

Name _____ **AGE:** _____ **DOB:** _____

I am happiest when I participate in these activities:

I am here today because:

_____ This began: _____

What is it you want to do that you can't do now? _____

I am taking medications for: _____ **I am allergic to LATEX: YES NO**

Previous Surgery(s):

GENERAL HEALTH:

Do you have, or have had, any of the following?
 Cancer? **YES NO**
 Diabetes? **YES NO**
 Pregnant (Currently)? **YES NO**
 Metal Implants? **YES NO**
 High Blood Pressure? **YES NO**
 Seizures? **YES NO**
 Concussion? **YES NO**

Do you have orthotics, heel lifts, or any other foot inserts in your shoes? **YES NO**
 Does one of your feet turn out more than the other? **YES NO**
 Do you feel unstable with one or both of your ankles? **YES NO**

NECK/JAW/HEAD:

Do you experience facial pain? **YES NO**
 Do you feel a click or pop when you open or close your mouth? **YES NO**
 Do you experience weekly headaches? **YES NO**
 Do you wake up with a dry mouth? **YES NO**
 Do you feel pain in the front of your ear, or ear "fullness" or "ringing"? **YES NO**
 Do you feel tension at the base of your skull when you turn your head in the upright position? **YES NO**

VISION:

Do you wear contacts? **YES NO**
 Do you wear glasses? **YES NO**
 Do you wear bifocals? **YES NO**
 Do you occasionally bump into objects while walking? **YES NO**
 Do you have difficulty driving at night? **YES NO**
 Do you have blurry vision or double vision? **YES NO**
 Do you feel dizzy? **YES NO**
 Do you feel lateral leg & ankle strain, back tightness, or pain at the bottom of one or both feet? **YES NO**

BREATHING:

Do you snore? **YES NO**
 Do you have difficulty breathing with simple activity, i.e.: going up steps? **YES NO**
 Do you still feel tired after a full night of sleep? **YES NO**
 Do you have asthma? **YES NO**
 Do you use an inhaler? **YES NO**
 Do you have to sleep in an upright position? **YES NO**
 Have you been diagnosed with sleep apnea? **YES NO**

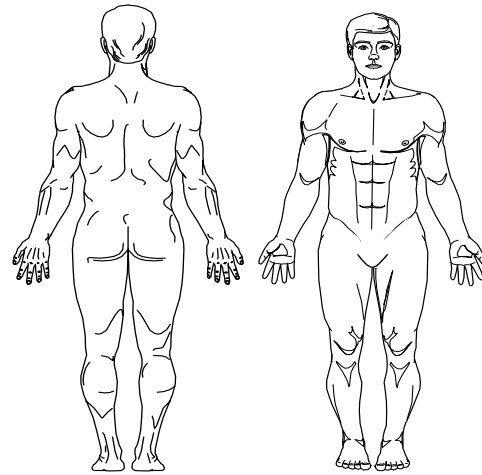
LUMBO/PELVIC/FEMORAL:

Do you ever experience small amounts of urine leakage when you cough, sneeze, laugh, lift or exercise? **YES NO**
 Do you ever experience small amounts of urine leakage associated with a strong sensation of needing to go to the bathroom? **YES NO**
 Do you experience frequent trips to the bathroom that disrupt your day or do you plan trips out based on where the bathrooms are? **YES NO**
 Do you experience pain, discomfort or pressure in your pelvic area when sitting or standing for prolonged periods of time? **YES NO**
 Do you frequently strain to have a bowel movement or to empty your bladder? **YES NO**
 Do you experience the sensation of pressure in your lower abdomen or pelvic region? **YES NO**

FEET:

Do you have flat feet? **YES NO**
 Do you have pain on the bottom of your feet when you are standing? **YES NO**
 Do you have a large bony bump near either of your big toes? **YES NO**

PLEASE INDICATE ON THE PICTURES TO THE RIGHT THE **LOCATION OF YOUR ISSUE(S)** & PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT ITS **WORST AND BEST** ON THE SCALE BELOW



0	1	2	3	4	5	6	7	8	9	10
0 = NO DISCOMFORT					10 = EXTREME DISCOMFORT					

Patient-Specific Functional Scale INITIAL or FOLLOW UP

Date of Today's PT Visit: _____
 Date of Birth: _____

1. Please identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your _____ problem.

****Consider these examples: getting dressed, walking your dog, yard work, sports activities, etc.**

Activity	Score	√ Most Limited
1.		
2.		
3.		

2. Please **score** each activity in the above chart using the scale below.

0	1	2	3	4	5	6	7	8	9	10
Able to perform activity at the same level as before injury or problem					Unable to perform activity					

3. Please check √ which of the activities is **most limited today**, because of your _____ problem.

PATIENT REGISTRATION INFORMATION

PLEASE PRINT & COMPLETE FULLY

DATE _____

PATIENT NAME (FIRST) _____ (MI) _____ (LAST) _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

DATE OF BIRTH -- -- _____ SEX ___ M ___ F

SS # (IF NEEDED FOR INSURANCE): _____ - _____ - _____ SINGLE ___ MARRIED ___ OTHER

PHONE (HOME) _____ (WORK) _____ (CELL) _____

EMPLOYER _____ JOB TITLE _____

STUDENT ___ NO ___ YES (WHERE) _____ (FULL TIME) ___ (PART TIME) ___

EMERGENCY CONTACT _____ (PHONE) _____ (RELATIONSHIP) _____

INJURY/ACCIDENT DATE: _____ **WORK COMP Related?** YES NO **MVA Related?** YES NO

IF YES, ARE YOU WORKING WITH AN ATTORNEY? YES NO **NAME OF ATTORNEY?** _____

WOULD YOU LIKE TO BE ON OUR E-MAILING LIST? EMAIL ADDRESS: _____

REFERRING DOCTOR OR DENTIST:

(FIRST) _____ (LAST) _____ ___ MD ___ DDS ___ DO ___ DC

(CITY) _____ (STATE) _____

HOW DID YOU HEAR ABOUT US? _____

IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM _____

PRIMARY INSURANCE INFORMATION:

TYPE OF INSURANCE: ___ WORK COMP ___ MEDICARE ___ GROUP INS ___ AUTO INS(MVA) ___ 3RD PARTY

INSURED/POLICY HOLDER NAME (FIRST) _____ (MI) _____ (LAST) _____

___ SPOUSE ___ MOTHER ___ FATHER ___ OTHER

ADDRESS _____ (CITY) _____ (STATE) _____ (ZIP) _____

HOME PHONE _____ WORK PHONE _____

SS # _____ DATE OF BIRTH _____

EMPLOYER _____

INSURANCE COMPANY NAME _____

ADDRESS _____

ID # _____ GROUP # _____

INSURANCE COMPANY PHONE # _____

WORK COMP or MVA INFORMATION:

INSURANCE COMPANY NAME _____

ADDRESS _____

CASE MANAGER & PHONE# _____

CLAIM # _____

**MEDICALLY INFORMED CONSENT And
ASSIGNMENT AND RELEASE**

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and /or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at the Hruska Clinic Inc. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for a period not to exceed **one year**.

I hereby authorize my insurance benefits be paid directly to Hruska Clinic, Inc., and understand that I am financially responsible for non-covered services. I understand that if Hruska Clinic Inc. does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize Hruska Clinic Inc. to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at Hruska Clinic Inc.**

I (or _____ for _____) have read this form and fully understand and accept its terms and conditions.

Patient or person authorized to consent for patient / relationship Date / Time

Reason patient was unable to consent Witness signature

**Acknowledgement of Receipt of Notice, PRIVACY PRACTICES
HRUSKA CLINIC INC.
RESTORATIVE PHYSICAL THERAPY SERVICES
BECKY FISHER, ADMINISTRATIVE SERVICES MANAGER, PRIVACY OFFICER**

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

Signed: _____ **Date:** _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate Relationship:

- parent or guardian of minor patient
- guardian or conservator of an incompetent patient
- beneficiary or personal representative of deceased patient

SUMMARY OF NOTICE OF PRIVACY PRACTICES

This summary is provided to assist you in understanding
Our office's complete NOTICE OF PRIVACY PRACTICES

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations & other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas & as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notices of our privacy practices.

If you have a question, concern or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.

INTRODUCTION TO OUR FINANCIAL POLICY:

The Hruska Clinic strongly believes that all patients deserve the very best care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this information to acquaint you with our financial and insurance policies. Our professional services are rendered to you, rather than your insurance company. Therefore payment for treatment is your responsibility.

INSURANCE

THE HRUSKA CLINIC CURRENTLY CONTRACTS WITH **BLUECROSS/BLUESHIELD PPO, MIDLANDS CHOICE, COVENTRY AND MEDICARE**. You will be responsible for any deductibles, co pays, coinsurance and any services not covered by your plan. We strongly encourage you to check with your insurer on your specific physical therapy benefits. Should your plan have a co-pay for physical therapy, we ask that it be paid at each visit.

If you are covered by MEDICARE, you will need a prescription for physical therapy from your *medical* doctor. A referral from a different health professional such as a dentist or chiropractor will not be accepted by Medicare. Once you have received a prescription from your doctor, it will expire for use in 30 days, so please schedule your initial appointment within that time frame. Medicare has imposed a financial "cap" of \$1840 per calendar year for outpatient physical therapy & speech therapy. Once that cap has been exceeded, you will be responsible for payment.

If your health insurance company is not listed above as a contracted or networked insurance, then you will be responsible for all amounts not paid by your plan. A \$30 payment will be due each visit.

OTHER PAYORS

WORKERS COMP: Hruska Clinic will bill your workers compensation carrier for your charges. In the event your claims are denied, you will become financially responsible for all treatment charges. In the event that you seek legal representation in the settlement of your claim, then we ask that you follow our policy listed under "Personal Liability/Litigation".

MVA: We will bill your automobile insurance provided you have auto med-pay coverage with your policy. If that benefit is not available, we will submit your claims to your health insurance provider. In the event that you seek legal representation in the settlement of your claim, then we ask that you follow our policy listed under "Personal Liability/Litigation".

PERSONAL LIABILITY/LITIGATION: If you are working with an attorney for your claim, and are not yet to the point of settlement, our financial policy is as follows:

- If your account balance reaches \$500, as a courtesy we ask for 10% payment monthly, or \$50.
- If the balance of your account reaches \$1000, we will ask that you continue to pay 10% of the balance, or \$100 a month.
- Should your balance reach \$1500, you will be seen on a pay-as-you-go basis.
- If your claim is denied, you are to assume full responsibility for payment.

SELF -PAY: Self-paying patients are required to pay a minimum of \$100 on the first visit and \$50 on each subsequent visit. If these payments do not cover all treatment costs, then you will be billed for the remaining amount per monthly statement. In certain situations, a payment plan can be established to meet your budget by calling our business manager. Monthly payments must be made in order to maintain good credit.

OUR BILLING PROCESS

We automatically file all insurance claims for our services. Although it may take 30-60 days to receive a bill for your deductible and co-insurance, all co-pays are due at the time of service. The following is intended to help you better understand our billing process:

- Charges for your visit are sent by your therapist to our billing staff
- The billing staff then submits these charges to your insurance company for reimbursement
- Hruska Clinic generally receives payment within 30-60 days
- Hruska Clinic will submit a statement to you after your insurance has paid or made a decision on services rendered (usually within 30-60 days)
- For your convenience, we accept cash, check, MasterCard, Visa, Discover and American Express.
- Payment plans can also be arranged to fit your budget. All plans require payments on a monthly basis.

** Please feel free to contact us if you would like to receive a record of your charges prior to receiving your bill. We appreciate your understanding and cooperation, and will be happy to answer any questions you may have about our procedures.