



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

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Pacemaker |
| <input type="checkbox"/> | <input type="checkbox"/> | Angina |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack |
| <input type="checkbox"/> | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Congestive Heart Failure |
| <input type="checkbox"/> | <input type="checkbox"/> | COPD |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV/AIDS |
| <input type="checkbox"/> | <input type="checkbox"/> | Systemic Lupus |
| <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy |
| <input type="checkbox"/> | <input type="checkbox"/> | Rheumatoid Arthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Fibromyalgia |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoarthritis |
| <input type="checkbox"/> | <input type="checkbox"/> | Recent weight loss or gain (unexplained) |
| <input type="checkbox"/> | <input type="checkbox"/> | Osteoporosis |
| <input type="checkbox"/> | <input type="checkbox"/> | Depression |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer- Location: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Tobacco- packs/day _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 _____

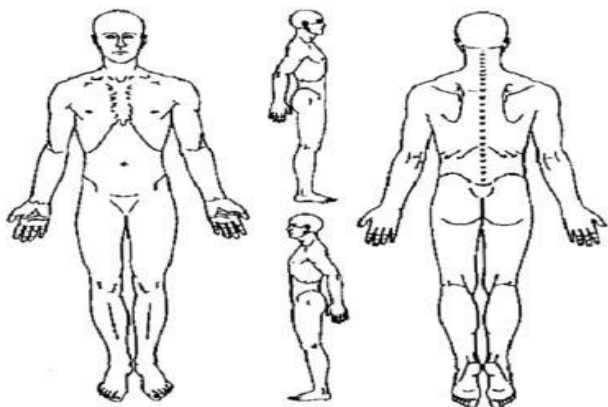
Was this treatment effective: Yes No

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*

- | | |
|----------------------------------|--------------------------------|
| <input type="radio"/> Sharp pain | <input type="radio"/> Numbness |
| <input type="radio"/> Dull/ache | <input type="radio"/> Shooting |
| <input type="radio"/> Throbbing | <input type="radio"/> 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, coinsurance 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 \$2230 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 (MVA): **Please inform our office immediately if your care is related to a recent motor vehicle accident.** We are currently **NOT** accepting MVA clients; however, we are happy to extend our self-pay rates if your injury is the result of an MVA. 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.**

SELF-PAY/ NON-INSURED: Self-Pay Physical Therapy examinations are \$125 and Follow-Up Physical Therapy Treatment visits cost \$85.

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 \$35 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: _____

Description: This survey is meant to help us obtain information from our patients regarding their current levels of discomfort and capability. Please circle the answers below that best apply.

1. Please rate your pain level with activity: NO PAIN = 0 1 2 3 4 5 6 7 8 9 10 = VERY SEVERE PAIN

MODIFIED OSWESTRY DISABILITY SCALE – INITIAL VISIT

1. Pain Intensity

- (0) I can tolerate the pain I have without having to use pain medication.
- (1) The pain is bad, but I can manage without having to take pain medication.
- (2) Pain medication provides me with complete relief from pain.
- (3) Pain medication provides me with moderate relief from pain.
- (4) Pain medication provides me with little relief from pain.
- (5) Pain medication has no effect on my pain.

2. Personal Care (washing, dressing, etc.)

- (0) I can take care of myself normally without causing increased pain.
- (1) I can take care of myself normally, but it increases my pain.
- (2) It is painful to take care of myself, and I am slow and careful.
- (3) I need help, but I am able to manage most of my personal care.
- (4) I need help every day in most aspects of my care.
- (5) I do not get dressed, wash with difficulty, and stay in bed.

3. Lifting

- (0) I can lift heavy weights without increased pain.
- (1) I can lift heavy weights, but it causes increased pain.
- (2) Pain prevents me from lifting heavy weights off the floor, but I can manage if the weights are conveniently positioned (eg, on a table).
- (3) Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- (4) I can lift only very light weights.
- (5) I cannot lift or carry anything at all.

4. Walking

- (0) Pain does not prevent me from walking any distance.
- (1) Pain prevents me from walking more than 1 mile.
- (2) Pain prevents me from walking more than ½ mile.
- (3) Pain prevents me from walking more than ¼ mile.
- (4) I can only walk with crutches or a cane.
- (5) I am in bed most of the time and have to crawl to the toilet.

5. Sitting

- (0) I can sit in any chair as long as I like.
- (1) I can only sit in my favorite chair as long as I like.
- (2) Pain prevents me from sitting more than 1 hour.
- (3) Pain prevents me from sitting more than ½ hour.
- (4) Pain prevents me from sitting more than 10 minutes.
- (5) Pain prevents me from sitting at all.

6. Standing

- (0) I can stand as long as I want without increased pain.
- (1) I can stand as long as I want but, it increases my pain.
- (2) Pain prevents me from standing more than 1 hour.
- (3) Pain prevents me from standing more than 1/2 hour.
- (4) Pain prevents me from standing more than 10 minutes.
- (5) Pain prevents me from standing at all.

7. Sleeping

- (0) Pain does not prevent me from sleeping well.
- (1) I can sleep well only by using pain medication.
- (2) Even when I take pain medication, I sleep less than 6 hours.
- (3) Even when I take pain medication, I sleep less than 4 hours.
- (4) Even when I take pain medication, I sleep less than 2 hour
- (5) Pain prevents me from sleeping at all.

8. Social Life

- (0) My social life is normal and does not increase my pain.
- (1) My social life is normal, but it increases my level of pain.
- (2) Pain prevents me from participating in more energetic activities (eg. sports, dancing).
- (3) Pain prevents me from going out very often.
- (4) Pain has restricted my social life to my home.
- (5) I have hardly any social life because of my pain.

9. Traveling

- (0) I can travel anywhere without increased pain.
- (1) I can travel anywhere, but it increases my pain.
- (2) My pain restricts my travel over 2 hours.
- (3) My pain restricts my travel over 1 hour.
- (4) My pain restricts my travel to short necessary journeys journeys under 1/2 hour.
- (5) My pain prevents all travel except for visits to the physician/therapist or hospital.

10. Employment / Homemaking

- (0) My normal homemaking/job activities do not cause pain.
- (1) My normal homemaking/job activities increase my pain, but I can still perform all that is required of me.
- (2) I can perform most of my homemaking/job duties, but pain prevents me from performing more physically stressful activities (eg, lifting, vacuuming).
- (3) Pain prevents me from doing anything but light duties.
- (4) Pain prevents me from doing even light duties.
- (5) Pain prevents me from performing any job or homemaking chores.

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Therapist Use Only		
Comorbidities:	Cancer Diabetes Heart Condition High Blood Pressure Multiple Treatment Areas	Neurological Disorders (e.g., Parkinson's, Muscular Dystrophy, Huntington's, CVA, Alzheimer's, TBI) Obesity Surgery for this Problem Systemic Disorders (e.g., Lupus, Rheumatoid Arthritis, Fibromyalgia)
		ICD Code: _____