

Patient Intake Questionnaire

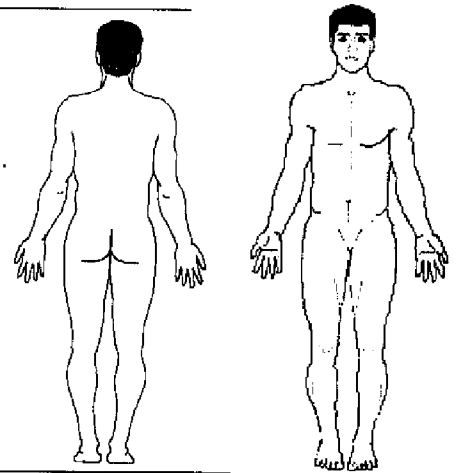
Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____ Sex: _____

About Your Current complaint...

1. What is the complaint that brought you here? _____
2. When did this complaint begin or recently become worse? Approx Date: _____
3. What caused this complaint? _____
4. Does this complaint affect your activity choice, tolerance, efficiency or effectiveness? Y N
If "Yes", what activities? _____
5. What makes this complaint better? _____ Worse? _____
6. Does this complaint affect your comfort, mood or ability to sleep? Y N
7. What symptoms are you experiencing with this complaint?
 Swelling Loss of Balance or Coordination
 Loss of Motion Numbness Pain :Draw pain on body diagrams...
 Weaknes Tingling Other (Specify) _____
8. How frequent are the symptoms experienced?
 Constant Intermittent
9. How much pain are you experiencing?
 None Very Mild Mild Moderate Severe Very Severe
(0) (1-2) (3-4) (5-6) (7-8) (9-10)
10. What tests have you had for this complaint?
 XRay CAT Scan MRI Myelogram Bone Scan Results _____
11. What treatment have you had for this complaint? Physical Therapy
 Occupational Therapy Athletic Training Chiropractic Alternative Medicine _____
12. Is this complaint work related ? Yes No
If yes, your employer's name. _____
13. Work Status? Full Time Part Time Working Medical Restrictions Medical Leave
14. Your Occupation? _____ Last Date Worked? _____
15. Is this complaint auto related? Yes No



About Your General Health...

16. Please check all medical conditions that you have, or have had.
 Arthritis Heart Disease Stomach Disorder Thyroid Problems
 Pace Maker Anxiety Depression Panic Attacks
 Cancer Diabetes Stroke Lung Disease
 High Blood Pressure Other: _____
17. Please check all of the following items that currently apply to you:
 Hearing Problems Vision Problems Learning Problems
 Pregnant Smoke Bowel or Bladder Control
18. Please list surgeries. _____
19. Please list allergies. _____
20. Please list Medications you are currently taking. _____

21. Have you had recent immunizations? Yes No Please List _____
22. Are you currently receiving psychosocial services? Yes No
Do you want us to help you find a source for psychosocial services? Yes No
23. What goals do you want to achieve through treatment? _____
24. Which is your dominant hand? Right Left

PATIENT REGISTRATION (Please Print!)

Date _____

Last Name _____ First _____ MI _____

SS# _____ Birth Date _____ Male/Female _____

Street Address _____

City _____ State _____ Zip Code _____

E-mail address: _____

Home Phone () _____ Cell or Emergency Phone () _____

Marital Status: _____ Married _____ Single _____ Divorced _____ Other _____

Employment Status: _____ N/A _____ Full-Time _____ Part-Time _____ Student _____

Employer Name _____

Employer Address _____

Employer Phone () _____

Date of Injury or Onset of Illness _____

Name of Doctor who sent you here: _____

Date of next appointment with doctor who sent you here: _____

INSURANCE INFORMATION

Group Health, Medicare, etc:

Primary Insurance _____

Insured's Name _____ SS# _____ DOB _____

Secondary Insurance _____

Insured's Name _____ SS# _____ DOB _____

Workers Comp: *If you have medical insurance, please complete information above. This is to assure payment in the event that the workers comp carrier denies your claim. Your medical insurance will not be billed otherwise.*

Date of Injury _____ Claim# _____

Insurance Carrier Name _____ Insurance Phone () _____

Rehab Consultant/Nurse _____ Phone () _____

Name of Rehab Company _____

Auto: *If you have medical insurance, please complete information under **Medical** above. This is to assure payment in the event the carrier denies your claim or benefits exhaust before completion of treatment. Your medical insurance will not be billed otherwise.*

Date of Accident _____ Name of Insurance _____

Insurance Co. Address _____

Insurance Agent Name _____ Policy # _____

Self-Pay *If you have no insurance coverage, you agree to be personally responsible for all charges incurred and will pay the balance of your account in six months or less.*

I authorize the release of any medical or other information necessary to process my insurance claim. I also authorize payment of medical benefits to the provider of services who accepts assignment. If for any reason my charges are not paid by my insurance company, I understand it's my responsibility to remit payment promptly.

SIGNED _____ (Patient or responsible party)

*****NOTICE TO AUTO INSURANCE PATIENTS*****

I hereby authorize Rehab Associates to apply for and receive payments from motor vehicle insurer for basic reparation benefits, as defined in KRS Chapter 304;

It is my intent that motor vehicle insurer pay amounts for basic reparation benefits prior to the payment of any such benefits for work loss.

I also affirm that as of this date I have not directed basic reparation benefits be used to compensate for lost wages.

Patient Signature

Date

*****NOTICE TO MEDICARE PATIENTS*****

Medicare will only pay for services it determines to be "reasonable and necessary" under Section 1862(a)(1) of the Medicare law. If Medicare determines that a particular service, although it would otherwise be covered, is not "reasonable and necessary" under Medicare program standards, Medicare will deny payment for that service. **I believe that, in your case, Medicare is likely to deny payment for hot and cold packs, therapy supplies and orthotics, because they are deemed to be medically unnecessary.**

I have been notified by my provider/supplier that he/she believes that, in my case, Medicare is likely to deny payment for the services identified above, for the reason stated. If Medicare denies payment, and I choose to accept any of the services/supplies stated above, I agree to be personally, fully, responsible for payment.

Patient Signature

Date

FOR OFFICE USE ONLY

Diagnosis _____ Frequency/Duration _____

OV Co-pay \$ _____ Deductible \$ _____ PTA can treat? _____

% due from patient _____ Deductible met\$ _____ Hot/Cold Packs? _____

Pre-Cert necessary? _____ Max # visits _____ Exclusions _____

Send claims to _____

Phone () _____

Spoke to _____

Authorization # _____

VERIFY: _____ Open Claim
_____ Claims Being Paid
_____ Require Records with Claims
_____ Benefits Available

Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, have received the Notice of
Privacy Practices from Weitlauf & Vance, PSC.

X _____ **Date** _____

In lieu of patient signature, I, _____,
a staff member of Weitlauf & Vance, PSC, state that _____
_____ has been given our current Notice of Privacy Practices.

X _____ **Date** _____

REHAB ASSOCIATES

PATIENT APPOINTMENT POLICY

We strive to provide our patients with a high level of professionalism and exceptional service. Our commitment to your well-being and the improvement of your physical abilities is something that everyone who participates in your treatment takes quite seriously.

We realize that it would be a disservice if we did not emphasize the importance of your obligation to the plan of treatment developed by your physical/occupational therapist.

Your adherence to the recommended or prescribed number of treatment visits is vital to your progress. Therefore, we have certain guidelines that need to be followed in order to ensure optimum results.

You will be given a schedule of appointment dates and times.

If you need to re-schedule an appointment we require 24-hours notice. Please contact our Front Desk Receptionist to assist you.

If you cancel without 24-hours notice or if you do not show up for a scheduled appointment, we reserve the right to charge you a \$25.00 missed appointment fee.

If you repeatedly miss scheduled visits, we reserve the right to discontinue care and inform your physician of the reason care was terminated.

We do appreciate the opportunity to assist you in accomplishing your functional goals and improving your quality of life.

Rehab Associates Partners:

**Mark Vance, P.T.
David Weitlauf, P.T.
Kathy Rorer, P.T.
Mark Hammons, P.T.**

I have read and understand this policy.

Patient Name _____ Date _____