BACKWAY'S PHYSICAL THERAPY, PLLC: INSURANCE CLIENT INFORMATION FORM

Welcome to our Practice! ***Sorry these forms are lengthy****, but they will assist us in fully evaluating your condition and establishing a meaningful treatment plan for you. Please fill them in to the best of your ability.*

NAME________________________ **AGE**______ **BIRTHDATE**___________ **HT**______ **WT**______ **SEX**____
ADDRESS________________________ **CITY**________________ **STATE**_____ **ZIP**__________
Phone: Home____________________ **Work**__________________ Ext_______ **Cell** ____________________
Email: ________________________ **PROFESSION**____________________
MARITAL STATUS: S M W D Sep. **Spouse's Name**____________________________
YOUR SOC. SEC.#_______-______-_________ **SPOUSE'S SOC. SEC.#**_______-______-_________
EMERGENCY CONTACT: Name: ________________________ **Phone#**____________________

DOCTORS' NAMES & PHONE #

1ST Dr.	2ND Dr.
Phone #	Phone #

Have you received any physical therapy, speech therapy, home health care or hospice care services? ☐Yes ☐No
If yes, when? ____________________ Please explain: ____________________
____

INSURANCE INFORMATION:

✶ ✶ ***Please be sure to bring your insurance cards and your picture ID with you.*** *The law requires that we copy them.* ✶ ✶
Please fill in the following information as it relates to the type of insurance we will be billing for you.
HEALTH INSURANCE: *(Please write the Insurance Co. name, but only list the other information if it differs from your Card.)*

Primary Insurance Company Name:	**Secondary/Supplemental Insurance Company Name:**
Insured's Name:	**Insured's Name:**
Insured's Date of Birth:	**Insured's Date of Birth:**

Were you injured on the job? ☐ Yes ☐ No **Is this a Workers Compensation Claim? ☐ Yes ☐ No**
Were you injured in an Auto Accident? ☐ Yes ☐ No
If you answered yes to any of these questions*, please fill in the following information:*
AUTO or WORKERS COMP INSURANCE (*circle one*)

Ins. Company Name & Address:	**Phone #**
	Claim #
	Claims-person:
	Place & Date of Accident:

Is an attorney involved in your case? ☐ Yes ☐ No. *If yes, please give us the name, address & phone number:*

Attorney's Name:	**Phone #**
Address:	**City, State, zip:**

RESPONSIBLE PARTY (If not you, who will be responsible for paying the bill?)
Name____________________________ Relationship To You____________________
Address____Zip______________
HomePhone#____________________WorkPhone#____________________Ext____________

* * *

We believe that patients who understand and participate in their health care will achieve the best results. We respect your individuality, your rights, and your privacy, and we will give you the best care we possibly can.

Please read the following, and sign below. [Page 9 contains further details on our Financial and Office Policies]

Financial Responsibility: You are responsible for paying your deductible and your co-pay/co-insurance at each visit. If you cannot afford to pay, you will be expected to set up, and adhere to, a payment plan. Late fees may be charged on overdue account balances if you miss making regular payments. A fee of $25 will be charged on bank-returned checks.

Missed Appointments: If you need to cancel an appointment, let us know before 8AM of the day prior to your scheduled appointment. If you cancel late, or if you do not attend your appointment, **you will be charged** a missed-appointment fee.

I have read the two statements above, and understand them. I hereby consent to treatment by Backway's Physical Therapy, PLLC.

Signed____________________________________**Date**____________________

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Physical Therapy: Initial Appointment Questionnaire: <u>Present</u> <u>Problems</u>

*It is important that you inform us of **<u>ALL</u>** medical/health conditions at your first appointment, and immediately inform us of any changes in your medical/health condition during your course of treatment.*

Please answer these questions to the best of your ability. ***If something is confusing, leave it blank.***

Information About What Brought You Here:

How did you hear about our services? ______________________________

What are the main symptoms that bring you to Physical Therapy today? ______________________________

____

Onset: When did your symptoms begin (most recent flare-up)? ______________________________

Was the onset sudden, due to an accident/activity, or was the onset gradual? ______________________________

Tests: What diagnostic tests have been performed for your problem (MRI, x-ray, CT) and what are the results?

____

____

Previous Treatment: Have you had any **non-PT** treatment for these symptoms? Yes _____ No _____

If "yes," please describe______________________________

Have you had any previous **Physical Therapy** treatment for these symptoms? Yes _____ No _____

If "yes," please describe______________________________

Other Services: Have you received <u>any</u> **physical therapy, speech therapy, home health <u>or</u> hospice care services in the past year?** Yes _____ No _____ If yes, when? ______________________________

Please explain: ______________________________

Aggravating Factors: What activities make your symptoms worse? ______________________________

____

Easing Factors: What makes your symptoms better? ______________________________

____

Self-care: What are you currently doing for self-care of your symptoms? ______________________________

____

Previous Level of Function: What were you able to do before these symptoms began that you cannot do now?

____

____

What limits do you have to set on your normal activities due to this problem?

Activity	**Any time limits?**	**Any special modifications?**	
Sitting			
Move Sitting to Standing			
Sleeping			
Move Lying to Sitting			
Working			
Computer use			use ☐Laptop? ☐Desktop?
Phone use			use headset Yes☐ No☐
Reading			use Bifocals Yes☐ No☐
Sports or Fitness			
Driving			☐Automatic? ☐Manual?
Recreation (list):			

Goals: What results do you want from Physical Therapy? ______________________________

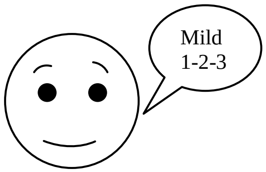
____

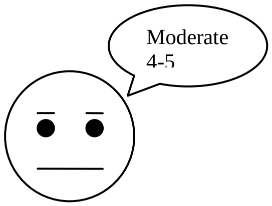
Patient name: ______________________________ Date: ___________

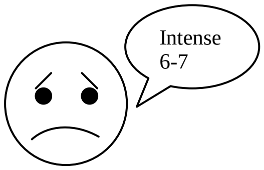
Backway's Physical Therapy Initial Appointment Questionnaire: <u>"0-9"</u> <u>Pain</u> <u>Scale</u>

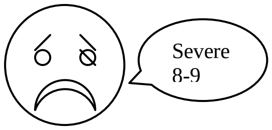
Please use the following information when rating your pain and answering questions regarding your problem.

Draw an "X" on the vertical line to indicate the intensity of your pain.









None

Severe

<u>Mild Pain</u>: Pain does not interfere with most activities. You may use medication or devices such as cushions.

1....Vague Discomfort: Very light, barely noticeable pain.

2....Minor pain: like lightly pinching the webbed tissue at thumb

3....Uncomfortable but Tolerable: Very noticeable pain, like a cut, or an injection, which you can ignore after a while.

<u>Moderate Pain</u>: Pain interferes with many activities & requires lifestyle changes but you remain independent and functional.

4....Annoying: Medium, deep pain, like a toothache or stubbed toe, can't be ignored. You do many activities, but w/pain.

5....Very Uncomfortable: Noticeable pain all the time; you're preoccupied w/managing it; normal lifestyle curtailed.

<u>Intense Pain</u>: Pain interferes with your job or normal interactions. You require some assistance to function.

6....Distressing or Intense: Strong pain dominates your thoughts; thinking is sluggish. Work & social life are curtailed.

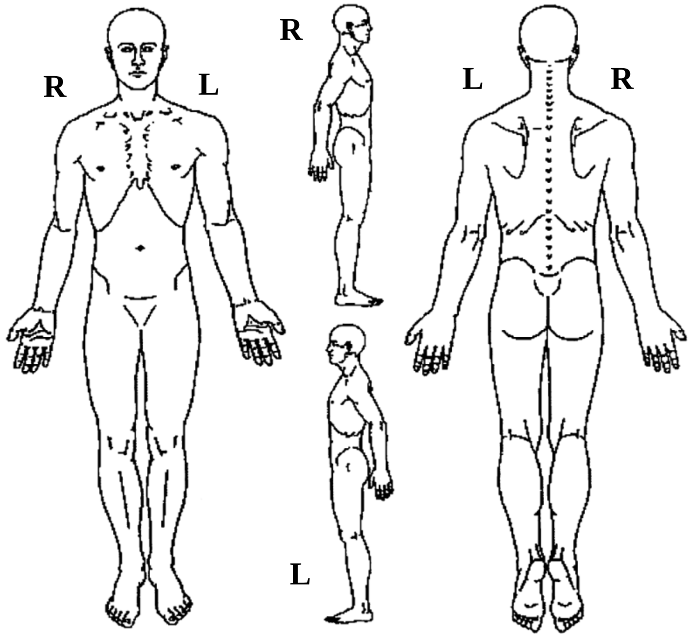
7....Very Intense: Strong pain causes you to think unclearly 50% of the time. You're partly disabled and need help @ home.

<u>Severe</u>: You are unable to engage in normal activities. You find yourself disabled and unable to function independently.

8....Excruciating: Due to the pain, you no longer think clearly; there is no joy in life, and you are willing to take painkillers or have surgery, no matter what the risks.

9....Intolerable or Unbearable: You feel like you're going to pass out. You consider going to the emergency room.

Please indicate, on the figures below, the area(s) in which you are experiencing symptoms:



Also, please list your most painful areas and rate them using the 0-9 scale above *(if you have more than 3 areas, list on the back of this form)*

(1) ____________________________

Usual pain level during a normal day:
Lowest pain level in past week:
Highest pain level in past week:
% of time at highest pain level: ___

(2) ____________________________

Usual pain level during a normal day:
Lowest pain level in past week:
Highest pain level in past week:
% of time at highest pain level: ___

(3) ____________________________

Usual pain level during a normal day:
Lowest pain level in past week:
Highest pain level in past week:
% of time at highest pain level: ___

What % of time are you free of pain? ____%

Patient name: ________________________________ Date: ___________ *(PT: Initial Insurance Forms Page 3 of 9)*

Backway's PT: Initial Appointment Questionnaire: Modified Oswestry Disability Questionnaire

This questionnaire helps us to understand how much your pain affects your ability to perform everyday activities.
Please check **the one box in each section** that **most** clearly describes your problem ***RIGHT NOW.***

SECTION 1: Overall Pain Intensity
☐ The pain is very mild and comes and goes.
☐ The pain is mild and does not vary much.
☐ The pain is moderate and comes and goes.
☐ The pain is moderate and does not vary much.
☐ The pain is severe and comes and goes.
☐ The pain is severe and does not vary much.

SECTION 2: Personal Care (washing, dressing, etc.)
☐ I do not have to change the way I wash and dress myself in order to avoid pain.
☐ I do not normally change the way I wash or dress myself even though it causes some pain.
☐ Washing and dressing increases my pain, but I can do it without changing my way of doing it.
☐ Washing and dressing increases my pain, and I find it necessary to change the way I do it.
☐ Because of the pain, I am partially unable to wash and dress without help.
☐ Because of the pain, I am completely unable to wash or dress without help.

SECTION 3: Lifting
☐ I can lift heavy weights without increased pain.
☐ I can lift heavy weights but it causes increased pain.
☐ Pain prevents me from lifting heavy weights off the floor but I can manage if they're conveniently positioned (example: on a table, etc.).
☐ Pain prevents me from lifting heavy items. I can manage light-medium weights if they're conveniently positioned.
☐ I can only lift very light weights.
☐ I cannot lift or carry anything at all.

SECTION 4: Walking
☐ I have no pain when walking.
☐ I have some pain when walking but I can still walk my required normal distances.
☐ I cannot walk more than one mile without increasing pain.
☐ I cannot walk more than ½ mile without increasing pain.
☐ I cannot walk more than ¼ mile without increasing pain.
☐ I cannot walk at all without increasing pain.

SECTION 5: Sitting
☐ I can sit in any chair as long as I like without pain.
☐ I can sit only in my favorite chair as long as I like.
☐ Pain prevents me from sitting more than 1 hour.
☐ Pain prevents me from sitting more than ½ hour.
☐ Pain prevents me from sitting for more than 10 minutes.
☐ I avoid sitting because it increases pain immediately.

SECTION 6: Standing
☐ I can stand as long as I want without pain.
☐ I can stand as long as I want but some pain develops.
☐ Pain prevents me from standing more than 1 hour.
☐ Pain prevents me from standing more than ½ hour.
☐ Pain prevents me from standing more than 10 minutes.
☐ I avoid standing because it increases my pain immediately.

SECTION 7: Sleeping
☐ I have no pain while in bed.
☐ I get pain in bed but it does not prevent me from sleeping well.
☐ Because of pain, I sleep only ¾ of my normal time.
☐ Because of pain, I sleep only ½ of my normal time.
☐ Because of pain, I sleep only ¼ of my normal time
☐ Pain prevents me from sleeping at all.

SECTION 8: Social Life / Recreation
☐ My social/recreation activities are normal and without pain.
☐ My social/recreation activities are normal, but increase the degree of pain.
☐ Pain has little effect on my social/recreation activities except limiting more energetic interests, e.g. dancing, etc.
☐ Pain restricts my social/recreation activities and I do not go out very often.
☐ Pain restricts my social/recreation activities to my home.
☐ I have hardly any social/recreation life because of pain.

SECTION 9: Traveling / Driving
☐ I can travel/drive without increased pain.
☐ I can travel/drive unrestricted, but it increases my pain.
☐ My pain restricts travel/drives of over 2 hours.
☐ My pain restricts my travel/drives of over 1 hour.
☐ My pain restricts my travel/driving to short necessary journeys under ½ hour.
☐ Pain prevents all forms of travel except that done lying down, or for visits to the doctor, therapist or hospital.

SECTION 10: Employment / Homemaking
☐ My normal job/homemaking duties do not cause pain.
☐ My normal job/homemaking duties increase my pain, but I can still perform all that is required of me.
☐ I can perform most of my job/homemaking duties, but pain prevents me from performing more physically stressful activities like lifting, vacuuming, etc.
☐ Pain prevents me from doing anything but light duties.
☐ Pain prevents me from doing even light duties.
☐ Pain prevents me from performing any job or homemaking chores.

(for therapist's use only) **DI Score______%**

Patient name: __________________________________ Date: ____________

Backway's PT Initial Appointment Questionnaire: *Health History Questionnaire*

Please give names of *all* other Health Care Professionals you are seeing (Massage, Psychologist, Chiropractor, Acupuncture, etc.):

____

____

"Substance" Use	**Never**	**Rarely**	**Daily**	**Current use: how much?**	**Past use:**
Alcohol	☐	☐	☐	____________ drinks/day	not in _______ wks/months/yrs
Tobacco	☐	☐	☐	____________ packs/day	not in _______ wks/months/yrs
Recreational Drugs	☐	☐	☐	Explain:	not in _______ wks/months/yrs

Please indicate if you now have, or in the past had, any of the following (check all that apply):

Nervous System

☐ Head / Brain Injury
☐ Stroke
☐ TIA's
☐ MS
☐ Parkinson's
☐ Peripheral Neuropathy
☐ Epilepsy / Seizure Disorder
☐ other Neurologic problems *(list)*

Respiratory System

☐ Asthma
☐ Emphysema or COPD
☐ Pneumonia
☐ Sinus surgeries
☐ Deviated Septum
☐ Allergies
☐ other Lung problems *(list)*

Digestive & Eliminatory

☐ IBS
☐ Frequent Loose Stools
☐ Frequent Constipation
☐ Discomfort following meals
☐ Hiatal Hernia
☐ Disordered Eating
☐ Kidney Disease
☐ Liver Disease
☐ Urinary Incontinence

Endocrine & Immune System

☐ AIDS
☐ HIV positive
☐ Hepatitis A B C (circle)
☐ Diabetes Type 1 or 2 (circle)
☐ Thyroid Imbalance
☐ Low Blood Sugar
☐ Cancer
Please describe:

____

Cardiac / Circulation System

☐ Heart Attack
☐ Angina or Chest Pain
☐ Irregular Heart Rhythm
☐ Stents placed
☐ Bypass Surgery
☐ Heart Failure
☐ Pacemaker or Defibrillator
☐ Aneurism
☐ Blood Clot
☐ Bleeding / Bruising tendency
☐ Deep Vein Thrombosis (DVT)
☐ Neck, arm, jaw or upper back pain with exertion
☐ High Blood Pressure
☐ High Cholesterol

Musculoskeletal & Connective Tissue Conditions

☐ Osteoarthritis
☐ Spinal Stenosis
☐ Spondylolisthesis
☐ Herniated Disc Neck
☐ Herniated Disc Low Back
☐ Osteoporosis or Osteopenia
☐ Compression Fractures
☐ Stress Fracture
☐ Carpal Tunnel Syndrome
☐ Thoracic Outlet Syndrome
☐ Rheumatoid Arthritis
☐ Lupus
☐ Gout
☐ Fibromyalgia
☐ Migraine
☐ Frequent Headaches
☐ TMJ
☐ Teeth Grinding
☐ Other: *(list)*

Traumas (please note year)

☐ Whiplash
☐ Fractures / broken bones *(list)*

☐ Dislocations ______________
☐ Ligament Tear ____________
☐ Meniscus Tear_____________
☐ Bad Sprains *(list)*

☐ Motor Vehicle Accident(s)
1) When?______________
Driver ☐ Passenger ☐
Injured: Yes ☐ No ☐
If yes, what ____________
2) When?______________
Driver ☐ Passenger ☐
Injured: Yes ☐ No ☐
If yes, what ____________
3) When?______________
Driver ☐ Passenger ☐
Injured: Yes ☐ No ☐
If yes, what ____________
☐ Other: *(list)*

Patient name: ________________________________ Date: ___________

Backway’s PT: Health History continued

General Challenges

☐ Falls. If yes, are they frequent (more than 2 in a year)? ☐
☐ Shortness of Breath
  ☐ on exertion ☐ lying flat
☐ Dizziness
☐ Balance Disturbance
☐ Anemia
☐ Memory Loss
☐ Hearing Loss
☐ Vision Loss
☐ Sleep Apnea
☐ Insomnia
☐ Unusual Fatigue
☐ Alcoholism
☐ Substance Abuse (current or in recovery)
☐ Clinical Depression
☐ Mental or Emotional disorders or difficulties

Please Explain:

Surgeries *Please list **all** surgical procedures with approximate dates **or** your age at the time* (include metal & plastic implants, joint replacements, cosmetic & reconstructive surgeries, etc.)

Other Illnesses, Accidents & Hospitalizations
List, if not included elsewhere:

Please list any other information regarding your medical or health history that you believe we should know:

Please look over this Initial Questionnaire form carefully & be sure it is complete.

Providing incorrect information can be dangerous to your health.

***Please Note**: Your Therapist has the right to dismiss from treatment any patient who intentionally withholds pertinent medical / health information.*

***Thank you** for providing this information for us. Please remember to immediately inform us of any changes in your medical/health condition during your course of treatment.*

***The following forms** will tell us about your medications, your insurance & contact information. They ask you for your signatures to give us permissions for billing, treatment, and communication purposes; and to indicate you understand how your insurance, our billing, and the HIPAA Privacy Act work.*

Backway's Physical Therapy: Intake Form **Patient Medication List & Recent Fall History**

Have you fallen in the past 12 months? ☐Yes ☐No **How many times?** _______ **Were you injured from falling?** ☐Yes ☐ No

Please look at the labels on your medications & supplements; then list them below. This includes all prescription, over-the-counter, herbals, vitamins, minerals and dietary/nutritional supplements you take routinely, and/or on an as-needed basis.

Medication or Supplement Name	**Dosage**	**How many times/day?**	**Is this taken by mouth or other route?**	**What condition is this for?**	**"May cause dizziness" label on it?**	**Does this med make you dizzy?**
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No
					Yes No	Yes No

Therapist notes: Is form complete? ☐ Yes, ☐ No. If no, reason not completed: ☐ Pt refused ☐ Emergency ☐ Pt cog unable **(initials: ________)**

Patient Name: ________________________________ **Date:** ____________________

Backway's Physical Therapy, PLLC **AUTHORIZATIONS & CONSENTS FORM**

You have the right to revoke the following authorizations, unless we have already taken action relying on the authorization. Requests to revoke any authorizations must be made in writing. ____________ (please initial)

****

Optional: **Consent for Use of Information for Presentations, Research and/or Publications (optional)**
I grant permission, now and in future, to Backway's Physical Therapy, or their duly appointed representative, to use my records, or those of my dependent, for other consultations and for professional education, research and publications, **providing reasonable precautions are taken to guard against the disclosure of the client's identity**. My signing of this authorization is **not** a condition to receive treatment by Backway's Physical Therapy personnel.

(Optional) Patient's/Guardian's Signature ________________________________Date ____________

****

All Authorizations below are Mandatory:

Authorization for release of information to Insurance Company & for payment from Insurance:
I authorize the staff of Backway's Physical Therapy to release information acquired in the course of my evaluation and treatment to my insurance company as needed to determine the benefits payable for the related service; and I request that any payment of authorized insurance benefits be made on my behalf to Backway's Physical Therapy, at their business address, for all services furnished that were not paid in full by me at the time services were rendered. **(_____ initials)**

Authorization for "Signature on File:" I authorize the staff of Backway's Physical Therapy to submit completed claim forms to my insurance company using the notation "signature on file" to indicate that I have signed this Authorizations Form. This one-time signature is valid for claims resulting from this and future services provided to me by Backway's Physical Therapy, PLLC. **(_____ initials)**

Authorization to leave Messages: In the event that Backway's Physical Therapy cannot speak to me in person regarding the appointments or evaluation results, I give permission to Backway's Physical Therapy to contact me and leave a message on *(check all that apply)*: **(_____ initials)**

Answering Machine ___________ Cell Phone ____________ or other location_____________________

Consent for Mutual Exchange of Information: I authorize the mutual exchange of information regarding myself, or my dependent, between the Backway's Physical Therapy staff members, and all professional practitioners involved in my healthcare, or that of my dependent, at any time (i.e. doctor, chiropractor, counselor, etc). Your office may also talk with the non-practitioner persons listed below about my health information: **(_____ initials)**

☐ Spouse	Name:	phone#:
☐ Child	Name:	phone#:
☐ Parent	Name:	phone#:
☐ Other	Name:	phone#:
☐ Other	Name:	phone#:

Consent for Treatment: I hereby authorize the professional staff of Backway's Physical Therapy to evaluate and treat me or my dependent. During the course of evaluation and treatment, I authorize the licensed personnel at Backway's Physical Therapy to use any and all techniques they have been trained to use, which they believe will benefit me, in order to help me recover. I have the right to refuse a specific technique or form of treatment, if I so choose. **(_____ initials)**

Receipt of HIPAA Patient Privacy Notice: My signature below indicates that I have received the HIPAA Patient Privacy Notice. I consent to your use and disclosure of protected health information about me for treatment, payment, health care operations, and/or as required by law and by HIPAA. **(_____ initials)**

➔Patient's/Guardian's Signature ______________________________________ Date ____________

Patient name: _______________________________ Date: ____________

Backway's Physical Therapy, PLLC FINANCIAL, BILLING & OFFICE POLICIES

At Backway's PT, we are committed to assisting you, even with billing your insurance company. It is important that you realize **our relationship is with you,** ***not*** your insurance company. *Please* read these financial, billing and office policies to understand what we expect from you in this process; then sign below.

1. **Insurance:** We participate with most insurance plans, but not all of them. Each insurance company has many different plans, so we cannot know exactly what your plan covers. Therefore, it is **your** responsibility to know your insurance benefits. If you don't know, please call your insurance company and ask: What are my benefits for Physical or Speech Therapy? What is my deductible & has any been met? What restrictions or limits apply to my care? What is not covered? What is my copayment amount or coinsurance percent?
2. **Insurance Verification:** ***As a courtesy***, we call your insurance company to verify your insurance coverage. However, all insurance companies tell us the information they give us is "an estimate and is not a guarantee of coverage or benefits." Since your insurance company does not take responsibility for the information they provide to us, we cannot be sure of your coverage until they **actually process** your claim. ***Because of this***, **we cannot guarantee** payment of claims by your insurance company.
3. **You are responsible**. You are responsible for making sure your account is paid in full. Filing of all insurance claims, other than Medicare, is a **courtesy** provided by this office. We will assist you in any way we reasonably can to help get your claims paid. If your claim is reduced or denied by your insurance company, or you exceed your limits of coverage, you will be responsible for paying the balance on your account, up to your insurance company's normally allowed amount.
4. **Non-covered & Disallowed services:** Many health insurance companies do not allow or pay for supplies & maintenance services. Additionally, unbeknownst to us, in some rare cases, a portion, or all of the services you receive may not be covered or may be considered "not reasonably necessary" by your insurance plan. Because of this, we will bill you, and you agree to pay for services and/or supplies which may be denied as "non-covered" by your insurance plan.
5. **Payment is due at time of service**.

✶*Cash, check & credit card payments accepted with an added fee for use of a credit card.* ✶

Credit Card payments are accepted for $50 or more, and are subject to an added $5 PayPal fee.

You are responsible for paying your deductible, co-payment or coinsurance amount at the time of service. This arrangement is part of your contract with your insurance company.

If you do not have sufficient funds to pay at the time of the visit, we expect payment to be made within 10 days of the visit, ***whether or not you receive an invoice from us.***

✶ ✶ ***If you have financial problems that affect your ability to make timely payment on your account***, please discuss this with us before or at the time of service, so that you can make payment arrangements. ✶ ✶

6. **Overdue Accounts**: All overdue accounts are subject to late fees. Amounts billed to your insurance company are considered overdue 30 days after they process a specific service date (even if this processing did not result in payment for that service date). Liens start accruing fees 90 days after discharge from therapy.

Late fee tabulation:

Past Due Balance	$20 - $100	$101 to $750	$751 to $3000	Greater than $3000
Monthly Late Fee	$15	$25	$50	$75

Returned check fee: A fee of $25 is charged on all returned checks.

Collections: Returned checks and failure to pay account balances overdue for 90 days may result in our referring your account to an outside collection service.

7. **Missed appointments:** this policy was already stated at the bottom of page 1.
8. **We may refuse service** to a client under certain circumstances. Refusal is usually due to, but is not limited to: non-payment of past accounts; repeated missed/canceled appointments; inappropriate or belligerent behavior; and the therapists' opinion that our services won't benefit a client or aren't medically necessary.

I have read and understand the financial, billing & office policy information presented above.

Signed____ Date__________________

Patient Name: ____