

**Patient Current Condition**

Please answer the following in relation to the condition for which you are CURRENTLY coming to therapy  
 All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

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

**Condition Information**

**Primary Complaint:** \_\_\_\_\_

**Diagnosis from your doctor:** \_\_\_\_\_

**Who referred you for this episode of care?** \_\_\_\_\_

**Has your doctor explained to you your diagnosis & prognosis?**  Yes  No

**Was this an injury?**  Yes  No **Date of Injury or Symptom Onset:** \_\_\_\_\_

**Describe injury or onset of symptoms:** \_\_\_\_\_

**Any recent change in activity level or type (work, household, recreational)?**  Yes  No

**If yes, describe:** \_\_\_\_\_

**Since onset / injury, have your symptoms:**  Improved  Worsened  No Change

**Have you had any surgeries for this condition or for this body part?**

Type of Surgery	Surgeon	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Have you had any of the following for this condition? (Check all that apply)**

	Outcome / Result	Dates
<input type="checkbox"/> Physical Therapy	_____	_____
<input type="checkbox"/> Chiropractic	_____	_____
<input type="checkbox"/> Massage Therapy	_____	_____
<input type="checkbox"/> Acupuncture	_____	_____
<input type="checkbox"/> X-Ray	_____	_____
<input type="checkbox"/> MRI	_____	_____
<input type="checkbox"/> CT scan	_____	_____
<input type="checkbox"/> Bone Scan	_____	_____
<input type="checkbox"/> Nerve Conduction	_____	_____
<input type="checkbox"/> Other	_____	_____

## Pain Information

Rate your pain using the following scale: At Rest: \_\_\_\_\_ Best: \_\_\_\_\_ Worst: \_\_\_\_\_







What increases your pain? \_\_\_\_\_  
 \_\_\_\_\_

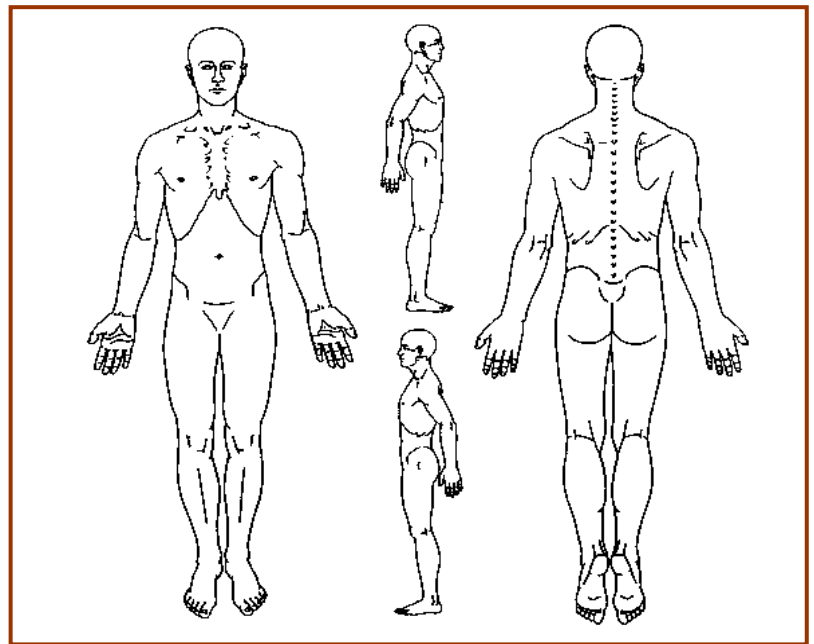
What decreases your pain? \_\_\_\_\_  
 \_\_\_\_\_

Describe your pain: \_\_\_\_\_  
 \_\_\_\_\_

**Indicate where you have symptoms on the diagram:**

**XX – Pain    /// - Tingling or Burning    ## - Numbness**

	Scale	
No pain	0	
	1	
Mild, annoying pain	2	
	3	
Nagging, uncomfortable, troublesome pain	4	
	5	
Distressing, miserable pain	6	
	7	
Intense, dreadful, horrible pain	8	
	9	
Worst possible, unbearable, excruciating pain	10	



## Activity Information

What activities are you restricted from by your condition? (Check all that apply)

- |                                   |                                  |                                  |                                   |                                     |                                       |
|-----------------------------------|----------------------------------|----------------------------------|-----------------------------------|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Bathing | <input type="checkbox"/> Eating  | <input type="checkbox"/> Driving  | <input type="checkbox"/> Housework  | <input type="checkbox"/> Sleeping     |
| <input type="checkbox"/> Walking  | <input type="checkbox"/> Lifting | <input type="checkbox"/> Sitting | <input type="checkbox"/> Standing | <input type="checkbox"/> Lying Down | <input type="checkbox"/> Recreational |
| <input type="checkbox"/> Pushing  | <input type="checkbox"/> Pulling | <input type="checkbox"/> School  | <input type="checkbox"/> Work     | <input type="checkbox"/> Sports     | <input type="checkbox"/> Yard Work    |

Please provide details of specific activities you are restricted from doing: \_\_\_\_\_  
 \_\_\_\_\_

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Work Information**

I am currently:  Employed Full Duty  Employed with Restrictions  On Medical Leave  
 Not Employed AND  Not Seeking Employment  Seeking Employment

Job Title: \_\_\_\_\_

Duties: \_\_\_\_\_

Restrictions: \_\_\_\_\_

**Physical Follow-Up**

Next scheduled Doctor appointment(s):

Date \_\_\_\_\_ Physician \_\_\_\_\_

Date \_\_\_\_\_ Physician \_\_\_\_\_

Date \_\_\_\_\_ Physician \_\_\_\_\_

We are committed to a team approach to your care. Please inform your therapist whenever you have a scheduled appointment so we may send a progress note before your visit.

**Physical Therapy Goals & Commitment**

What do you WANT TO achieve from having therapy? Check all that apply:

- Improve home activities
- Improve mobility/walking activities
- Improve leisure/sports activities
- Improve health/wellness
- Improve self care activities
- Return to work/regular work duties

What is your goal for therapy?

\_\_\_\_\_  
\_\_\_\_\_

Please include any additional information you feel would help us provide your care

(I.e. any apprehensions about treatment, special communication, language, spiritual or cultural needs).

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Will you have any problems attending therapy sessions?  Yes  No

If yes, please describe: \_\_\_\_\_

Will you have any problems performing a home program?  Yes  No

If yes, please describe: \_\_\_\_\_

I agree to be committed to my physical therapy program including attendance at scheduled visits and compliance with home program. I will inform my therapist if at any time I am unclear on my program or progress. I certify that the above history is true to the best of my knowledge:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Check one)  Patient  Legal Guardian (minor child)  Medical Power of Attorney (must provide proof)



855 Citadel Dr. E  
Colorado Springs, CO 80909  
(719) 465-1502

## **Cancellation/Missed Appointment Policy**

While we understand situations may arise that prevent you from making your scheduled appointment, please remember that your appointment time is valuable and has been specifically reserved for you. Last-minute cancellations and missed appointments are costly to our practice and take up appointment slots that could be offered to other patients waiting to get in. Therefore, out of respect for the physical therapists, staff, and other patients, we ask that you provide **24-hours notice** when cancelling or rescheduling an appointment. Failure to do so will result in a cancellation/missed appointment fee being applied to your account. This fee will **not** be covered by your insurance and is **your responsibility**.

### **FIRST APPOINTMENT – INITIAL EVALUATION**

Due to the longer appointment time that is set aside to conduct the initial evaluation, failure to attend a first appointment or provider **24-hours notice** prior to cancelling may result in a **\$50.00** cancellation/missed appointment fee. This fee must be paid in full prior to rescheduling.

### **SUBSEQUENT APPOINTMENTS**

Following the initial evaluation, appointment cancellations require **24-hours notice** or a **\$25.00** cancellation/missed appointment fee may apply. This amount will be collected at your next scheduled appointment, and if no future visits are scheduled, must be paid in full prior to scheduling. Since unplanned situations and unexpected emergencies do arise, two cancellation/missed appointment fees will be forgiven during your course of treatment.

If you arrive more than 15 minutes after your scheduled appointment and we cannot accommodate you, you will be rescheduled and charged a **\$25.00** missed appointment fee. Every effort will be made to accommodate you, but we are a hands-on facility and need individual time with every patient. Whenever possible, please call to let us know you will be arriving late so that we can better plan our patient care and more easily accommodate you.

If you miss and/or cancel three appointments, we reserve the right to discharge you as a patient. A large part of the success of physical therapy is your participation. If you frequently cancel and do not show for appointments, your likelihood of improvement is significantly decreased. While we understand special circumstances, if it is a chronic issue we reserve the right to terminate your care at our facility.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of any fees my absence may result in.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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## **Patient Privacy Policy & Procedure Statement (HIPAA)**

Dear Patient:

REZAC & ASSOCIATES PHYSICAL THERAPY maintains compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy regulations passed into law on December 20, 2000.

We obtain your voluntary consent to provide treatment and release medical records to the appropriate entities, and those who you designate, to provide health care treatment, obtain payment, and conduct daily operations at the facility.

Our clinical and front office staff will use patient information to ensure quality care and appropriate billing for services.

You may correct, amend, access, and request a copy of your medical record and access history by signing a letter for release of your medical information. The cost for copies of medical records is in accordance with state law.

We protect all patient information within the guidelines provided by federal, state, and local government.

If you have any grievance pertaining to the privacy of medical records or wish to inquire further about how our facility manages patient information, please contact our Privacy Officer at (719)465-1502.

Rezac & Associates Physical Therapy reserves the right to amend, change, and or revise our privacy policy at any time in accordance with federal, state, and local rules, regulations, and guidelines.

Thank you for choosing Rezac & Associates Physical Therapy for your healthcare.

Signature \_\_\_\_\_ Date \_\_\_\_\_



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### PHONE MESSAGE CONSENT

Rezac & Associates Physical Therapy, LLC PC will at times need to contact you. By filling out the information below we will be better able to serve.

In effort to protect you privacy, we have developed a policy on leaving medical care messages:

- We will **NOT** leave messages with anyone except the patient or legal guardian.
- We will **NOT** leave any confidential information on an answering machine.
- We will **NOT** leave any messages on a voicemail.

### UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO.

I, \_\_\_\_\_ give Rezac & Associates Physical Therapy, LLC PC my permission to speak with and/or leave phone messages regarding my medical care and/or billing with the following. I fully understand that this consent will remain valid until revoked in writing.

Preferred Phone Number(s): \_\_\_\_\_

Authorized Individuals: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### EMAIL REMINDERS/NEWSLETTER SIGN-UP

Rezac & Associates Physical Therapy, LLC PC has the ability to send reminders via email to remind you of the day and time of scheduled appointments. We also offer a monthly Health and Wellness video newsletter. If you would like to subscribe to either of these services, please check the appropriate box(es) below.

- Add me to your Video Newsletter       Add me to your Email Reminders

Email Address: \_\_\_\_\_



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### **Consent for Care and Treatment**

I, Undersigned, do hereby agree and give my consent for Rezac & Associates Physical Therapy to furnish medical care and treatment to \_\_\_\_\_ which is considered necessary and proper in the diagnosing or treating of my (their) physical condition.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **Benefit Assignment/ Release of Information**

I, the undersigned, hereby assign all medical benefits, i.e.: Medicare, private insurance, major medical benefits, Workers' Compensation and any other health plans to which I am entitled to Rezac & Associates Physical Therapy, LLC PC. A photocopy of this assignment is to be considered as valid as the original. I hereby authorize Rezac & Associates Physical Therapy, LLC PC to release all medical information and records necessary to secure payment for services rendered.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### **Financial Policy Statement**

It is our policy to bill your insurance carrier or other provider of medical benefits as a courtesy to you, although you are responsible for the entire bill when the service is rendered. Required co-payments and estimated co-insurances are to be made as services are rendered and arrangements are to be made for payment of all amounts not covered by your medical benefits as soon as those amounts are known. If your medical benefits are not paid within sixty (60) days, the balance will be due in full from you.

**All co-insurance percentages paid at the time of service are estimated. Your actual liability may be more. You are responsible for any difference between the estimated and actual co-insurance due.**

If any payments of medical benefits are made directly to you for services rendered by Rezac & Associates Physical Therapy, LLC PC, you must promptly remit such payment directly to Rezac & Associates Physical Therapy, LLC PC.

If you are a Workers' Compensation patient the above policy does not apply to you. Be advised, however, that you may be responsible for our charges if your Workers' Compensation claim is successfully controverted.

If you fail to make timely payment for any amount for which you are responsible, you will be responsible for all costs of collection, including court costs, collection agency fees, and/or a reasonable attorney fee.

I have read the above information and/or it has been explained to me and I accept the terms and conditions of the above and will be responsible for the payment of my account.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_