FRITTER, SCHULZ & ZOLLINGER PHYSICAL AND OCCUPATIONAL THERAPY
A Professional Physical Therapy Partnership: IRS No. 77-0037850
FRITTER, SCHULZ & CONLAN PHYSICAL AND OCCUPATIONAL THERAPY
A Professional Physical Therapy Partnership: IRS No. 77-0533591

PATIENT INFORMATION

(Please Print Clearly)

Patient's Name: _____ Soc. Security No. _____
Driver's License No._____

Spouse's Name: _____ Soc. Security No. _____

Parent/Guardian Name: _____ Soc. Security No. _____
(If patient is a minor) Driver's License No. _____

Date of Birth: _____ Home Phone: _____ Work/Cell Phone: _____

Patient Address: _____

Billing Address: _____
(If different from patient address)

Emergency Contact: _____ Relationship: _____ Phone:_____

Date of Injury/onset of problem: _____ Injured Area: _____

Referring Doctor's Name: _____ Address:_____
(We require a prescription/referral/script by a qualified healthcare professional for all treatments)

Type of Claim: ( ) Worker's Comp. ( ) Private ( ) Medicare ( ) Other: _____
(Please Explain)

Insurance Company: _____ ID/Claim #: _____
(We require a copy of your private insurance and/or Medicare Card)

Employer: _____ City:_____ Phone No. _____

If this is a Worker's comp. claim, please indicate employer's name at the time injury occurred:
_____

PLEASE READ THE FOLLOWING: INSURANCE & FINANCIAL INFORMATION

INSURANCE IS NOT A SUBSTITUTE FOR PAYMENT. Contact your insurance company if you have questions.

You are ultimately responsible for payment for any services rendered that are not paid by your insurance company. *(Exception: Worker's compensation claims).* If you have an attorney involved in this claim, it is your responsibility to provide us with their name, address, and a signed "Release of Information" form.

- Complete and sign all FSZ/FSC documentation to the best of your ability. It is your responsibility to provide FSZ/FSC with information necessary to process your insurance claim, such as: your private insurance card, your employer's workers' compensation insurance information, a copy of your DWC-1 form (report of injury to the employer) and claim number, if known.
- FSZ/FSC will attempt to verify eligibility and benefits of your private insurance and inform you of your co-payment or co-insurance responsibility. If a worker's compensation claim is on delay or denied, we will notify you immediately. You will have to provide FSZ/FSC with your private insurance information to continue treatment. If and when the worker's comp. claim authorizes treatment; we will refund any monies paid by you and your private insurance company.

(Patient's Initials) ____

(Please turn over and review the back page of this policy)

1. **Billing** is a courtesy provided by FSZ/FSC PT/OT and may be denied if a patient does not meet the responsibilities of co-payments, co-insurance per visit or has given false information. Payment from your insurance company is expected within a reasonable time.

2. **Private Secondary/ Supplement Billing** is not provided without management's approval.

3. **Self-pay:** FSZ/FSC will provide a statement of charges and a copy of the physician's referral if you would like to bill your own insurance company. Payment for services will be due at each scheduled visit.

4. **MEDICARE:** Patients who have a secondary/supplement plan (recognized by Medicare) must give both cards to the front office. Patient will be responsible for Medicare's annual deductible and any amounts exceeding the Medicare limit of coverage. Medicare covers 80% of approved charges; the Medicare Beneficiary is responsible for 20% of Medicare's allowed amount for these charges. Medicare does not cover out-patient physical therapy if you are receiving home care services. **If you have received home care services recently, please verify that you have been discharged from their services prior to starting your physical therapy treatments in our office. You will be financially liable for all out-patient physical therapy charges if you fail to do so.**

5. **HMO, POS or any managed care insurance plan requires that authorization be attained before treatment begins.** If you fail to notify us that you have a plan that requires pre-authorization, you will be financially responsible for payment of any unauthorized services.

6. **Auto claims** require that the insured have Med-Pay available for this claim. In addition, FSZ/FSC requires your private medical insurance information. In the event that your auto med-pay is exhausted, you will be financially responsible for all services rendered.

7. **Lien/Litigation:** Requests will require all pertinent legal information be reviewed and approved by FSZ/FSC management. A finance fee of 1-1/2% per month after 90 days on the unpaid balance will be added. Liens are not accepted as a final means of payment, unless payment satisfies the balance in full.

8. **Co-insurance or Co-payment:** $25.00 is due at the time of visit until benefit eligibility is verified, unless the patient has a "no co-pay" plan.

9. **Broken Appointment:** $25.00 may be charged to your account for failing to notify us that you are unable to make your scheduled appointment.

10. **Interest & Transaction Fees:** If your account becomes 30 days past due, you will be charged interest of 1-1/2% per month and you will be charged for all collection and court fees incurred by FSZ/FSC to collect the delinquent unpaid balance.

11. **NSF – Check Return:** A $25.00 fee will be charged to your account if a check is returned for insufficient funds or a closed account.

I have read, understand, and agree that I am financially responsible for all services rendered to me or to my minor child. I hereby assign medical benefits pertaining to physical and occupational therapy benefits to which I am entitled, including Medicare, to FSZ/FSC Physical and Occupational Therapy. This is considered a legal and binding agreement. If you do not receive a copy, please ask the front desk.

Your Printed Name	Your Signature	Today's Date

Fritter, Schulz and Zollinger

PHYSICAL THERAPY ASSESSMENT

*Required for Medicare Patients.

Name: _____ Age: _____

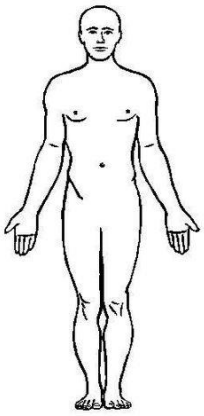
*Height: _____ *Weight: _____

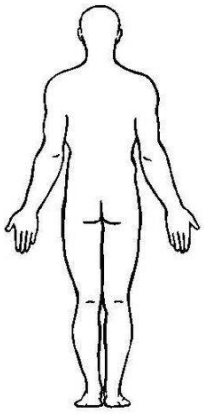
Occupation: _____

Please draw the area(s) of discomfort on the body chart and describe symptoms (Sharp, dull ache, numbness)

PLEASE ANSWER THE FOLLOWINGN QUESTIONS:

1. When did the problem Start? _____
   _____
2. Have you ever had anything like this before? YES NO
   If yes, please describe: _____
   _____
3. How did the symptoms come on? _____Suddenly
   _____Gradually
4. What was your activity at onset? _____
   _____
5. When are you aware of your pain?
   _____all the time
   _____only during the day
   _____only at night
   _____various times during the night and day
   _____only with certain activities
6. What activities or positions increase pain? _____
   What activities positions or self-care decreases pain? _____
   _____
   What activities can you not do because of this problem? _____
7. Is your problem…… _____getting worse (in what way) _____
   _____staying the same
   _____getting better
8. Is your sleep affected by this problem _____Yes _____No _____Sometimes
9. Does the problem limit your ability to work? _____Yes _____No
10. Have you received any previous physical therapy or other treatment for this problem?
    _____Yes _____No If yes, what? _____
    Did it help? _____Yes _____No
11. *Do you take any medications? _____Yes _____No
    If yes, please list or attach list: _____
    _____
12. *Have you had a fall with injury or two falls or more in the last 12 months? _____Yes _____No
13. Have you had any diagnostic tests? (Do you have reports showing the results?)
    _____MRI _____X-ray _____Cat Scan _____Other





CONFIDENTIAL MEDICAL QUESTIONNAIRE

Have you ever had, or do you now have any of the following....

HEART DISEASE	YES	NO
Heart Attack	_____	_____
Arteriosclerosis Heart Disease	_____	_____
Myocardial Infarction	_____	_____
Angina Pectoris	_____	_____
Rheumatic Heart Disease	_____	_____
Heart Murmur	_____	_____
Pacemaker	_____	_____
High Blood Pressure	_____	_____
High Cholesterol	_____	_____
RESPIRATORY SYSTEM		
Asthma	_____	_____
Emphysema	_____	_____
Shortness of Breath	_____	_____
MUSCLE CONDITIONS		
Back Problems	_____	_____
Leg or Feet Cramps	_____	_____
Arm or Hand Cramps	_____	_____
Limited Movement of the Limbs	_____	_____
OTHER CONDITIONS		
Muscular Dystrophy	_____	_____
Arthritis	_____	_____
Osteoporosis	_____	_____
Multiple Sclerosis	_____	_____
Epilepsy	_____	_____
Cancer	_____	_____
AIDS-HIV	_____	_____
Gout	_____	_____
Diabetes	_____	_____
Mastectomy	_____	_____
Polio	_____	_____
Hearing Loss	_____	_____
Poor Eyesight	_____	_____
Fainting	_____	_____
Do you have Metal Implants	_____	_____
Are you Pregnant	_____	_____
Do you Smoke	_____	_____

Other _____

MEDICATION

Are you taking seizure medication	_____	_____
Are you taking medication that may affect your lungs, heart, consciousness, or general well being while participating in class	_____	_____
Do you swim	_____	_____

I will advise my therapist if there is any change in my physical condition, which would alter my response to any of the questions on this form.

Name: _____ Date: _____