MR# _____

HEALTH QUESTIONNAIRE

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Home Phone Number: _____ Cell Number: _____

SS#: _____ Marital Status: _____

Email Address: _____

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Number: _____

Employer: _____ Employer Phone: _____

How did you hear about us? ____ Doctor ____ Friend ____ Yellow Pages ____ News Ad _____ Fitness Center ____ Former Patient
Name of Referring Person: _____

Referring Doctor: _____ Date of Injury: _____

Do you have, or previously had, any of the following conditions?

	Yes	No		Yes	No
Allergies			Hepatitis		
Aneurysm			High Blood Pressure		
Asthma			Implanted Stimulator		
Blood Clot			Low Blood Pressure		
Cancer			Osteoporosis		
Chest Pain			Pacemaker		
Congestive Heart Failure			Respiratory Infection		
Diabetes			Shortness of Breath		
Epilepsy			Stroke		
Fainting Spells			Are you currently pregnant?		
Heart Attack			Do you smoke?		
Heart Problems			Other		

List any medications your are currently taking: _____

Past surgeries: _____

_____

Are you currently receiving any type of Home Health assistance? Yes _____ No _____

I have answered these questions to the best of my ability. If there is any change in my contact information or my physical condition, I will inform my physical therapist.

_____ _____
PATIENT OR PATIENT'S AGENT DATE

PATIENT AUTHORIZATION RECORD

Initial here	
	Authorization for Treatment I hereby give authorization for the performance of such rehabilitation procedures as permitted by North Carolina Statutes under the appropriate scope of practice that are, in the judgment of my Therapist and/or specific instructions of my physician, deemed necessary.
	Authorization for Release of Information I agree that Nantahala Physical Therapy may provide information from my medical record to persons involved in my medical care. I authorize the release of medical information necessary to obtain payment of any benefits available to me to Nantahala Physical Therapy for services rendered. I agree that Nantahala Physical Therapy may obtain information from others who have provided medical care to me and/or are responsible for the payment of all or part of my bills when this information is needed in order to treat, bill, and/or receive payment. I have read "Notice of Privacy Practices" mandated by HIPAA.
	Authorization for Release of Payment I authorize that direct payment of any benefits available to me be released to Nantahala Physical Therapy for services rendered.
	Patient Agreement I agree to pay Nantahala Physical Therapy charges for services rendered to me during my course of treatment. I agree to pay those charges which may not be paid by my health insurance and are my responsibility per my insurance benefit. If I do not pay for charges that are my responsibility, I agree to pay Nantahala Physical Therapy's collections costs, including attorney and court fees.
	Medicare, Medicaid, and Similar Benefits I agree that the information given to Nantahala Physical Therapy in applying for benefits under Medicare, Medicaid, and Maternal or Child Health services are complete and accurate. I agree that Nantahala Physical Therapy may give Social Security Administration or its fiscal intermediary's information necessary to process claims.
	Workers Compensation I agree that the information given to Nantahala Physical Therapy in applying for benefits under Workers Compensation is complete and accurate. I agree that Nantahala Physical Therapy may give intermediary's information necessary to process claims.

_____

Patient or Patient's Agent Signature Date

_____

Printed patient name Witness Signature Date

ATTENDANCE POLICY

Cancellation and Failure to Show Policy:

- In order for your physical therapy to be effective and for goals to be met in a timely fashion, it is imperative that you attend scheduled appointments, comply with instruction and perform your home exercise program.
- Nantahala Physical Therapy requires a 24 hour notice in the event of a cancellation, except in cases of inclement weather (see below). It is the patient's responsibility, when he/she calls in, to have an alternative time in mind that will ensure he/she gets in the full prescribed number of treatments that week whenever possible. (In some cases, this may not be possible since some forms of treatment do not work well if given two sequential days.)
- There is a $15 charge for a cancellation without prior notice. This charge will not be covered by insurance, so is the responsibility of the patient. When patients do not show up for their scheduled appointments, three people suffer: The patient him/herself because he/she doesn't get the treatment he/she needs as prescribed by his/her doctor and/or PT; the therapist who now has a space in his/her schedule since the time was reserved for that patient personally; and another patient who could have been scheduled for treatment had there been proper notice.
- In cases of inclement weather, NPT follows the school system schedule. NPT tries to remain open during business hours; however, if you are unable to make your appointment due to the weather, please call to cancel.
- If a patient does not show up for the scheduled appointment, NPT will telephone you at the number you provide in order to reschedule.
- If a patient misses three consecutive appointments without contacting NPT, or if a patient has excessive cancellations, NPT reserves the right to discharge you from therapy without any further attempt to make contact. NPT will also notice your doctor if discharge should occur.

I understand that this is, in effect, a contract between Nantahala Physical Therapy, my therapist, and me. The goal is to achieve my rehabilitative goals. The undersigned certifies that he/she has read and accepts the terms.

_____ _____

PATIENT OR PATIENT'S AGENT DATE

MEDICARE SECONDARY

Medicare law requires that we determine if your medical services might be covered by another insurer. In order to assist us in the correct billing of physical therapy services, please answer the following questions:

1) Is Medicare the primary insurance? YES _____ NO _____

2) If the patient is entitled to Medicare, it is based on: AGE _____ DISABILITY _____
END STAGE RENAL DISEASE _____

3) Is the patient over the age of 65? YES _____ NO _____

4) Is illness/injury due to:
   - A work-related accident/condition? YES _____ NO _____
   - Condition covered under the Federal Black Lung Program? YES _____ NO _____
   - An automobile accident? YES _____ NO _____
   - An accident other than an automobile accident? YES _____ NO _____
   - The fault of another party? YES _____ NO _____

   **If the answer is "yes" to any of the above, please provide us with the following information:*
   - Name of insurance or liability insurer: _____
   - Claim number: _____
   - Date of accident: _____

5) Please answer the following:
   - Is the patient currently employed? YES _____ NO _____
   - Is the patient's spouse currently employed? YES _____ NO _____
   - Is the patient covered by the spouse employer's group health? YES _____ NO _____
   - Is the patient a dependent covered under a parent/guardian's employer group health plan? YES _____ NO _____

   **If the answer is "yes" to any of the above, please provide us with the following information and a copy of the card:*
   - Does the employer employ 20 or more employees? YES _____ NO _____
   - Does the employer employ 100 or more employees? YES _____ NO _____

_____ _____
PATIENT OR PATIENT'S AGENT DATE