# Cancellation and No-show policy

The following are policies regarding cancellations and no-shows. We take this subject seriously at this clinic because it can make the difference between whether you succeed in your treatment or not. Usually your referring doctor and/or therapist have prescribed a set frequency of treatments. Showing up as scheduled for these visits is your most important job. Other than that, all you need to do is follow you therapist's instructions and we will be able to help you achieve your goals in treatment.

We require 24 hours notice in the event of a cancellation. It is your responsibility, when you call in, to have an alternative time in mind that will ensure you get the full treatment for that week. In some cases this may not work.

We do reserve the right to charge $35.00 for a cancellation without proper notice. This charge will not be covered by insurance, but will have to be paid by you personally.

You may need to be seen by a different therapist than the one that normally treats you if you rearrange your appointment. All of our therapists are experienced professionals, and they will study your patient chart, so you will be in good hands.

Please understand that your pain will probably increase and decrease as your course of treatment progresses and before you are finally released. Either condition can seem like a reason not to come in; a) you're feeling worse and you feel treatment is not working, b) you're feeling better and it's a great day to go shopping or to sporting events. Neither of these conditions is legitimate as a reason not to come:

a) If you are in pain, come in and get it fixed.
b) If you are out of pain, now is the time that we can begin doing some real correction of underlying causes of your problem or educate you so you will not re-injure yourself.

When a patient doesn't show as scheduled, three people are hurt:

1) You, because you won't get the treatment you need as prescribed by the doctor or PT.
2) The therapist, who now has a space in their schedule since the time was reserved for you personally.
3) Another patient who could have been scheduled for treatment if there had been proper notice.

Please cooperate with us in this regard and we will have you out of pain and back to full function as swiftly as possible. We're looking forward to working with you.

Patient signature_____Date_____

## AUTHORIZATION FOR TREATMENT AND RELEASE OF RECORDS

1. **Consent to Treatment/Testing:** I hereby consent to the administration of treatment and testing as is considered therapeutically necessary for my condition.
2. **Release of Records:** I authorized the release of medical record information including but not limited to, information concerning drug related conditions, alcoholism, psychological documentation and psychiatric conditions, HIV testing, AIDS diagnosis, and AIDS related conditions, my medical conditions, to the applicable government authority, insurance carriers, third-party payers or their representatives, review organizations or their representatives, the physician or agency responsible for my follow-up care, and/or the healthcare facility that I am transferred to from Guenthner Physical Therapy.

**I have read and understand the above:**

Signature of Responsible Party Date

Relationship to Patient Witness

## GUENTHNER PHYSICAL THERAPY ACKNOWLEDGMENT OF RECEIPT OF PROTECTION OF HEALTH INFORMATION PRACTICES

I, _____, acknowledge that Notice of Privacy Practices issued by Guenthner Physical Therapy has been made available to me.

I, _____, authorize _____ to discuss my health information with the following persons:

Spouse _____
Children _____
_____
Parent _____
_____
Other _____
_____

Date Signature of Patient

# Sales Disclosure for GPT Patients

Guenthner Physical Therapy's (GPT) primary business is providing outpatient rehabilitation services. As a convenience to our patients, GPT stocks commonly needed items that may be recommended for your rehabilitation by your doctor or therapist. All items are for sale on a cash, check, or credit basis only. You are free to purchase these items at any location. No insurance / Medicare will be billed for these items. These items may be covered by your insurance which may require you to buy from a different source and if so, your purchase from GPT may not be reimbursed. Medicare will not cover your purchase from GPT. You may submit the invoice to your insurance company directly.

Patient Signature: _____ Date: _____

*You will be reminded of this policy if you are ever in need of purchasing anything from GPT.

# Medicare Secondary Payer Questionnaire

**Beneficiary Information:**
Medicare Beneficiary: _____ Patient Account #_____
HIC#: _____ DCN#: _____ Provider #: _____
Dates of Service From: _____ Through: _____ Person who Supplied Information_____
Relationship to Patient: _____ Provider Rep. Name: _____ Date: _____

**1. Workers' Compensation (WC):**
Per the patient, should the illness/injury be covered by a WC claim? ____Yes ____No
*If yes, this should be an MSP or conditional claim, not Medicare primary. Please note, WC is primary only for claim related to a WC injury.*
Original Date of Illness/Injury: _____ Claim Number: _____
Name of WC Plan: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Name of Employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____

**2. Federal Black Lung (BL):**
Is the patient covered by the BL program? ____Yes ____No
Date Benefits Began: _____(BL is primary only for claims related to BL.)

**3. Department Of Veterans Affairs (DVA):**
Is the patient entitled to benefits through the DVA? ____Yes ____No
If yes, does the patient want the DVA to be contacted for authorization of these services? ____Yes ___No

**4. Public Health Service (PHS):**
Are the services to be paid by a Government Program such as a Research Grant? ____Yes ____No
If yes, the Government Program will pay primary benefits for these services.
What is the name of the PHS? _____
Mailing Address: _____
City: _____ State:_____ Zip:_____

**5. Accident:**
Are these services the result of a non-work related accident? ____Yes ____No
If yes, what type of accident was this or give a description of the accident (for example: auto, slip and fall, malpractice, product liability, homeowners)?
Date of Accident: _____ Location of accident (home, restaurant, etc): _____

**A. *Non-liability Insurance:***
Is non-liability insurance available (for example: premises medical, auto medical coverage, no-fault Homeowners premises)? ____Yes ____No
If yes, name of the insurance company: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Who is listed as the insured? _____ Claim Number: _____

**B. *Liability Insurance:***
Does the patient feel someone else is responsible for the accident/injury? ____Yes ____No
If yes, name of responsible party's insurance company: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Name of responsible injured party: _____ Claim Number: _____

**6. Employer Group Health Plan (EGHP):**
Is the patient covered by *any* EGHP, including Federal Employee Health Benefits or *any* retirement policy?
*(If no, this questionnaire is complete. If yes, please continue).* ____Yes ____No

**7. Working Aged:**
Is the patient 65 years or older? ____Yes ____No
**(If no, please continue with Question #8)**
Is the patient currently employed by an employer of 20 or more employees? ____Yes ____No
If yes, name of the employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____

Is the spouse currently employed by an employer of 20 or more employees? ____Yes ____No
If yes, name of the employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
If the patient or spouse is employed by an employer of 20 or more employees, is the patient covered by the EGHP?
____Yes ____No
Mailing Address: _____

City: _____ State: _____ Zip: _____
Policy #: _____ Group Identification #: _____
Name of Policyholder: _____ Relationship to the patient _____
If the beneficiary is no longer employed, please give a retirement date: _____(MM/DD/CCYY)
If the spouse is no longer employed, please give a retirement date: _____(MM/DD/CCYY)
**Note: If the patient is covered through their own or a spouse's EGHP of 20 or more employees, the EGHP should be primary. Please go on to the ESRD/Dual Entitlement questions. (Please continue with Question #9)**

**8. Disability:**
Is the patient under the age of 65? ____Yes ____No
**(If no, please continue with Question #9)**
If yes, is the patient entitled to Medicare due to a disability other than End Stage Renal Disease? ____Yes ____No
**(If no, please continue with Question #9)**
If yes, is the patient currently employed by an employer of 100 or more employees? ____Yes ____No
Name of Employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Is a family member currently employed by an employer of 100 or more employees? ____Yes ____No
Name of Employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Is the patient covered by that Large Group Health Plan (LGHP)? ____Yes ____No
Name of Insurance Company: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Policy #: _____Name of Policy Holder: _____
Relationship to the Patient: _____ Group identification #: _____
**Note: If the patient is covered by their own or a family member's LGHP of 100 or more employees, the LGHP should be primary. Please go on to the ESDR/Dual Entitlement questions. (Please continue with Question #9)**

**9. End Stage Renal Disease (ESRD):**
Is the patient entitled to Medicare due to End Stage Renal Disease? ____Yes ____No
**(If no, please continue with Question #10)**
Is the patient covered by any EGHP through a current or former employer of any size? ____Yes ____No
Name of group health plan: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Policy #: _____ Name of Policy Holder: _____
Relationship to the Patient: _____ Group identification #: _____
Name of Employer: _____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Is the patient within 30-month coordination of benefits period? ____Yes ____No
What is the month/year of the first regular dialysis? _____(MM/CCYY)
If the patient participated in a self-dialysis training program, provide date training started: _____(MM/CCYY)
Has the patient had a kidney transplant? ____Yes ____No
If yes, date of transplant: _____(MM/CCYY)
**Note: If the patient is within the 30-month coordination of benefits period, the GHP should be primary. (Please continue with Question #10.)**

**10. Dual Entitlement:**
Is the patient entitled to Medicare on the basis of either ESRD and age or ESRD and Disability? ____Yes ____No
Was the patient's initial entitlement to Medicare (including simultaneous entitlement) based on ESRD? ____Yes ____No
Does the Working Aged or MSP Disability provision apply (i.e., is the GHP primary based on the age or disability entitlement)? ____Yes ____No
**Note: If yes to the last question, the GHP remains primary for the 30-month COB period.**

What is the month/year of the first regular dialysis?_____

**If patient answers "Yes" to questions 5A, please complete the following:**

1. Is the patient related to the responsible party? ____Yes ____No

2. Does the patient believe that his/her future safety is at risk? ____Yes ____No

3. Does the patient believe that the safety of others in the home is at risk? ____Yes ____No

4. Would the patient like to talk to someone about the concerns? ____Yes ____No
(That is, to have a referral for an evaluation of the patient's situation by a licensed Social Worker)

Patient Phone number: _____

Best time to contact: _____

# Guenthner Physical Therapy Services Patient History Form

Name _____Age_____Date of Onset_____

Present Complaint: _____

**How did it occur? (please check all that apply, describe)**

□ Accident □ Fall □ Gradually □ Work Injury □ Lifting □ Sport □ Other:_____

_____

**Describe what caused the problem:**_____

_____

**What medical attention have you received:**_____

_____

What **tests** have been done for this condition?

□ CT Scan □ MRI □ X-ray □ EMG □ Bone Scan □ None

At what facility were the tests done? _____

How would you rate your **diet?** □ Good □ Fair □ Poor

Do you have any of the following:

| | | |
|---|---|---|
| Unexplained weight gain or weight loss? | □ Yes | □ No |
| Chewing or swallowing problems? | □ Yes | □ No |
| Problems with speech, communicating, or memory? | □ Yes | □ No |
| Problems learning or lack of motivation? | □ Yes | □ No |
| Have you ever experienced domestic violence or abuse? | □ Yes | □ No |

**Past Medical History (please check/add/describe)**

High Cholesterol □ Yes □ No _____ Stroke □ Yes □ No _____
High Blood Pressure □ Yes □ No _____ Blood Clots □ Yes □ No _____
Cancer □ Yes □ No _____ Diabetes □ Yes □ No _____
Seizures □ Yes □ No _____ Pacemaker □ Yes □ No _____
Heart Problems □ Yes □ No _____ Do you smoke? □ Yes □ No _____
Bone/joint problems □ Yes □ No _____
Mental/Emotional □ Yes □ No _____ Are you pregnant? □ Yes □ No _____
Asthma/breathing problems? □ Yes □ No _____
Others: _____

Significant Past **Surgeries:** _____

Are you taking any prescription or over the counter **medications? (please list)** _____

_____

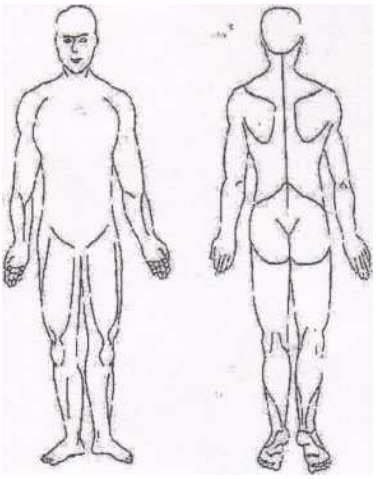
Allergies to Medications:

_____

Allergies to Latex/Tape? □ No □Yes List: _____

1. Do you have pain? □ No □ Yes

If yes, mark your areas or **pain** with an "X" on the body chart.



My pain is: □ aching □ burning □ stabbing □ pins & needles
□ dull □ sharp □ other: _____

**Rank pain** on a scale of 0-10. "0" being no pain and "10" being "emergency room" level pain: 0 1 2 3 4 5 6 7 8 9 1 0

2. Do you have any areas of **numbness/tingling:** □ No □ Yes

If yes, mark numb areas with an ● on the body chart.

3. Is your pain worse in the (circle) morning / afternoon / evening?

4. Is the pain constant / or come and go? (circle)

5. What makes pain worse? _____

6. What eases pain? _____

7. Do you have difficulty sleeping? □ No □ Yes why?_____

What position do you sleep in? _____ How many pillows do you use? ____

8. Have you had physical therapy for this problem before? □ Yes □ No when? _____

9. Are you on an exercise program? □ Yes □ No Describe: _____

10. Do you have any exercise equipment available to you? Please list: _____

11. What was your normal level of activity prior to your injury? What did you like to do? (recreation, leisure, hobby, sports) _____

12. Are you currently working? □ full □ light duty □ off □ homemaker □ not applicable

13. What is your occupation? _____

14. Who lives with you? _____

15. What does your job and/or home duties require? (check)

| | | |
|---|---|---|
| □ lifting | □ pushing/pulling | □ writing |
| □ sitting | □ reaching | □ computer work/typing |
| □ standing | □ twisting | □ repetitive movements |
| □ walking | □ kneeling/squatting | □ other: _____ |
| □ climbing | □ carrying | □ other: _____ |

16. List difficult work/homemaking duties: _____

17. When is your next doctor's appointment? _____

This is a list of your **goals** for physical therapy. Please check the goals you would like to work on. Add goals you have that are not listed, related to physical therapy/activities.

□ Decrease pain.
□ Improve my flexibility.
□ Increase strength.
□ Increase my endurance (increase time able to walk, exercise).
□ Increase my mobility (getting in/out of bed, walking, going up and down stairs, get up/down from chairs/floor).
□ Improve my activities of daily living (dress, house cleaning, laundry, etc.).
□ Improve my posture.
□ Return to work/improve my ability to work (increase sit/stand tolerance, increase ability to lift, carry, etc.)
□ Return to sport.
□ Improve my walking.
□ Improve my balance and coordination.
□ Other: _____

Patient Signature _____ Date _____

Guardian Signature (if patient is a minor) _____ Date _____

Reviewed by _____ Date _____