



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 _____

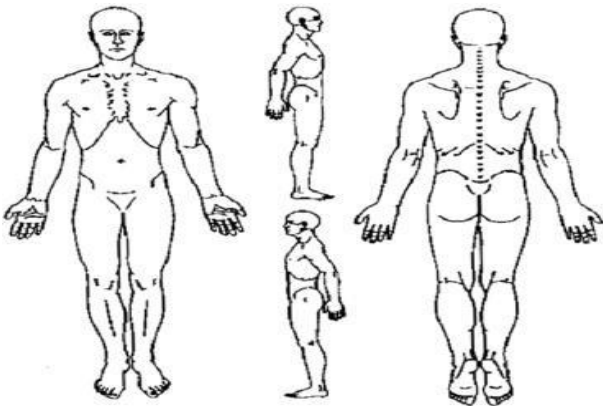
Was this treatment effective: Yes No

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
- Dull/ache
- Throbbing
- Numbness
- Shooting
- 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.

INSTRUCTIONS

This questionnaire asks about your symptoms as well as your ability to perform certain activities.

Please answer every question, based on your condition in the last week, by circling the appropriate number.

If you did not have the opportunity to perform an activity in the past week, please make your best estimate of which response would be the most accurate.

It doesn't matter which hand or arm you use to perform the activity; please answer based on your ability regardless of how you perform the task.

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

	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, neighbors 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
	NONE	MILD	MODERATE	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

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