

HOWELL PHYSICAL THERAPY
AUTO ACCIDENT, THRID PARTY PATIENT INFORMATION QUESTIONNAIRE

WELCOME! Please fill in the appropriate or highlighted areas below.

PERSONAL

Name: _____ Today's Date: _____

Social Security #: _____ Date of Birth: _____

Address: _____ City: _____ St: _____ Zip: _____

COMMUNICATION

Home phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Would you like to receive our monthly email newsletter (e-newsletter)? (check one): YES _____ NO _____
(Our monthly e-newsletter has great tips for healthy living, local events and clinic news)

CONTACT INFORMATION

Who should we contact in case of emergency?: _____

Relationship: _____ Emergency contact phone: _____

REFERRAL INFORMATION

Date of Accident/Injury: _____

Who referred you to our clinic? _____

Who is your primary physician (if different from above): _____

What was the date of your last physician, nurse practitioner or physician assistant visit? _____

What is the date of your NEXT physician, nurse practitioner or physician assistant visit? _____

INSURANCE INFORMATION

Our goal is to get you treatment, so we will work with you on insurance.

1) Please bring any appropriate insurance information with you to the first visit.

2) Your therapist will discuss insurance at the first visit.

3) Please refer to the PAYMENT INFORMATION SHEET for additional insurance information.

4) If you are sure about who we will be billing, go ahead and list the information below. Otherwise leave it blank.

Insurance Company: _____ Phone: _____

Claim #: _____ Adjustor/CaseManager/Contact Name: _____

EMPLOYMENT

Current Employer: _____

What kind of work do you do? _____

HOWELL PHYSICAL THERAPY MEDICAL HISTORY FORM

Name: (Please Print): _____ Age: _____ Date: _____

INSURANCE REQUIRES US TO DOCUMENT THIS INFORMATION SO PLEASE ANSWER ALL OF THE QUESTIONS BELOW TO THE BEST OF YOUR ABILITY:

1. Briefly explain what happened (accident, injury, illness etc) that caused you to come to Physical Therapy?

2. **WHEN** did this happen? (give approximate date): _____

3. Please list all the things you can't do or have difficulty doing because of your condition:

4. Please list **ALL MEDICATIONS** you are taking (if you don't know the names, please list the type):

5. Please list any **ALLERGIES** (medication, food, environmental) that you have:

6. Check off all the following that you have or have had in the past:

<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> TB/tuberculosis
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Seizures	<input type="checkbox"/> Cough > 2 weeks
<input type="checkbox"/> Stroke	<input type="checkbox"/> Cancer	<input type="checkbox"/> Fever > 2 weeks
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Falls	<input type="checkbox"/> Unexplained weight loss
<input type="checkbox"/> Dizziness	<input type="checkbox"/> Night Sweats	

7. Please briefly list all **SURGERIES**:

8. Have you had any special tests recently (MRI, CT-Scan, X-rays, etc.)? Yes _____ No _____
If you answered yes, please list the test and results:

9. **WOMEN ONLY**: Are you pregnant now, or is there a chance you may be pregnant? No _____ Yes _____

10. At the present time, how would you say your health is: (Circle one)
Excellent Very Good Fair Poor

11. Have you had any Physical Therapy for the same condition elsewhere? Yes _____ No _____
If you answered yes, please list the clinic, year and how many visits (approximately) that you had:

12. Are you receiving any other care? Please circle all those that apply:

OT-Occupational Therapy

SLP-Speech Therapy

Chiropractic

Nursing care

Radiation treatments

Chemotherapy

Personal Trainer

Other:

13. Have you been discharged from a rehabilitation facility, skilled nursing facility or home health recently? Yes_____ No_____

If you answered yes, please list the date you were discharged:_____

14. Do you use any medical equipment? (Cane, walker, wheelchair etc) Yes_____ No_____

If you answered yes, please provide a brief list of equipment that you have:

15. Has this illness/injury/accident caused you to miss time working? Yes _____ No _____

16. Have you ever had an injury that prevented you from working? Yes_____ No _____

If you answered yes, please explain:

I certify that my answers to the above questions are correct and true:

Signature:

HOWELL PHYSICAL THERAPY PAIN QUESTIONNAIRE

Name: _____ Date: _____

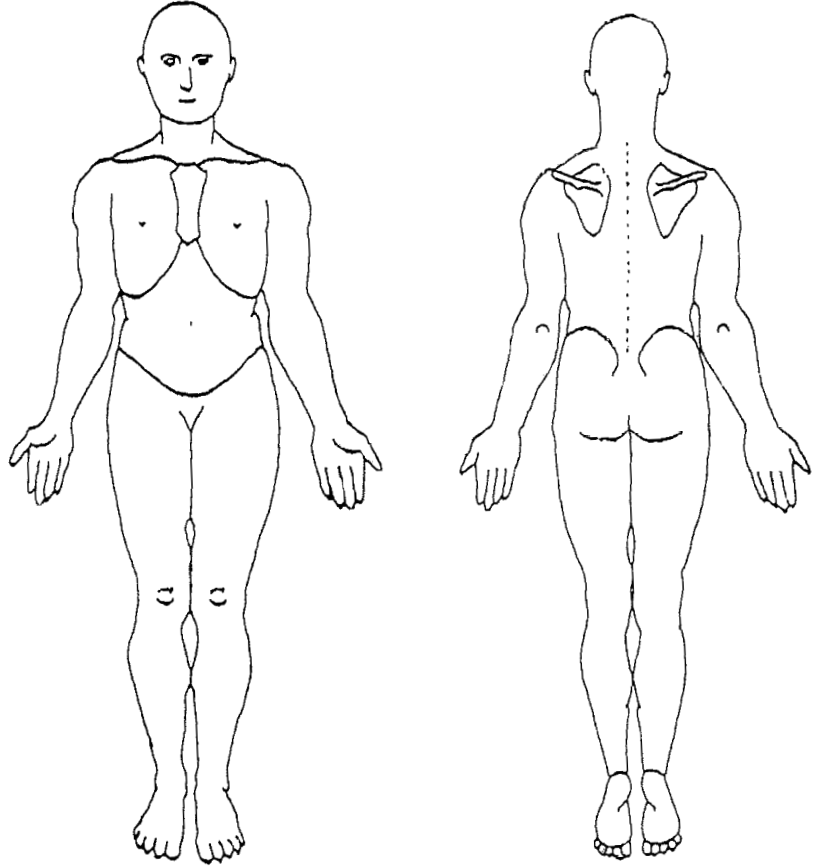
1. BODY DIAGRAM

Indicate your symptoms on the body diagrams using the symbols in the key below:

Key:

- ///// Stabbing
- XXX Burning
- OOO Pins and Needles
- ++++ Numbness
- AAAA Ache

If description is not found, circle area and write in what it feels like.



2. PAIN SCALE

On the line below, please make a line where you think your pain level is at when at rest (#1) and with activity (#2):

0 = no pain or symptoms

10 = the worst pain you've ever had

#1 REST: |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10

#2 ACTIVITY: |-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
0 1 2 3 4 5 6 7 8 9 10



Howell Physical Therapy

TK Howell Enterprises, Inc.

NOTICE OF PRIVACY PRACTICES HIPAA FORM 003

NOTICE OF CONFIDENTIALITY

Howell Physical Therapy and its staff will make every effort to keep your protected health care information (PHI) confidential and private. We will release information following federal regulations governing the use and disclosure of PHI.

QUESTIONS AND COMPLAINTS

If you have addition questions that have not been answered by our staff, you may contact our Privacy Officer, **Tom Howell, P.T., M.P.T.** at the numbers listed below.

If at any time during your treatment with us you feel that we may have violated your privacy rights or did not maintain the security of your PHI, you should contact the person above. If successful resolution of your concern is not achieved by our Privacy Officer and you believe our office is not complying with the Privacy/Security Rules, you may file a complaint with the Office of Civil Rights (OCR) either by paper or electronically. You must file this complaint within 180 days from when you knew or should have known that the act occurred. You may obtain more information at www.hhs.gov/ocr/hipaa.

NOTICE OF PRIVACY PRACTICES

You may obtain a copy of the Notice of Privacy Practices at our clinic OR on our web page, howellphysicaltherapy.com

I have been offered a copy of, read or received the Notice of Privacy Practices

X _____
Patient/Client or Personal Representative Signature

Date

Print Name

539 S. Fitness Place, Suite 100 Eagle, ID 83616
Phone: 208-336-9755, Fax: 208-336-8605
howellpt@fiberpipe.net
Located just south of Eagle Idaho Athletic Club

HOWELL PHYSICAL THERAPY PAYMENT INFO

GENERAL:

- We thank you in advance for choosing Howell Physical Therapy! We will provide you with the best physical therapy, massage and fitness services. In return we hope that you will make timely payments. To assist you, we have written out our payment policies for both insurance and private pay.
- Howell Physical Therapy will give you a verification of your benefits as soon as we can get the information (generally at the first visit).
- **While we will work with you as best we can on payment solutions, this does not replace your responsibility to understand your own insurance benefits. We recommend you contact your insurance company to verify your coverage prior to your first visit.**
- ***Payment is YOUR responsibility.***

TYPES OF PAYMENT ACCEPTED:

- We accept cash, checks, debit and credit cards (VISA, Mastercard)

WHEN IS PAYMENT DUE?

- Payment of copays and out-of-pocket charges are requested at the time of service.
- Howell Physical Therapy will try to verify your benefits before or during your first visit. If we cannot, we may delay your first payment until benefits can be verified.
- If you have multiple visits in a week, we recommend that you pay once for the full week.
- If your copay amounts are steep, we can spread them out through a payment plan. For example, if your copay is \$30.00/visit and you have 3 visits per week (\$90.00 total), we can spread out the payments with a payment plan. We recommend starting at \$50.00/week but we can be flexible depending on your budget.
- Deductible amounts can be paid off immediately; however, we recommend waiting until the first EOB (Explanation of Benefits) is received so we have an exact amount.
- Howell Physical Therapy will make every effort to keep you updated with timely statements

DO YOU HAVE PAYMENT PLANS?

- **Yes!!** We will work out a payment plan to meet your needs. **This includes stretching out large copays in a payment plan. We DO NOT charge interest on accounts that are paid in a timely fashion.**

(Continued on the back)

WHAT IS THE COST PER TREATMENT?

- Our BILLED cost per visit averages \$150.00 (most PT clinics run close to \$200.00/visit). But remember, we spend most of your visit with one-on-one time.
- Physical Therapy, unlike MD visits, must be billed PER PROCEDURE, not per visit. This is the only way we are allowed to bill. Therefore, your billing will list individual procedures.
- The per-procedure charge that we bill is a standard charge, many in 15-minute units. The charge is the same for 1 minute or the full 15. If more time is spent, more units may be billed.
- Even though we bill set amounts, we are reimbursed differently from each insurance carrier based on a contracted fee schedule. Your deductible is based on **what the insurance allows**, not on what we actually bill.

PRIVATE PAY OPTION

- If you have insurance and we are contracted providers with that insurance, we **cannot** use a private pay option. We are required by your insurance to bill services as contracted providers. Please note that to not bill your insurance when we are contracted with them is FRAUD.
- If you need to pay all costs out of pocket, we have a **PRIVATE PAY** option. After signing an agreement, the cost is \$160.00 for the first treatment (Evaluation is \$80.00 and treatment is \$80.00, then \$80.00 for each additional treatment. Payment is requested per visit; however, we can also sign a payment plan agreement.

AUTO ACCIDENT, WORKERS' COMP AND THIRD PARTY CLAIMS

- We do not require, as many other clinics now do, that you pay up front; **HOWEVER, this does not change your ultimate responsibility for payment for services.**
- Because insurance companies and other parties including businesses, attorneys and case managers may be involved directly in your claim, we require a LIEN form be signed prior to treatment.
- Claims may take a long time to resolve so we ask that you stay in touch and give us any address/phone number changes

PLEASE DON'T LET COST BE A FACTOR PREVENTING YOU FROM GETTING THE HELP YOU NEED. WE ARE A SMALL CLINIC AND CAN BE FLEXIBLE IN WORKING WITH YOU!

