HEALTHQUEST THERAPY

Patient Information

Date_____

Name_____Age_____ Gender: M F

Date of Birth_____/_____/_____ Social Security #_____

Address_____City_____State_____Zip_____

Home Phone (_____)_____Cell Phone (_____)_____

Email_____ (for appointment reminders)

Status: (please circle) Single Married Widowed

Emergency Contact: Name_____Ph#_____

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Work Status: (please circle) F/T Employment P/T Employment Retired Student Disabled

Employer_____Phone (_____)_____

Job Title/Description_____

Job Requirements_____

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Family MD_____ Ph#(_____)_____

Referring MD_____ Ph#(_____)_____

**********YOU DO NOT NEED TO ENTER INSURANCE INFORMATION IF WE HAVE COPIED YOUR CARD**********

Primary Insurance_____ Group #_____ Member #_____

Secondary Insurance_____ Group #_____ Member #_____

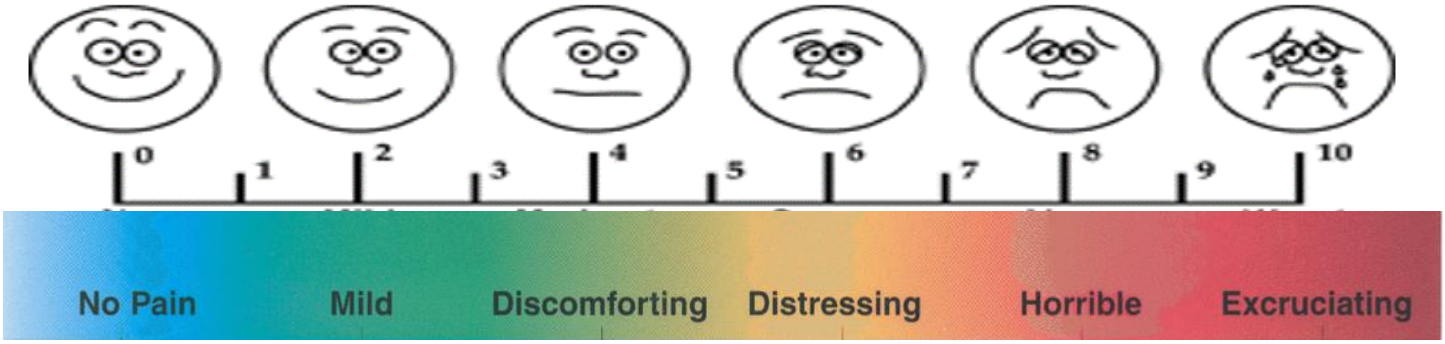
Is this a workman comp. case? Yes No Claim #_____

Case Manager_____Ph#(_____)_____

Address to send claim_____

Have you ever had any previous therapy? _____Occupational _____Physical _____Speech

Treating what symptoms?_____



Pain at your Worst:_____ Currently:_____ At Best:_____

Pain Description: Burning Sharp Dull/Aching Throbbing Shooting Numbness/Tingling

My condition is related to: Work Auto Accident Surgery Fall Sports Injury Other

Date of Injury _____/_____/_____ Date of Surgery_____/_____/_____

Medical History: (please circle) Stroke R or L side Diabetes Type I or II COPD or Asthma Lupus Poor Circulation Blood Clots Frequent Falls Oxygen Use Heart Disease Rheumatoid Arthritis High Blood Pressure Parkinson's TBI Fibromyalgia Current Infection Dementia Alzheimer's ALS Muscular Dystrophy Multiple Sclerosis Pacemaker/Defibrillator

Cancer (type/year) _____
Osteoarthritis: location_____
Current/Previous Fractures: location_____
Other (please list)_____
_____
_____

Are you allergic to latex? a. Yes b. No

How did you hear about us? a. radio b. newspaper c. phone book d. web search e. facebook f. friend/family g. MD

Are you currently receiving HOME HEALTH services?_____ Have you in the past 60 days?_____

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Medicare Patients Only

_____Height _____Weight (Verified by clinic scales)

1. How often do you have a drink containing alcohol?
   a. Never b. Monthly or less c. 2-4 times a month d. 2-3 times a week e. 4 or more times a week
2. How many standard drinks containing alcohol do you have on a typical day?
   None a. 1 or 2 b. 3 or 4 c. 5 or 6 d. 7 to 9 e. 10 or more
3. How often do you have six or more drinks on one occasion?
   a. Never b. Less than monthly c. Monthly d. Weekly e. Daily or almost daily
4. Are you a smoker? a. Yes b.No

Medication List

MEDICINE (prescription **AND** over-the-counter)	**DOSAGE** (mg or ml)	**FREQUENCY** (# times per day)	**METHOD** (oral/injection/drops cream/spray)

Surgery History

Type/Procedure	**Date**

HealthQuest Therapy
Financial Policy Agreement and Authorization Form
PLEASE READ CAREFULLY

Patient Name: _____Date:_____

I am here to receive services from HealthQuest Therapy.
These services may include, but are not limited to...

1. focused or comprehensive therapy examination with or without procedures
2. therapy procedures
3. patient education
4. issue of written therapy instructions
5. use of therapy related equipment

You may be charged a **$45.00 fee** for failure to provide a **24 hr notice of cancellation** of your scheduled therapy appointment. When you do not attend scheduled sessions, we do not get paid for that hour.
Our staff works on commission. We need 24 hr notice to fill that opening in our schedule.

We cannot provide services until this authorization form is read and signed.

- I authorize HealthQuest Therapy to verify that I have insurance coverage before receiving services. As the patient, or authorized agent acting on behalf of the patient, I understand it is my responsibility to know and understand my insurance policy's requirements, deductibles, patient responsibilities and procedures as it relates to my MD ordered therapy. **Our billing specialist can assist you in understanding your policy.**
- I understand that verification of insurance coverage DOES NOT guarantee that my insurance company will pay for the services that I receive today.
- If HealthQuest Therapy receives a notice from my insurance company which denies payment for the services that I have received, I will be responsible for paying the denied therapy services within 30 days of my insurance denial. **Our billing specialist can assist you in understanding your policy.**
- In the event the account becomes past due and must be placed for collection, I sign to be responsible for collection fees and other expenses including 135% of the amount sent for collection.
- Should I **choose** to have any therapy related equipment for home use, I understand that I must purchase the equipment in full if my insurance company will not purchase it or if it is not covered in my healthcare policy.
- **IF** this is a **Workman's Compensation Claim**, I understand and agree to provide all necessary information to HealthQuest Therapy to collect payment. This includes, but is not limited to my place of employment; the name, address, and phone number of my supervisor; the name, address, and phone number of the insurance representative that has been assigned to my case' the insurance claim number for my case; and injury-related information from my employer.

By signing my name below, I accept all conditions listed above. To decline any above listed options, I must write "decline" and place my initials beside that option.

X_____
Patient Signature, or Authorized Agent

Acknowledgement of Receipt of Privacy Practices and Patient's Rights and Responsibilities

Your name and signature on this sheet indicate that you have received a copy of HealthQuest Multidisciplinary Therapy and Rehabilitation's Notice of Privacy Practices and Patient Rights and Responsibilities on the date indicated.

Printed Name of Patient:_____

Signature:_____

Date:_____