

**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.

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Your Printed Name

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Your Signature

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Today's Date



Fritter, Schulz and Zollinger  
 Fritter, Schulz and Conlan  
**PHYSICAL THERAPY ASSESSMENT**

Name: \_\_\_\_\_

Age: \_\_\_\_\_

Occupation: \_\_\_\_\_

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

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

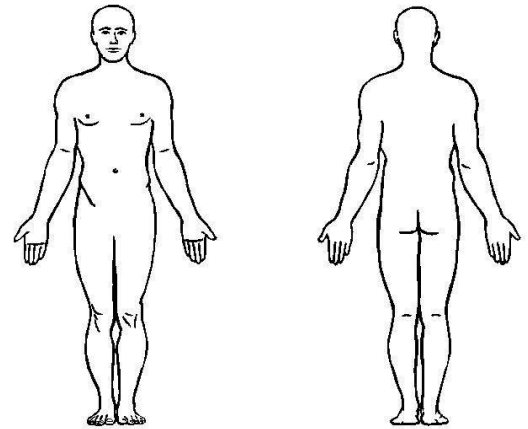
1. When did this problem start? \_\_\_\_\_  
 \_\_\_\_\_

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: \_\_\_\_\_  
 \_\_\_\_\_

12. Have you had any diagnostic tests?  
 \_\_\_\_\_ 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: \_\_\_\_\_