Initial Questionnaire

imua PHYSICAL THERAPY

Name: _____

Mailing Address: _____

_____

Phone: _____

Email: _____

Date of Birth: _____

SS#: _____

Accident: ❑ No ❑ Yes

Type: _____

Work Injury?: ❑ No ❑ Yes

Occupation/ Hrs worked per week: _____ Leisure Activities: _____

History of Hospitalization/Surgery: ❑ Yes ❑ No : _____

Other medical conditions we should know about: _____

Please list any medications you are taking (include dosage):_____

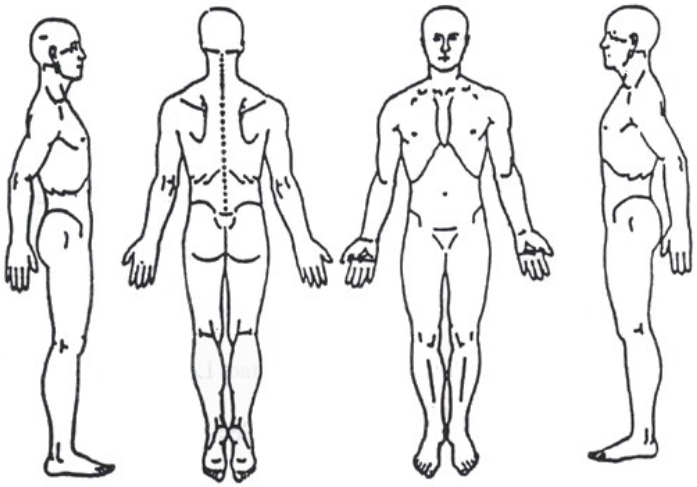
_____

What are your Physical Therapy goals?: _____

Please check if you have, or have had any of the following:

- ❑ Allergies
- ❑ Anemia
- ❑ Asthma
- ❑ Back Pain/Neck Pain
- ❑ Bowel/Bladder Issues
- ❑ Broken Bones
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chest Pain
- ❑ Cystic Fibrosis
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Headaches
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ HIV+/AIDS
- ❑ Joint Replacement
- ❑ Lung Disease
- ❑ Major Illness/Accident
- ❑ Migraine
- ❑ Multiple Sclerosis
- ❑ Osteoarthritis
- ❑ Osteoporosis
- ❑ Pace Maker
- ❑ Polio
- ❑ Recent Falls
- ❑ Rheumatoid Arthritis
- ❑ Seziures
- ❑ Shortness of Breath
- ❑ Stroke
- ❑ Surgery
- ❑ Thyroid Problems
- ❑ Tuberculosis
- ❑ Unexplained Weight Loss/Gain
- ❑ Tobacco Use
- ❑ Orthotic Use
- ❑ Possibly Pregnant
- ❑ X-Ray/MRI/CT Scan

Please mark the location of your symptoms (pain, muscle tightness, tension, stiffness, swelling, spasm, etc.)



What is your **current** pain level today?:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

The **highest** pain level in the past 24 hrs?:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

The **lowest** pain level in the past 24 hrs?:

(No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Severe Pain)

imua
PHYSICAL THERAPY

POLICY DISCLOSURE OVERVIEW

Imua Physical Therapy (IPT) is pleased to participate in your health care and we look forward to a lasting relationship as your physical therapy provider. In maintaining such a relationship, it is important that expectations, both yours and ours, be clearly communicated. What follows is an explanation of the basic and important steps you must take to ensure our ability to provide you with the services you need. We ask that you read this Policy Statement and ask us any questions you might have. Once you are satisfied with your understanding of this Policy Disclosure, we ask that you sign and date the last page.

RELATIONSHIP BETWEEN YOU, YOUR INSURER AND IPT

Your medical insurance contract is between you, the insured, and your insurance company, the insurance provider. IPT is a medical services provider and as such, we are not a party to that contract. Our contract—and our commitment – is with you as our patient. We can help you understand information about your insurance benefits, however you are primarily responsible for knowing what type of coverage you have and for any charges that you have incurred under your contract with us as your medical services provider. It is important that you relay any questions or concerns to us in a timely fashion so that we may help you understand and navigate this process.

CHECKING-IN AND CHECKING-OUT

Upon arrival to each appointment you must check-in at the front desk, show your insurance card if requested, and make payment if one is due. In accordance with CMS/Medicare guidelines, if you are a Medicare patient we are required to maintain a record of the time you check-in and check-out with us. If is important for you to know that we treat this sign-in/sign-out record as Protected Health Information (PHI) in accordance with HIPAA regulations.

CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE, AND SELF-PAY

According to your insurance plan, you are responsible for any and all co-payments, deductibles and co- insurance. We accept cash, checks, & all major credit cards. Our statements satisfy all flexible benefit/health savings account requirements and are available upon request by contacting our office.

CO-PAYMENTS

All co-payments are due at the time of service. If you forget your co-payment for one appointment please plan to make that payment with your next co-payment upon checking in for your following appointment. If you forget your co-payment a second time you may be asked to contact the billing office or reschedule your appointment.

DEDUCTIBLES AND CO-INSURANCE

Deductibles and co-insurance are due within 30 days of receipt of our bill. Some insurance carriers have set allowed amounts for physical therapy visits; in these instances IPT reserves the right to request the deductible and/or co-insurance payment at the time of service. The front desk can provide a list of known allowed amounts based on the type of insurance. If you participate with a high-deductible health plan ($1,500/year or greater), we require a copy of the health savings account debit/credit card or a personal credit card to remain on file.

SELF-PAY

If IPT is not in-network with your insurance carrier and you do not have out-of-network coverage you are responsible for payment in full. Self pay rates represent the average insurance reimbursement rates for the region; $110/evaluation and $100/follow-up. You may choose to pay for your services rather than go through your insurance, however IPT can't submit claims to your insurance carrier at a later date. This is due to claim filing limits, time restrictions in obtaining approval & lengthy data entry efforts.

CANCELLATION POLICY

24 hr. notice required for cancellation. IPT will bill your account $50.00 for any no-show or cancellation without notice.

MEDICAL RECORD FEES

IPT charges $25 to attorneys for medical records.

RETURNED CHECK FEES

A $25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

Signature: _____ **Date:** _____

INSURANCE

Patients must complete and sign information and insurance forms prior to being seen. You must present a current insurance card at each visit if requested. You have a responsibility to provide information to our office so a claim can be properly submitted. If your insurance company has not paid a claim on your behalf within 90 days because of information that you have not provided, you will be responsible for payment. If we receive payment at a later date, you will be reimbursed by IPT. If the insurance company that you designate is incorrect, you will be responsible for payment of the visit or visits. If we receive payment at a later date from the correct insurance company, you will be reimbursed by IPT. It is imperative that we receive new insurance as soon as possible so that we can submit our invoices for your visits to your insurance company within the filing limit, otherwise the insurer may deny our invoice for your services and you will become responsible for payment.

BILLING

Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your remittance is due within 30 days of the receipt of your bill. IPT reserves the right to collect past due balances at the time of service when treating beyond 30 days of your last statement date. Balances over 90 days will be forwarded to a collection agency.

PROMPT PAYMENT

Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay our bill promptly. In the case of financial hardship, or if you are unable to pay your bill in its entirety please contact our billing office to discuss payment options. If your account becomes delinquent and you fail to work with us in establishing a payment plan, your account will be turned over to a collection agency.

MINORS AND DEPENDENTS

A parent or guardian must accompany all minors (age 17 and under) to the initial evaluation to complete and sign required paperwork. For subsequent visits, patients under the age of 18 may be dropped off for the appointment as long as the Co-payment is paid. Parents and guardians are responsible for payments at the time services are rendered. To aid you in meeting this requirement the billing office can keep a credit card on file. The card will be billed weekly for any payments incurred during the week. Please contact the billing office if you wish to put a credit card on file. The subscriber to an insurance policy will be the party to receive bills from IPT for all dependents on the policy.

I understand and agree to comply with the terms of IPT's Policy Disclosure.

Signature: _____ Date: _____

Name (please print): _____

Relation to the patient: _____

If the patient is a minor a signature from the parent or guardian is requir**ed.**

Notice of Privacy Practice (HIPAA)

I understand that IPT is a health care provider and that it will use or disclose my health information for treatment, billing & health care operation. I have seen a copy of the notice of privacy practices that describes how my health information is used & shared. I understand that I have the right to request restrictions on uses and disclosures of my health information for treatment, payment & health care operations purposes.

Check One:
- ❑ I acknowledge receipt of a copy of the Notice of Privacy Practices from Imua Physical Therapy
- ❑ I have been offered a copy of the Notice of Privacy Practices from Imua Physical Therapy, but I have chosen to decline a copy at this time. _____

_____

Patient/Guardian Signature Date