419 E. MAIN ST. JEFFERSON, NC 28640

PHONE 336-846-7227

Legal Name: _____**Nickname:** _____

Mailing Address: _____

_____

EMAIL ADDRESS: _____

What reminder method do you prefer? ☐Email ☐Text ☐Call

Primary phone number: _____ **Secondary phone number:** _____

Height: _____ **Weight:** _____ **DOB:** _____

Primary Insurance: _____ **Secondary Insurance:** _____

Primary Care Provider: _____ **Referring provider:** _____

PAST	PRESENT	
☐	☐	High Blood Pressure
☐	☐	Pacemaker
☐	☐	Angina
☐	☐	Heart Attack
☐	☐	Stroke
☐	☐	Congestive Heart Failure
☐	☐	COPD
☐	☐	Asthma
☐	☐	HIV/AIDS
☐	☐	Systemic Lupus
☐	☐	Epilepsy
☐	☐	Rheumatoid Arthritis
☐	☐	Fibromyalgia
☐	☐	Diabetes
☐	☐	Osteoarthritis
☐	☐	Recent weight loss or gain (unexplained)
☐	☐	Osteoporosis
☐	☐	Depression
☐	☐	Cancer- Location: _____
☐	☐	Tobacco- packs/day_____
☐	☐	Other:_____

Prior hospitalizations / Surgical procedures:

_____
_____
_____
_____
_____
_____
_____

Medications (dosage/ MG, Times per day):

_____
_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____
_____

Please describe your current limitation or complaint:

_____

_____

Please describe **how** and **when** your problem began:

_____

_____

Indicate the intensity of your pain at best

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Indicate the intensity of your pain at worst

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (unbearable pain)

Your symptoms are worse in:

☐Morning ☐Afternoon ☐Night ☐Increased during the day ☐Same all day

Are you experiencing any issues with balance?

Yes○ No○ – If yes, how many falls have you had in the past 6 months?_____

Have you had any other treatment for this condition?

Yes○ No○ - If yes, please indicate treatment _____

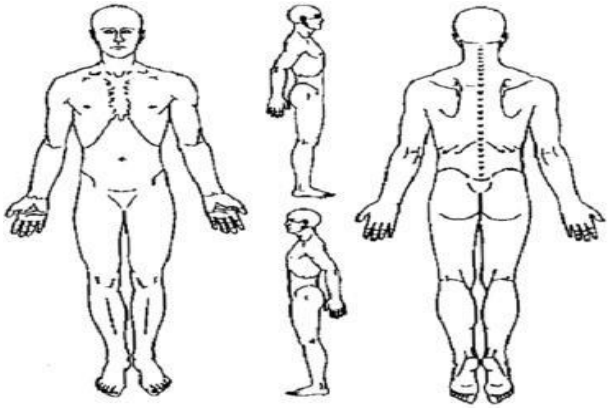
Was this treatment effective: Yes○ No○

Occupation: _____

Has your work status changed because of this condition? Yes○ No○

Is this the result of a work-related injury? Yes○ No○

Was this the result of a motor vehicle accident? Yes○ No○



Please describe the nature of your pain by marking the following image

☐ *Sharp pain* ☐ *Numbness*

☐ *Dull/ ache* ☐ *Shooting*

☐ *Throbbing* ☐ *Burning*

How did you hear about Schuster Physical Therapy? _____

FINANCIAL POLICY: It is the policy of Schuster Physical Therapy (SPT) that payment is due in-full at the time that services are rendered. This includes copayments, deductibles, co-insurance or self-pay fees. Please read the insurance benefits booklet that your insurance provided you to fully understand all waiting periods, frequency limitations, copays, deductibles and other exceptions/ exclusions for your individual plan.

COMMERCIAL INSURANCE PATIENTS: Please understand that any information we relay on behalf of your insurance is simply a courtesy to you and is not a guarantee of payment**.** Occasionally information provided to SPT may be limited or inaccurate. It may take several months for your insurance company to process your claim. If no payment has been made by your insurance company within 6 months of the date of service, you will be responsible for the balance. Occasionally, insurance companies will remit payment to the member rather than the provider's office. In this event, you will be responsible for the amount due to Schuster Physical Therapy. **Should your insurance plan or your insurance carrier change, please inform us immediately.**

MEDICARE: Medicare has an informal "cap" of $2010 per year for outpatient physical therapy and speech therapy but will readily make exceptions for care if it is deemed medically necessary. **Please inform SPT if you have any secondary insurance coverage.**

WORKERS COMPENSATION (WC): Please inform our office immediately if your care is related to a Worker's Compensation case. We will bill your worker's compensation carrier for treatment charges. If we do not have a worker's compensation claim id or case manager contact information and your claim is denied, you will be responsible for all expenses related to your treatment.

MOTOR VEHICLE ACCIDENT: Please inform our office immediately if your care is related to a recent motor vehicle accident. If you fail to inform SPT that your need for treatment is related to a motor vehicle accident and your insurance claims are denied, **you will be fully responsible for the cost of your care**. If you are working with an attorney or have a claim number for your accident, please inform our staff before your first visit.

SELF-PAY/ NON-ENSURED: Self-Pay Physical Therapy examinations are $125 and Follow-Up Physical Therapy Treatment visits cost $75.

Our Billing Process

- Insurance claims are sent on behalf of Schuster Physical Therapy, through our electronic billing partner, "The Medical Billing Center."
- After your insurance company has processed our claim and SPT has secured applicable payment and/ or received an Explanation of Benefits (EOB), The Medical Billing Center will send you a statement for any potential outstanding balance. Please understand that it may take several months for your insurance company to process claims and return final EOBs.
- Balances over 60 days past due will be subject to a 5% monthly finance charge.
- Returned checks will be charged a $40 fee.
- Unpaid balances that are 90 days past due will be sent to collections. We will be very pleased to make arrangements with you to avoid utilizing a collections agency.

Print Legal Name: _____

Schuster Physical Therapy Patient Informed Consent: I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and/ or referring provider. I acknowledge that no guarantees have been made to me as to the results of treatment at Schuster Physical Therapy. It is this clinic's sincere intent to educate me on every process of my rehabilitation. If techniques that are being used to address my symptoms are not understood fully or if I have any other questions or concerns about my care, I understand that it is my sole responsibility to communicate with my therapist or the management of Schuster Physical Therapy. By signing below, I consent to treatment, I agree to communicate any concerns regarding my therapy promptly and I will perform the prescribed activities and Home Exercise Plan to the best of my ability.

X Patient/Parent/Guardian Signature_____Date_____

Emergency Contact: Name_____Contact_____

Assignment of Benefits: I hereby authorize my insurance benefits be paid directly to Schuster Physical Therapy. I understand that I am financially responsible for all services. I agree to all terms and conditions listed above.

X Patient/Parent/Guardian Signature _____Date _____

Schuster Physical Therapy Privacy Policy: By signing below, I agree that I have reviewed the Notice of Privacy Practices and agree to these conditions.

X Patient/Parent/Guardian Signature_____Date_____

Schuster Physical Therapy Release of Information: In order to provide the highest standard of care, we may need to discuss your case with other health care professionals, lawyers, coaches or family. I authorize release of my medical records to the following:

Name_____ Contact _____

Name_____ Contact _____

Name_____ Contact _____

Schuster Physical Therapy Missed Appointment Policy: We are fully committed to partnering with you in the rehabilitation process and expect that you will attend all scheduled appointments (emergency situations not withstanding). Failure to cancel an appointment with less than 24 hours' notice will result in a $25 fee. In instances of repeated cancellations or "no-shows", SPT reserves the right to discontinue care. By signing below, I assert that I understand and agree to this policy. Charges for missed appointments are intended to help compensate for missed business opportunities. **I give Schuster Physical Therapy permission to charge my card on file for any no-show fees I have accrued**. Please understand you will not make improvements if you do not attend your prescribed therapy sessions.

X Patient/Parent/Guardian Signature_____Date_____

*Quick*DASH

Please rate your ability to do the following activities in the last week by circling the number below the appropriate response.

NAME DATE

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	UNABLE
1. Open a tight or new jar.	1	2	3	4	5
2. Do heavy household chores (e.g., wash walls, floors).	1	2	3	4	5
3. Carry a shopping bag or briefcase.	1	2	3	4	5
4. Wash your back.	1	2	3	4	5
5. Use a knife to cut food.	1	2	3	4	5
6. Recreational activities in which you take some force or impact through your arm, shoulder or hand (e.g., golf, hammering, tennis, etc.).	1	2	3	4	5

	NOT AT ALL	SLIGHTLY	MODERATELY	QUITE A BIT	EXTREMELY
7. During the past week, *to what extent* has your arm, shoulder or hand problem interfered with your normal social activities with family, friends, neighbours or groups?	1	2	3	4	5

	NOT LIMITED AT ALL	SLIGHTLY LIMITED	MODERATELY LIMITED	VERY LIMITED	UNABLE
8. During the past week, were you limited in your work or other regular daily activities as a result of your arm, shoulder or hand problem?	1	2	3	4	5

Please rate the severity of the following symptoms in the last week. *(circle number)*	NONE	MILD	MODERATE	SEVERE	EXTREME
9. Arm, shoulder or hand pain.	1	2	3	4	5
10. Tingling (pins and needles) in your arm, shoulder or hand.	1	2	3	4	5

	NO DIFFICULTY	MILD DIFFICULTY	MODERATE DIFFICULTY	SEVERE DIFFICULTY	SO MUCH DIFFICULTY THAT I CAN'T SLEEP
11. During the past week, how much difficulty have you had sleeping because of the pain in your arm, shoulder or hand? *(circle number)*	1	2	3	4	5

*Quick*DASH DISABILITY/SYMPTOM SCORE = $\left(\left[\frac{\text{(sum of n responses)}}{n}\right] - 1\right) \times 25$, where n is equal to the number of completed responses.

A *Quick*DASH score may <u>not</u> be calculated if there is greater than 1 missing item.