PRATT PHYSICAL THERAPY

GENERAL HEALTH QUESTIONNAIRE

PATIENT'S NAME:	DATE OF BIRTH:	SEX:	AGE:	PHYSICIAN:
SSN:	PHONE NUMBER:	ALTERNATE NUMBER:	ADDRESS:	EMAIL:

1. **MEDICAL HISTORY:** (Check all that apply to you)

_____Stroke _____Diabetes _____High Blood Pressure _____Fibromyalgia

_____Osteoporosis _____Spinal Condition _____Heart Disease _____Arthritis

_____Frequent Urination _____Pacemaker _____Dizziness _____Chest Pain

_____Fainting Spells _____Lung Problem _____Urinary Leakage _____Cancer

_____Others: _____

Surgeries:

___Joint Replacement; Body Part? Date? _____

___Neck/Back Surgery; Date? _____

___Abdominal Surgery; Date? _____

___Breast Surgery/Biopsy; Date? _____

___Heart Surgery; Date? _____

___Others:_____

2. **SOCIAL HISTORY:**

Marital Status: _____ No. Of Children _____ No. of family living with you: _____

Education Level: _____ Do you Drink/Smoke: _____

Occupation: _____ Employer Name: _____

3. **I prefer to learn by:**

_____ Listening (discussion, audio tape) _____ Seeing (reading, videos, slides)

_____ Doing (demonstration, practicing skill) _____ No preference

4. **MEDICATIONS YOU ARE NOW TAKING:** (attach another sheet if needed)

Medication	**Start Date**	**Reason for taking**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. **Are you allergic to any medication?** _____**Yes** _____**No**
   a. **If yes, please list:**

_____

_____

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6. **What was the date of the initial accident/injury/surgery or if no specific injury, when was <u>the first time you felt your symptoms?</u>** Date: _____ Describe: _____
   a. When did symptoms worsen to seek medical attention? Date:_____
7. **What are your goals for physical therapy? _____**

   Lessen pain: Where? _____ By how much %? _____

For OFFICE USE ONLY:

1. What increases your sx's/pain? _____	**<u>Breast Patients:</u>**
2. What reduces/eases your sx's/pain? _____	1. Radiation? _____
3. What daily activities are most effected by sx's/pain? _____	2. Chemo? _____
_____	3. Future surgery?_____

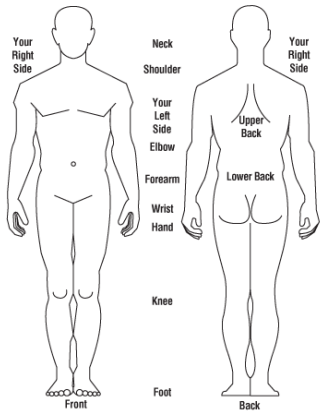
8. **Is there a caregiver, a nurse, or a therapist that comes to your house?** _____Yes _____No
9. **How did you hear about Pratt Physical Therapy?**

   _____Friend _____Referred by MD _____Newspaper _____Advertisement ____Word of Mouth

10. **I would like to discuss financial issues or a payment plan with a staff member for my physical therapy program.** _____Yes _____No

11. **Pain Drawing:** Please indicate your symptoms using the body chart and symbols below.

X = Pain **T = Tingling** **N = Numbness**



Area (s) to be treated: _____

Pain Rating (0 – 10) In the last 24 hours: **_____Now** **_____Lowest Level** **_____ Highest Level**

0	1	2	3	4	5	6	7	8	9	10
None		Min			Mild		Mod			Severe

By signing below, I certify that the above information is true to the best of my knowledge, and I consent for the provider to evaluate and recommend treatment for the condition or conditions present above.

_____ _____

Your signature and Date **Relationship to Patient**

PRATT PHYSICAL THERAPY

Consent for Care and Treatment

I, the undersigned, do hereby agree and give my consent for Pratt Physical Therapy, LLC to furnish the medical care and treatment considered necessary and proper in assessing or treating _____ 's physical and mental condition.

Patient/Guardian: _____ Date: _____

Benefit Assignment/Release of Information

I hereby assign all medical benefits to include major medical benefits to which I am entitled, including that from Medicare, Medicaid, private insurance and third party payers to Pratt Physical Therapy, LLC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize said assignee to release all information necessary, including Medical Records to secure payment.

Patient/Guardian: _____ Date: _____

Financial Policy Statement

Pratt Physical Therapy, LLC will bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event that your insurance company establishes an internal *usual and customary fee schedule*, you will be responsible for the difference remaining.

If you insurance company makes any payments directly to you for services rendered by us, you recognize an obligation to promptly remit the same to Pratt Physical Therapy, LLC.

The above does not apply for those claims considered under Worker's Compensation. However, be advised that if you claim Worker's Compensation benefits and are subsequently denied such benefits, you may be held responsible for the usual amount of charges for services rendered to you.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed to Pratt PT, including court costs, collection agency fees and attorney fees.

Estimated Insurance Benefits: _____

Estimated Patient Payment: _____

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I understand my responsibility for the payment of my account.

_____ _____

Patient/Guardian/Responsible Party signature Date

_____ _____

Pratt PT Representative/Witness Date

PATIENT AGREEMENT

- **LATE DISCLAIMER** – Patient may receive limited treatment time if late for appointment. If a patient is more than 15 minutes late, Pratt PT reserves the right to cancel the appointment and charge a $20.00 late-cancellation fee.
- A scheduled appointment **MUST BE CANCELLED AT LEAST 24 HOURS IN ADVANCE, OR THE PATIENT WILL BE CHARGED** a $20.00 late cancellation fee.
- **A late cancellation may be rescheduled TO AVOID THE CANCELLATION FEE** if the appointment is rescheduled within the same Monday – Friday period (prior to upcoming weekend). In other words, if a patient begins the week with two appointments and completes the week having had two treatments, no cancellation charges will be assessed due to the appointment being rescheduled.
- At the end of the each week, **ALL PATIENTS** including those eligible for No-Fault, Worker's Compensation, Medicare or any other insurance coverage, **WILL BE DIRECTLY RESPONSIBLE FOR PAYMENT OF $20.00 FOR EACH MISSED OR LATE-CANCELLED (non-rescheduled) APPOINTMENT.**
- Should a patient miss two consecutive appointments without calling to cancel, the patient will be taken off the master schedule and will forfeit all further permanent appointments.
- If a patient does not honor a rescheduled appointment, THE PATIENT WILL BE CHARGED FOR BOTH THE ORIGINAL CANCELLATION AND THE RESCHEDULED APPOINTMENT.
- **PLEASE INFORM THE FRONT DESK STAFF OF ALL SCHEDULING CHANGES. YOUR THERAPIST IS NOT RESPONSIBLE FOR YOUR SCHEDULE.**
- Outstanding deductible and co-insurance payments will be billed directly to patient on a monthly basis. ALL CO-PAYS are due at time of service unless other arrangements have been made with PRATT PT.
- If any changes are made to patient insurance/payment coverage, patient agrees to notify PRATT Physical Therapy as soon as possible of these changes.

_____ I understand that I will pay all treatment fees directly to Pratt Physical Therapy, LLC.
Initial

_____ I understand that I am responsible for my deductible, co-pays and all late cancellation or no-show fees.
Initial

_____ I hereby state that I am not eligible for SC Worker's Compensation Medicare or Medicaid.
Initial

I agree to treatment on the above terms:

Print Name _____ Date _____

Signature _____

PATIENT HIPAA AWARENESS AGREEMENT

With my permission, Pratt Physical Therapy, LLC (The Practice) may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to Pratt Physical Therapy's Notice of Privacy Practices for a more complete description of such uses and disclosures.

A copy of the Notice of Privacy Practices (see reverse side of this document) was made available to me prior to signing this consent. The Practice reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer.

_____
Initial

With my permission, the offices of Pratt Physical Therapy may call my home or other designated locations and leave a message on voicemail, or in person, in reference to any items that may assist The Practice in carrying out TPO, such as appointment reminders, insurance matters and any information pertaining to billing/collections or my clinical care, including laboratory results among others.

With my permission, the offices of Pratt Physical Therapy may mail to my home, or other designated location, any items that assist The Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that The Practice restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, though it it does so, is bound by this agreement.

By signing this form, I am allowing Pratt Physical Therapy, LLC to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

I may make the following special request for confidential communications:

_____
_____
_____

_____ _____
Signature of Patient or Legal Guardian Date

_____
Print Patient's Name

_____ _____
Print Legal Guardian's Name Date

Pratt Physical Therapy, LLC

Notice of Privacy Practices

To our patients, this notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized the laws are complicated, but we must provide you with the following important information.

Use the disclosure of your health information in certain special circumstances.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or are under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact your home rather than at work. We will accommodate reasonable requests.
2. You can request restriction in our use or disclosure of your health information for treatment, payment, or healthcare operations. Additionally, you have the right to request that we restrict our discloser of your health care information to only certain individuals involved in your care or the payment of your care, such as family members and friends. We are not required to agree to your requests; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that my able used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request to Pratt Physical Therapy.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as along as the information is kept by or for the practice. To request an amendment, your request must be made in writing and submitted to Pratt Physical Therapy. You must provide us with a reason that supports your request for an amendment.
5. Right to copy of this notice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this notice any time. To obtain a copy of this notice, contact our front desk receptionist.
6. Right to file a complaint. If you believe your privacy right has been violated, you may file a complained with our practice; contact Pratt Physical Therapy at (843) 900-0745. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Pratt Physical Therapy at (843) 900-0745.

To request the following restrictions to use or to disclose my health information:

_____

_____

I hereby acknowledge that I have been presented with a copy of Pratt Physical Therapy's Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal Guardian Date