverage through my insurance. I understand that payment for services will go directly to PTSR. I am also aware that I am responsible for payment on my account at the time services are rendered once my med pay has been exhausted. At that time, I understand I then have the option to submit claims to my health insurance plan

#### LAW SUIT/SETTLEMENT

\_\_\_\_\_ (Initial)

Although, I am involved in litigation, I am responsible for payment on my account at the time services are rendered. I understand that PTSR will not wait for payment from any settlement I may or may not receive in the future. I also understand that PTSR will not agree to bill an attorney for services rendered. I also have the option to submit claims to my health insurance plan once they have been notified of the situation.

Would you like to use our credit card payment option?  
(VISA, MasterCard, Debit Accepted)

Yes \_\_\_\_\_

No \_\_\_\_\_

On-Line Payment Coming Soon

OVER....

## INSURANCE INFORMATION

### PRIMARY HEALTH INSURANCE (If Applicable)

\* Photocopy of Card Required

Name of Insured \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_

### SECONDARY HEALTH INSURANCE (If Applicable)

\* Photocopy of Card Required

Name of Insured \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Insured DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_\_  
Employer \_\_\_\_\_  
Occupation \_\_\_\_\_

### WORKERS COMP INSURANCE (If Applicable)

Insurance Company \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
\_\_\_\_\_  
Insurance Phone # \_\_\_\_\_  
Case Manager \_\_\_\_\_  
Case Manager's Phone # \_\_\_\_\_  
Claim # \_\_\_\_\_

### AUTO/LIABILITY INSURANCE (If Applicable)

Insurance Company \_\_\_\_\_  
Contact Person \_\_\_\_\_  
Insurance Address \_\_\_\_\_  
\_\_\_\_\_  
Insurance Phone # \_\_\_\_\_  
Agent's Name \_\_\_\_\_  
Agent's Phone # \_\_\_\_\_  
Claim # \_\_\_\_\_

## DECLARATION

- \_\_\_\_\_(Initial) The undersigned hereby acknowledges that PTSR may release information from my medical records during the period of such care to the health insurance company, Worker's Compensation insurance, third party payors, other health plans and/or other health practitioners for the purpose of processing claims and to obtain payment on the account for services rendered.
- \_\_\_\_\_(Initial) The undersigned acknowledges responsibility for services not covered by insurance including care that insurance deemed as "*not medically necessary*".
- \_\_\_\_\_(Initial) The undersigned hereby acknowledges that Physical Therapy & Sports Rehab of Hastings has made available to me their "*Notice of Privacy Practices*" for protected health information.
- \_\_\_\_\_(Initial) The undersigned hereby acknowledges that Physical Therapy & Sports Rehab of Hastings will not agree to bill an attorney for services rendered on behalf of the patient.
- \_\_\_\_\_(Initial) The undersigned hereby acknowledges that any returned checks will be subject to a \$25.00 fee.
- \_\_\_\_\_(Initial) The undersigned hereby acknowledges that in the event the account is turned over to the collection agency, the collection fees, and/or legal fees, including attorney fees shall be my responsibility.

This agreement is binding upon the patient, his/her successors and assigns. My signature below indicates that I am accepting financial responsibility for all services rendered and certify accuracy of information as noted above. If signed by an individual other than the patient, that individual agrees that he/she will assume full financial responsibility for the patient and understands the Declaration. A copy of this financial agreement may be used in lieu of the original.

**MY SIGNATURE BELOW INDICATES THAT I HAVE READ THIS AGREEMENT AND UNDERSTAND IT FULLY.  
PTSR WILL PROVIDE ME WITH A COPY OF THIS DOCUMENT UPON MY REQUEST.**

\_\_\_\_\_  
Signature (*Must be 18 years old to sign*)

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Date

Witness/Date: \_\_\_\_\_