

**Name** \_\_\_\_\_ **AGE:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

I am happiest when I participate in these activities:

\_\_\_\_\_

I am here today because:

\_\_\_\_\_ This began: \_\_\_\_\_

What is it you want to do that you can't do now? \_\_\_\_\_

I am taking medications for: \_\_\_\_\_ **I am allergic to LATEX: YES NO**

**Previous Surgery(s):**

\_\_\_\_\_

**GENERAL HEALTH:**

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

Cancer?	<b>YES NO</b>
Diabetes?	<b>YES NO</b>
Pregnant (Currently)?	<b>YES NO</b>
Metal Implants?	<b>YES NO</b>
High Blood Pressure?	<b>YES NO</b>
Seizures?	<b>YES NO</b>
Concussion?	<b>YES NO</b>

**NECK/JAW/HEAD:**

Do you experience facial pain?	<b>YES NO</b>
Do you feel a click or pop when you open or close your mouth?	<b>YES NO</b>
Do you experience weekly headaches?	<b>YES NO</b>
Do you wake up with a dry mouth?	<b>YES NO</b>
Do you feel pain in the front of your ear, or ear "fullness" or "ringing"?	<b>YES NO</b>
Do you feel tension at the base of your skull when you turn your head in the upright position?	<b>YES NO</b>

**BREATHING:**

Do you snore?	<b>YES NO</b>
Do you have difficulty breathing with simple activity, i.e.: going up steps?	<b>YES NO</b>
Do you still feel tired after a full night of sleep?	<b>YES NO</b>
Do you have asthma?	<b>YES NO</b>
Do you use an inhaler?	<b>YES NO</b>
Do you have to sleep in an upright position?	<b>YES NO</b>
Have you been diagnosed with sleep apnea?	<b>YES NO</b>

**FEET:**

Do you have flat feet?	<b>YES NO</b>
Do you have pain on the bottom of your feet when you are standing?	<b>YES NO</b>
Do you have a large bony bump near either of your big toes?	<b>YES NO</b>

Do you have orthotics, heel lifts, or any other foot inserts in your shoes? **YES NO**

Does one of your feet turn out more than the other? **YES NO**

Do you feel unstable with one or both of your ankles? **YES NO**

**VISION:**

Do you wear contacts? **YES NO**

Do you wear glasses? **YES NO**

Do you wear bifocals? **YES NO**

Do you occasionally bump into objects while walking? **YES NO**

Do you have difficulty driving at night? **YES NO**

Do you have blurry vision or double vision? **YES NO**

Do you feel dizzy? **YES NO**

Do you feel lateral leg & ankle strain, back tightness, or pain at the bottom of one or both feet? **YES NO**

**LUMBO/PELVIC/FEMORAL:**

Do you ever experience small amounts of urine leakage when you cough, sneeze, laugh, lift or exercise? **YES NO**

Do you ever experience small amounts of urine leakage associated with a strong sensation of needing to go to the bathroom? **YES NO**

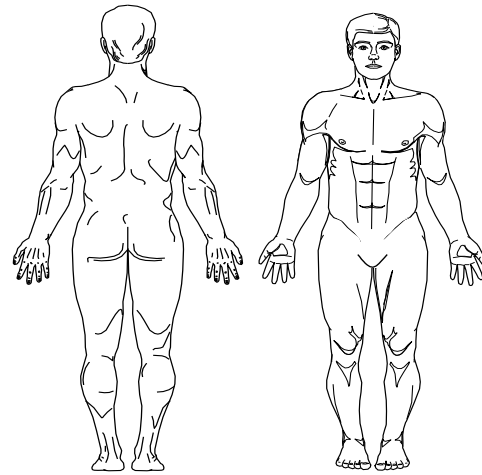
Do you experience frequent trips to the bathroom that disrupt your day or do you plan trips out based on where the bathrooms are? **YES NO**

Do you experience pain, discomfort or pressure in your pelvic area when sitting or standing for prolonged periods of time? **YES NO**

Do you frequently strain to have a bowel movement or to empty your bladder? **YES NO**

Do you experience the sensation of pressure in your lower abdomen or pelvic region? **YES NO**

PLEASE INDICATE ON THE PICTURES TO THE RIGHT THE **LOCATION OF YOUR ISSUE(S)** & PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT ITS **WORST AND BEST** ON THE SCALE BELOW



0	1	2	3	4	5	6	7	8	9	10
0 = NO DISCOMFORT					10 = EXTREME DISCOMFORT					

**Patient-Specific Functional Scale INITIAL or FOLLOW UP**

Date of Today's PT Visit: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

1. Please identify up to 3 important activities that you are unable to do or are having difficulty with as a result of your \_\_\_\_\_ problem.

**\*\*Consider these examples: getting dressed, walking your dog, yard work, sports activities, etc.**

Activity	Score	√ Most Limited
1.		
2.		
3.		

2. Please **score** each activity in the above chart using the scale below.

<b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	<b>10</b>
Able to perform activity at the same level as before injury or problem					Unable to perform activity					

3. Please check √ which of the activities is **most limited today**, because of your \_\_\_\_\_ problem.

# PATIENT REGISTRATION INFORMATION

PLEASE PRINT & COMPLETE FULLY

DATE \_\_\_\_\_

PATIENT NAME (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_ (LAST) \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

DATE OF BIRTH -- -- \_\_\_\_\_ SEX \_\_\_ M \_\_\_ F

SS # (IF NEEDED FOR INSURANCE): \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ SINGLE \_\_\_ MARRIED \_\_\_ OTHER

PHONE (HOME) \_\_\_\_\_ (WORK) \_\_\_\_\_ (CELL) \_\_\_\_\_

EMPLOYER \_\_\_\_\_ JOB TITLE \_\_\_\_\_

STUDENT \_\_\_ NO \_\_\_ YES (WHERE) \_\_\_\_\_ (FULL TIME) (PART TIME) \_\_\_\_\_

EMERGENCY CONTACT \_\_\_\_\_ (PHONE) \_\_\_\_\_ (RELATIONSHIP) \_\_\_\_\_

INJURY/ACCIDENT DATE: \_\_\_\_\_ WORK COMP Related? YES NO MVA Related? YES NO

IF YES, ARE YOU WORKING WITH AN ATTORNEY? YES NO NAME OF ATTORNEY? \_\_\_\_\_

EMAIL ADDRESS: \_\_\_\_\_

## REFERRING DOCTOR OR DENTIST:

(FIRST) \_\_\_\_\_ (LAST) \_\_\_\_\_ MD \_\_\_ DDS \_\_\_ DO \_\_\_ DC

(CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_

HOW DID YOU HEAR ABOUT US? \_\_\_\_\_

IF A FRIEND, PLEASE TELL US WHO SO WE MAY THANK THEM \_\_\_\_\_

## PRIMARY INSURANCE INFORMATION:

TYPE OF INSURANCE: \_\_\_ WORK COMP \_\_\_ MEDICARE \_\_\_ GROUP INS \_\_\_ AUTO INS(MVA) \_\_\_ 3<sup>RD</sup> PARTY

INSURED/POLICY HOLDER NAME (FIRST) \_\_\_\_\_ (MI) \_\_\_\_\_ (LAST) \_\_\_\_\_

\_\_\_ SPOUSE \_\_\_ MOTHER \_\_\_ FATHER \_\_\_ OTHER

ADDRESS \_\_\_\_\_ (CITY) \_\_\_\_\_ (STATE) \_\_\_\_\_ (ZIP) \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_

SS # \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

EMPLOYER \_\_\_\_\_

INSURANCE COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

ID # \_\_\_\_\_ GROUP # \_\_\_\_\_

## WORK COMP or MVA INFORMATION:

INSURANCE COMPANY NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CASE MANAGER & PHONE# \_\_\_\_\_

CLAIM # \_\_\_\_\_

**MEDICALLY INFORMED CONSENT AND  
ASSIGNMENT AND RELEASE**

I voluntarily consent to physical therapy treatment and services deemed necessary by my physical therapist and /or physician. I am aware that the practice of physical therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of these services at the Hruska Clinic Inc. It is this clinic's sincere intent to educate me on every process, from billing to treatment and eventually discharge from services. Therefore, if techniques that are being used to retrain, recruit & restore postural alignment are not understood, it is my responsibility to obtain a clearer understanding of what the therapist's objectives and outcomes are, and how he/she is trying to achieve them. This consent shall be ongoing for a period not to exceed **one year**.

I hereby authorize my insurance benefits be paid directly to Hruska Clinic, Inc., and understand that I am financially responsible for non-covered services. I understand that if Hruska Clinic Inc. does not contract with my insurance company, I will be responsible for the difference between what is charged and what my insurance pays. I also authorize Hruska Clinic Inc. to release any information necessary in order to process this claim. All of the information provided is correct and true to the best of my knowledge. **I am responsible for all charges incurred at Hruska Clinic Inc.**

I (or \_\_\_\_\_ for \_\_\_\_\_) have read this form and fully understand and accept its terms and conditions.

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**Patient** or Authorized guardian

Date

**MEDICALLY INFORMED CONSENT AND  
ASSIGNMENT AND RELEASE**

HRUSKA CLINIC INC. RESTORATIVE PHYSICAL THERAPY SERVICES

PAIGE DONCILLO, OFFICE COORDINATOR, PRIVACY OFFICER

I hereby acknowledge that I received a copy of this medical practice's **Notice of Privacy Practices**.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_ **Telephone:** \_\_\_\_\_

**FINANCIAL POLICY:**

The Hruska Clinic strongly believes that all patients deserve the very best care we can provide. Further, we feel that everyone benefits when definitive financial arrangements are agreed upon.

**IN-NETWORK INSURANCE**

**THE HRUSKA CLINIC CURRENTLY CONTRACTS WITH BLUECROSS/BLUESHIELD PPO, MIDLANDS CHOICE, MEDICA, & MEDICARE.** You will be responsible for any deductibles, co pays, coinsurance and any services not covered by your plan. We strongly encourage you to check with your insurer on your specific physical therapy benefits. Should your plan have a co-pay for physical therapy, we ask that it be paid at each visit.

If you are covered by **MEDICARE**, you will need a prescription for physical therapy from your **medical doctor**. Once you have received a prescription from your doctor, it will expire for use in 30 days. Medicare has imposed a financial “cap” of \$1980 per calendar year for outpatient physical therapy & speech therapy combined.

**OTHER PAYORS**

**WORKERS COMP:** Hruska Clinic will bill your workers compensation carrier for your charges. In the event your claims are denied, you will become financially responsible for all treatment charges. In the event that you seek legal representation in the settlement of your claim, then we ask that you please refer to our MVA/personal responsibility/ litigation policy handout.

**SELF -PAY:** Please refer to our Private Pay Agreement form.

**MVA / PERSONAL LIABILITY / LITIGATION:** Please refer to our MVA/personal responsibility/ litigation policy form.

**OUR BILLING PROCESS**

We automatically file all in network insurance claims for our services. Although it may take 30-60 days to receive a bill for your deductible and co-insurance, all co-pays are due at the time of service. The following is intended to help you better understand our billing process:

- Charges for your visit are sent by your therapist to our billing staff
- The billing staff then submits these charges to your insurance company for reimbursement
- Hruska Clinic generally receives payment within 30-60 days
- Hruska Clinic will submit a statement to you after your insurance has adjusted the claim.
- Payment is due within 30 days of when your statement is mailed out. A billing charge of 1.3% will be assessed on all overdue balances. If there is a month where you miss a payment a late fee of \$10 will be assessed on your account.
- Payment methods accepted are cash, check, MasterCard, Visa, Discover and American Express.
- Payment plans can also be arranged to fit your budget. All plans require payments on a monthly basis.
- Accounts that have not been paid on for 90 days will be turned over to collections.

I have read, understand and agree to Hruska Clinics' Financial Policy.

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_