Springfield Physical Therapy & Sports Rehab
Medical Questionnaire

Your Name: _____ Email: _____ DOB: _____

Please List all allergies: _____

_____

Do you currently have or have you had:

Asthma/Bronchitis/Emphysema?	Yes	No
Shortness of Breath/Chest pain?	Yes	No
Coronary Heart Disease or Angina?	Yes	No
Do you have a Pacemaker?	Yes	No
High Blood Pressure?	Yes	No
Heartattack or Heart Surgery?	Yes	No
Stroke/TIA?	Yes	No
Congestive Heart Failure?	Yes	No
Blood Clot/Emboli/DVT?	Yes	No
Epilepsy/Seizure disorder?	Yes	No
Thyroid Disease?	Yes	No
Diabetes?	Yes	No
Cancer/Chemo/Radiation?	Yes	No
Arthritis?	Yes	No
Osteoporosis?	Yes	No
Gout?	Yes	No
Sleeping difficulties?	Yes	No
Vision or hearing difficulties?	Yes	No
Numbness or tingling?	Yes	No
Severe or frequent headaches?	Yes	No
Dizziness or fainting	Yes	No
Bowel/bladder problems	Yes	No
Weakness	Yes	No
Weight/energy loss	Yes	No
Varicose veins	Yes	No
Metal implants/pins	Yes	No
Joint replacement surgery	Yes	No
Are you pregnant?	Yes	No
Do you use tobacco?	Yes	No
Emotional/Psychological problems?	Yes	No

Have you had any of the following medical services for THIS injury?

Home Health Care	Yes	No
CT scan	Yes	No
General Practitioner care	Yes	No
Neurologist	Yes	No
Orthopedist	Yes	No
Podiatrist	Yes	No
Skilled Nursing Facility stay	Yes	No
Speech Therapy	Yes	No
Chiropractic Care	Yes	No
Massage Therapy	Yes	No
Occupational Therapy	Yes	No
Physical Therapy	Yes	No
EMG/NCV	Yes	No
Myelogram	Yes	No
ER Care	Yes	No
Hospital Stay	Yes	No
MRI	Yes	No
Xray	Yes	No

If you circled yes for any medical imaging, please include where and when your imaging was done.

_____

_____

_____

Is there any additional information we should know that could affect your care?

_____

_____

Please List ALL medications, dosages, and times taken. REQUIRED

_____ _____

_____ _____

_____ _____

_____ **Please List Height & Weight. REQUIRED**

_____ _____

Who influenced you to come to Springfield PT? _____

What are your goals for PT? _____

Springfield Physical Therapy & Sports Rehab
Consent for Care & Treatment, Benefit of Assignment/Release of Information/ Financial Policy Statement

Consent for Care & Treatment

I, the undersigned, do hereby agree and give my consent for Springfield Physical Therapy & Sports Rehab to furnish medical care and treatment considered necessary and proper in diagnosing or treating.

_____ _____

Patient/Guardian/Responsible Party Date

Benefit of Assignment/Release of Information

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payors to Springfield Physical Therapy & Sports Rehab. 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/Responsible Party Date

Financial Policy Statement

We 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 request a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal (usual and customary fee schedule), you will be responsible for the difference remaining. If any payment is made directly to you for services billed by us, you recognize an obligation to promptly submit same to Springfield Physical Therapy & Sports Rehab.

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

When you pay by check: you expressly authorize Springfield Physical Therapy & Sports Rehab (if your check is dishonored for any reason) the right to charge you a returned check fee of $25.00 for the processing fee plus the amount of your check. The above language authorizes an electronic debit to your account for the recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however, mean that Springfield Physical Therapy & Sports Rehab cannot collect a returned check fee by other methods. 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, including court costs, collection agency fees, and attorney fees.

Information Privacy: Springfield Physical Therapy & Sports Rehab will use and disclose your personal health information to treat you, to receive payment for the care we provide, and for other health care operations. Health care operations generally include those activities we perform to improve the quality of care. We have prepared a detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regards to your personal health information. The terms of the notice may change with time and we will always post the current notice at our facilities, on our website and have copies available for distribution. The undersigned acknowledges receipt of this information. I UNDERSTAND MY RESPONSBILITY FOR THE PAYMENT OF MY ACCOUNT

_____ _____

Patient/Guardian/Responsible Party Date

Springfield Physical Therapy & Sports Rehab
Cancellation/Late/No Show Policy

PLEASE READ!

Cancellation/No Show/Late Policy For All Scheduled Appointments

1. **Cancel/No Show**

   We understand that there are times when you must miss an appointment due to emergencies or obligations for work and family. However, due to the large (1 hour) block of time needed for each patients' appointment, last minute cancellations and no shows cause problems and added expenses for the office.

   When you do not call to cancel an appointment or give us proper notice, you may be preventing another patient from getting much needed treatment. *Conversely, the situation may may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.*

   If an appointment is not cancelled at least 24 hours in advance, you will be charged a twenty-five dollar ($25) fee; this will not be covered by your insurance and you are solely responsible for this.

2. **Late**

   We also understand that delays can happen, however we must do our best to keep patients and providers on a schedule for *your benefit.*

   If you arrive thirty (30) minutes past your scheduled time (without notifying the office), we will reschedule your appointment and add a late fee of twenty-five dollars ($25) to your account. This fee is not covered by your insurance and you are solely responsible for this.

3. **Account Balances**

   We require patients with balances pay their account to zero (0) prior to receiving any further services by our providers. Patients with questions in regards to their bills, or those who would like to discuss a payment plan option, may call and ask to speak to a business office representative with whom they can review their account and concerns.

_____ _____

Patient/Parent/Guardian Date

Upper Perk Physical Therapy & Sports Rehab, New Hope Physical Therapy & Sports Rehab, Springfield Physical Therapy & Sports Rehab NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED, DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UPPT, NHPT, & SFPT is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices concerning your health information. This notice takes effect 10/01/03 and will remain in effect until we replace it.

A. USES AND DISCLOSURES OF HEALTH INFORMATION:

UPPT, NHPT, & SPT collects health information from you and is maintained in your chart and on the computer. We are permitted by law to use or disclose your health information for treatment, payment and healthcare operations. For example:

1. Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

2. Payment: We may use and disclose your health information to obtain payment for services we provide to you.

3. Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

4. Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use of disclose your health information for any reason except those described in this Notice.

5. Notification and Communication with family: We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or in the event of your death. If you are able and available to agree or object, we will give you the opportunity to object prior to making this notification. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. Required by law: As required by law, we may use and disclose your health information.

7. Public health: As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

8. Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings.

9. Judicial and Administrative Proceedings: We may disclose your health information in the course of any administrative or judicial proceeding.

10. Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena and other law enforcement purposes.

11. Deceased person information: We may disclose your health information to coroners, medical examiners and funeral directors.

12. National Security: We may disclose your health information for military, national security or similar government functions.

13. Worker's Compensation: We may disclose your health information as necessary to comply with worker's compensation laws.

14. Marketing: We may contact you to provide appointment reminders or to give you information about other treatments or health-related benefits and services that may be of interest to you.

15. Change of Ownership: In the event that UPPT, NHPT, & SPT is sold or merged with another organization, your health information/record will become the property of the new owner.

B. PATIENT RIGHTS:

1. **Access:** You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you a reasonable fee according to the laws and regulations of the State of Pennsylvania for staff time to locate and copy your health information, and postage of you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)
2. **Disclosure Accounting:** You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
3. **Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.
4. **Amendment:** You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
5. **You have a right to a paper copy of this Notice.**

C. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES:

UPPT, NHPT, & SPT reserves the right to amend this Notice of Privacy Practices at any time in the future, and to make the new provisions effective for all information that it maintains, including information that was created or received prior to the date of such amendment. Until such amendment is made, UPPT, NHPT, & SPT is required by law to comply with this Notice. Revised Notices will be posted in a prominent location at each UPPT, NHPT, & SPT office, and available upon request by contacting the Office's Privacy Official.

D. COMPLAINTS:

Complaints about this Notice of Privacy Practices or how UPPT, NHPT, & SPT handles your health information should be directed to the appropriate UPPT, NHPT, & SPT Office Privacy Official at:

Jay Kauffman
Upper Perk Physical Therapy & Sports Rehab, Inc.
2767 Geryville Pike
Pennsburg, PA 18073

I have received a copy of Notice of Privacy Practices for Upper Perk Physical Therapy & Sports Rehab, Inc, New Hope Physical Therapy & Sports Rehab and Springfield Physical Therapy & Sports Rehab.

_____ _____

Patient/Guardian/Responsible Party Date