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 ____

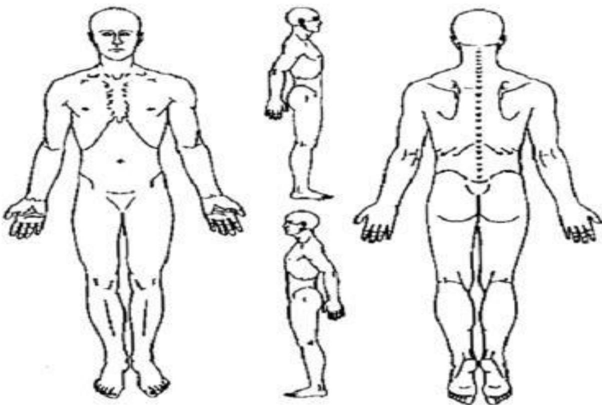
Was this treatment effective: Yes No

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: ____

<u>Schuster Physical Therapy Patient Informed Consent:</u> 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___________________

<u>Assignment of Benefits:</u> 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 ________________

<u>Schuster Physical Therapy Privacy Policy:</u> 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________________

<u>Schuster Physical Therapy Release of Information:</u> 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 ________________________

<u>Schuster Physical Therapy Missed Appointment Policy:</u> 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________________

Patient Name: ________________________ **Date:** _____________

TMD Disability Index Questionnaire

Please check the one statement that best pertains to you (not necessarily exactly) in each of the following categories.

Section 1 - Communication (Talking)

(0) I can talk as much as I want without pain, fatigue or discomfort.
(1) I talk as much as I want, but it causes some pain, fatigue and/or discomfort.
(2) I can't talk as much as I want because of pain, fatigue and/or discomfort.
(3) I can't talk much at all because of pain, fatigue and/or discomfort.
(4) Pain prevents me from talking at all.

Section 2 - Normal Living Activities (Brushing Teeth/Flossing)

(0) I am able to care for my teeth and gums in a normal fashion without restriction, and without pain, fatigue or discomfort.
(1) I am able to care for all my teeth and gums, but I must be slow and careful, otherwise pain/discomfort, jaw tiredness results.
(2) I do manage to care for my teeth and gums in a normal fashion, but it usually causes some pain/discomfort, jaw tiredness no matter how slow and careful I am.
(3) I am unable to properly clean all my teeth and gums because of restricted opening and/or pain.
(4) I am unable to care for most of my teeth and gums because of restricted opening and/or pain.

Section 3 - Normal Living Activities (Eating, Chewing)

(0) I can eat and chew as much of anything I want without pain/discomfort or jaw tiredness.
(1) I can eat and chew most anything I want, but it sometimes causes pain/discomfort and/or jaw tiredness.
(2) I can't eat much of anything I want, because it often causes pain/discomfort, jaw tiredness or because of restricted opening.
(3) I must eat only soft foods (consistency of scrambled eggs or less) because of pain/discomfort, jaw fatigue and/or restricted opening.
(4) I must stay on a liquid diet because of pain and/or restricted opening.

Section 4 - Social/Recreational Activities (Singing, Playing Musical Instruments, Cheering, Laughing, Social Activities, Playing Amateur Sports/Hobbies, and Recreation, etc)

(0) I am enjoying a normal social life and/or recreational activities without restriction.
(1) I participate in normal social life and/or recreational activities but pain/discomfort is increased.
(2) The presence of pain and/or fear of likely aggravation only limits the more energetic components of my social life (sports, exercising, dancing, playing musical instrument, singing).
(3) I have restrictions socially, as I can't even sing, shout, cheer, play and/or laugh expressively because of increased pain/discomfort.
(4) I have practically no social life because of pain.

Section 5 - Non-Specialized Jaw Activities (Yawning, Mouth Opening and Opening my Mouth Wide)

(0) I can yawn in a normal fashion, painlessly.
(1) I can yawn and open my mouth fully wide open, but sometimes there is discomfort.
(2) I can yawn and open my mouth wide in a normal fashion, but it almost always causes discomfort.
(3) Yawning and opening my mouth wide are somewhat restricted by pain.
(4) I cannot yawn or open my mouth more than two finger widths (2.8-3.2 cm) or, if I can, it always causes greater than moderate pain.

Page 1 Total: __________

Patient Signature: ________________________ **Date** ________________________

Therapist Signature: ______________________ **Date** ________________________

Patient Name: ________________________ **Date:** _____________

TMD Disability Index Questionnaire

Section 6 - Sexual function (Including Kissing, Hugging and Any and All Sexual Activities to Which You Are Accustomed)

(0) I am able to engage in all my customary sexual activities and expressions without limitation and/or causing headache, face or jaw pain.
(1) I am able to engage in all my customary sexual activities and expression, but it sometimes causes some headache, face, or jaw pain, or jaw fatigue.
(2) I am able to engage in all my customary sexual activities and expression, but it usually causes enough headache, face or jaw pain to markedly interfere with my enjoyment, willingness and satisfaction.
(3) I must limit my customary sexual expression and activities because of headache, face or jaw pain or limited mouth opening.
(4) I abstain from almost all sexual activities and expression because of the head, face or jaw pain it causes.

Section 7 - Sleep (Restful, Nocturnal Sleep Pattern)

(0) I sleep well in a normal fashion without any pain medication, relaxants or sleeping pills.
(1) I sleep well with the use of pain pills, anti-inflammatory medication or medicinal sleeping aides.
(2) I fail to realize 6 hours restful sleep even with the use of pills.
(3) I fail to realize 4 hours restful sleep even with the use of pills.
(4) I fail to realize 2 hours restful sleep even with the use of pills.

Section 8 - Effects of Any Form of Treatment, Including, But Not Limited to, Medications, In-office Therapy, Treatment, Oral Orthotics (eg, Splints, Mouthpieces), Ice/Heat, etc.

(0) I do not need to use treatment of any type in order to control or tolerate headache, face or jaw pain and discomfort.
(1) I can completely control my pain with some form of treatment.
(2) I get partial, but significant, relief through some form of treatment.
(3) I don't get "a lot of" relief from any form of treatment.
(4) There is no form of treatment that helps enough to make me want to continue.

Section 9 - Tinnitus, or Ringing in the Ear(s)

(0) I do not experience ringing in my ear(s).
(1) I experience ringing in my ear(s) somewhat, but it does not interfere with my sleep and/or my ability to perform my daily activities.
(2) I experience ringing in my ear(s) and it interferes with my sleep and/or daily activities, but I can accomplish set goals and I can get an acceptable amount of sleep.
(3) I experience ringing in my ear(s) and it causes a marked impairment in the performance of my daily activities and/or results in an unacceptable loss of sleep.
(4) I experience ringing in my ear(s) and it is incapacitating and/or forces me to use a masking device to get any sleep.

Section 10 - Dizziness (Lightheaded, Spinning and/or Balance Disturbance)

(0) I do not experience dizziness.
(1) I experience dizziness, but it does not interfere with my daily activities.
(2) I experience dizziness which interferes somewhat with my daily activities, but I can accomplish my set goals.
(3) I experience dizziness, which causes a marked impairment in the performance of my daily activities.
(4) I experience dizziness, which is incapacitating.

Page 2 Total: __________

Total Score (Page 1 + Page 2): __________

Total Score / Total # Possible = % Disability

_____ % Disability

Patient Signature: ________________________ **Date** ________________________

Therapist Signature: ______________________ **Date** ________________________