Cross Keys PHYSICAL THERAPY

Account # _____

Patient Health Questionnaire

(W/C)

Patient Name_____ ***DOB***_____/_____/_____

1. ***Describe your symptoms/complaints or limitations:*** _____

   _____

   _____

2. ***Please describe how your problem began:*** _____

   _____

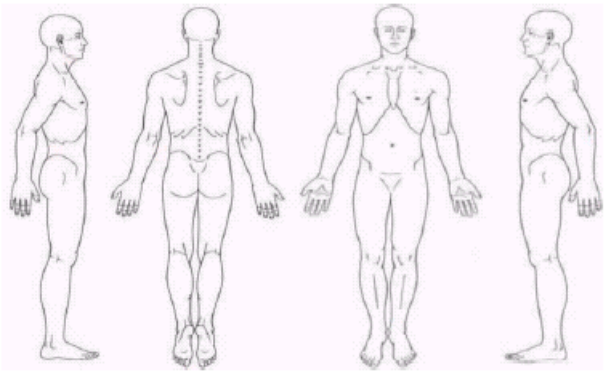
3. ***When did your symptoms begin/Specific date if possible:*** _____

   Did you have surgery? ☐ Yes ☐ No Date _____/_____/_____

4. ***How often do you experience your symptoms?***
   - ☐ Constantly (76-100% of the day)
   - ☐ Frequently (51-75% of the day)
   - ☐ Occasionally (26-50% of the day)
   - ☐ Intermittently (0-25% of the day)

5. ***Please describe the nature of your symptoms?***
   - ☐ Sharp ☐ Dull (Pain) Ache
   - ☐ Numbness ☐ Shooting ☐ Throbbing
   - ☐ Burning ☐ Tingling ☐ Radiating

6. ***Since your symptoms began they have?***
   - ☐ Decreased
   - ☐ Not Changed
   - ☐ Increased



(MARK ON PTICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS)

7. ***Indicate the intensity of your pain at rest:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

8. ***Indicate your pain with movement:*** **(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Unbearable Pain)**

9. ***Your symptoms are worse in:*** ☐ morning ☐ afternoon ☐ night ☐ increased during the day ☐ same all day

10. ***In the past*** have you been treated for the same problem? ☐ Yes ☐ No

    If yes, who did you see for this condition? ☐ MD ☐ Physical Therapist ☐ Chiropractor ☐ Other

    When and what treatment did you receive? _____

11. ***What is your occupation?*** _____

    Has your work status changed because of this condition? ☐ Yes ☐ No. If yes, how? _____

    _____

12. ***Do you have high blood pressure?*** ☐ Yes ☐ No

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Patient Name_____ ***DOB***_____/_____/_____

13. ***Do you have a heart condition or artery disease?*** ☐ Yes ☐ No

    If yes, please explain:_____

14. ***Do you have a pacemaker or defibrillator?*** ☐ Yes ☐ No
15. ***Are you pregnant?*** ☐ Yes ☐ No
16. ***Do you have diabetes?*** ☐ Yes ☐ No If yes, what type: _____
17. ***Have you had any type of cancer?*** ☐ Yes ☐ No If yes, what type: _____
18. ***Have you ever had a stroke?*** ☐ Yes ☐ No If yes, when: _____
19. ***Do you ever have seizures?*** ☐ Yes ☐ No If yes, when was your last: _____
20. ***Do you have any type of metal implants?*** ☐ Yes ☐ No
    Including hip, knee or shoulder replacements: _____
21. ***Do you have osteoporosis?*** ☐ Yes ☐ No
22. ***Do you experience occasional dizziness?*** ☐ Yes ☐ No If yes, when: _____
23. ***Do you have a hiatal hernia?*** ☐ Yes ☐ No
24. ***Do you have any drug allergies?*** ☐ Yes ☐ No If yes, what: _____
25. ***Please list all medications you are currently taking:*** _____

    _____

    _____

    _____

26. ***Please list any hospitalization/surgical procedures that have not been described elsewhere:***

    _____

    _____

    _____

Patient's Signature:_____ **Date:**_____

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PATIENT INFORMATION

PATIENT NAME:_____ DOB_____ □ M □ F

Emergency Contact Name:_____ **Phone No.:**_____

PRIMARY INSURANCE:_____

Address:_____

ID/Claim #:_____ Group #:_____ Copay $:_____ Deductible $:_____

Phone No.:_____ Ext.:_____ Fax No.:_____

Policy Holder Name:_____ Relation:_____

Policy Holder Date of Birth:_____ SS#:_____

Date of Accident:_____ Adjuster's Name:_____

Have you been treated for this condition before? □Y □N If yes when:_____

Was this treatment billed to your current insurance? □Y □N or was it due to □ MVA □ WC

*****If MVA, was PIP application Submitted to Insurance Care? □Y □N If no, you need to do this before insurance company will honor your claims.***

SECONDARY INSURANCE:_____ **Type:** □W/C □MVA □PERS.

Address:_____ Auth/Cert: □Y □N

ID/Claim #:_____ Group #:_____ Copay $:_____ Deductible $:_____

Phone No.:_____ Ext.:_____ Fax No.:_____

Policy Holder Name:_____ Relation:_____

REFFERING DOCTOR:_____ **Diagnosis**:_____

Address:_____

Phone No.:_____ Fax No.:_____ UPIN No.:_____

Did you have surgery? □Y □N If yes, give date:_____ Procedure:_____

NAME OF ATTORNEY (If applicable):_____

Address:_____ Contact:_____

Phone No.:_____ Fax No.:_____

IS ALL OF THE ABOVE INFORMATION COMPLETE AND ACCURATE: □Y □N

SIGNATURE:_____ **DATE:**_____

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Patient HIPPA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.
I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.
I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: _____ Date: _____

Signature: _____

Disclosure of Insurance Information

New Jersey provides that patients disclose all insurance information to a Health Care Provider at their initial visit.

Cross Keys Physical Therapy will make a copy of the front and back of all your insurance card(s) – primary and secondary.

By signing this form, I am stating that all my insurance information has been given to *Cross Keys Physical Therapy,* and that I have no other insurance than those I have presented.

Print Patient Name: _____ Date: _____

Signature: _____

Cross Keys
PHYSICAL THERAPY

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Appointment Policy

Our job is to help you reach your goals and achieve your maximum potential in physical therapy. At Cross Keys Physical Therapy we are very proud of our success rate. In order for us to help you reach your goals, it is important for you to keep all of your scheduled appointments. We cannot help you if you are not here. Keeping your appointments will help you meet all of your goals and prepare you for discharge.

To do this best, we reserve an appointment for each of our patients. Since we strive to meet all patient appointments requests, we ask that you keep you scheduled appointment time. However, if you cannot, we will be glad to cancel and reschedule a makeup appointment for you. This will allow us to release your reserved appointment time to another patient.

Please call the location your appointment is scheduled at. (See below for telephone number) **Must call at least 24 hours in advance**, For **Monday** appointment, patient must notify us before 3:00 pm on Friday. ***Any appointment cancelled after 24 hours will be charged a $25.00 cancellation fee. This fee will have to be paid before next appointment.***

The insurance companies view patients with missed appointments as "Non-Compliant". Patient cancellations and "no shows" will negatively affect insurance certifications for future visits. (If your prescription is for 3 times per week and you miss an appointment, you may reschedule it for later that week, or make it up the following week by coming in 4 times.)

If you are a Workers Compensation Patient you must be aware that your Employer and the Workers Comp Insurance Carrier will be notified of all missed appointments.

Early discharge or dismissal from your physical therapy program may occur for the following reasons:

1. Any patient who cancels 2 appointments without making them up.
2. Any patient who "No Shows" for appointments and does not reschedule, and/or return our call to reschedule.

At the completion of you therapy a Discharge Letter and Re-evaluation will be sent to your doctor.

SIGNATURE: _____ **DATE:** _____

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WORKMAN'S COMPENSATION

PAYMENT AGREEMENT & GUIDELINES

It is understood that I present to Cross Keys Physical Therapy with an injury that is ***work related.*** As such, I wish the bills for services rendered to be billed to my Employer's Workers Compensation Insurance Carrier.

It is understood that should for any reason the Workers' Compensation Insurance Company deny treatment, I will allow *Cross Keys Physical Therapy* to bill my Medical Insurance Carrier.

It is understood that should my Medical Insurance Carrier be billed I will be responsible for my DEDUCTBILE / COINSURANCE / COPAYMENTS as required by my plan.

PRINT NAME: _____ Date: _____

SIGNATURE: _____

WITNESS TO SIGNATURE:_____