HRUSKA CLINIC

Restorative Physical Therapy Services

*PATIENT NAME*_____*DATE*_____

GENERAL HEALTH:

Laxtex Allergy? **YES NO**

Do you have, or have had the following?

Cancer? **YES NO**
Diabetes? **YES NO**
Pregnant (Currently)? **YES NO**
Metal Implants? **YES NO**
High Blood Pressure? **YES NO**
Seizures? **YES NO**
Concussion? **YES NO**

NECK/JAW/HEAD:

Do you experience facial pain? **YES NO**
Do you feel a click or pop when you open or close your mouth? **YES NO**
Do you experience weekly headaches? **YES NO**
Do you wake up with a dry mouth? **YES NO**
Do you feel pain in the front of your ear, or ear "fullness" or "ringing"? **YES NO**
Do you feel tension at the base of your skull when you turn your head in an upright position? **YES NO**
Do you wear any type of dental appliance? **YES NO**
Have you had any permanent teeth pulled? **YES NO**
History of braces? **YES NO**

BREATHING:

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

FEET:

Do you have flat feet? **YES NO**
Do you have pain on the bottom of your feet when you are standing? **YES NO**
Do you have a large bony bump near either of your big toes? **YES NO**
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**
Have you ever sprained your ankle? **YES NO**
Do you feel lateral leg & ankle strain, back tightness, or pain at the bottom of one or both feet? **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 or double vision? **YES NO**
Do you feel dizzy? **YES NO**
Are you/Have you been in mono-vision correction? **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 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 disrupts your day? **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 sensation of pressure in your lower abdomen or pelvic region? **YES NO**

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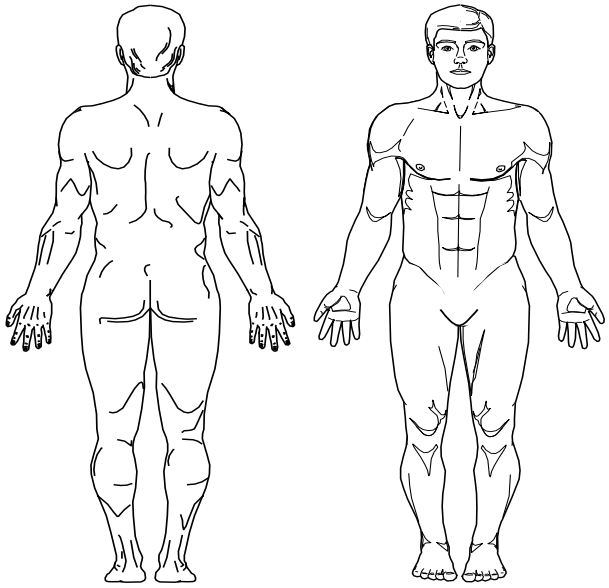

PLEASE INDICATE ON THE PICTURES TO THE RIGHT THE **LOCATION OF YOUR ISSUE(S)**
&
PLEASE INDICATE YOUR LEVEL OF DISCOMFORT AT ITS **WORST** AND **BEST** ON THE SCALE BELOW

0	1	2	3	4	5	6	7	8	9	10

0 = NO DISCOMFORT **10 = EXTREME DISCOMFORT**

I am here today because: _____This began: _____

I am happiest when I participate in these activities:

_____

Please identify up to 3 activities that you are unable to do or have difficulty with:

_____

Previous Surgeries:

_____

Current medications:

_____

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PATIENT REGISTRATION INFORMATION

PLEASE PRINT & COMPLETE FULLY

DATE_____

PATIENT NAME *(*FIRST)_____(MI)_____(LAST)_____

ADDRESS_____

CITY_____STATE_____ZIP CODE_____ EMAIL _____

DATE OF BIRTH_____--_____--_____ SEX M___ F__ SINGLE __MARRIED __OTHER___

STUDENT___NO___YES(*WHERE)*_____SS # *(IF NEEDED FOR INSURANCE)*: _____-____-_____

PHONE *(HOME)*_____*(WORK)* _____*(CELL)*_____

EMPLOYER_____JOB TITLE_____

EMERGENCY CONTACT_____ *(PHONE)* _____*(RELATIONSHIP)*_____

ARE YOU WORKING WITH AN ATTORNEY? YES__NO__ **NAME OF ATTORNEY? _____**

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REFERRING DOCTOR OR DENTIST:

*(FIRST)*_____ *(LAST)*_____ MD __DDS __DO __DC__

HOW DID YOU HEAR ABOUT US? _____

PRIMARY INSURANCE INFORMATION:

INSURED/POLICY HOLDER NAME (*FIRST)*_____*(MI)*_____*(LAST)*_____
___ SPOUSE ___ MOTHER ___ FATHER ___ OTHER

INSURED ADDRESS (IF DIFFERENT FROM PATIENT)

_____*(CITY)*_____*(STATE)*_____*(ZIP)*_____

HOME PHONE_____ DATE OF BIRTH OF POLICY HOLDER_____

EMPLOYER_____INSURANCE COMPANY NAME_____

ID #_____GROUP #_____

WORK COMP or MVA INFORMATION:

INSURANCE COMPANY NAME_____

ADDRESS_____

CASE MANAGER & PHONE#_____

CLAIM #_____

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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 to process this claim. All 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 agree to receive communication from Hruska Clinic via email and text message.

_____I hereby acknowledge that I have read, understand, and agree to Hruska Clinics' **Notice of Privacy Practices**.

_____I hereby acknowledge that I have read, understand, and agree to Hruska Clinics' **Financial Policy/Late cancellation.**

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:

_____All initial evaluations will have a $15 charge that is NOT billable to your insurance company. This charge will be used to cover items used/provided during your course of treatment. (1 bag of balloons, 1 ball, 1 fit-loop, 1 piece of tubing, shoe insert(s), mouthguard) as well as administrative costs.

_____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.

_____Accounts that have not been paid on for 90 days will be turned over to collections.

_____The following situations are considered a "No-Show" appointment:

- You do not arrive to the appointment
- You cancel the appointment with less than 24 hours' notice
- Late arrival > 30 minutes late we will need to cancel the appointment and reschedule.

1. After the first "No-Show" appointment, you will receive notification that you have not followed our policy.
2. If you have 2 "No-Show" appointments, you will be subject to a $25.00 fee.
3. All no-show payments must be paid prior to your next scheduled visit.

Signed: _____ **Date:** _____

Patient Name (print): _____Relationship to patient: _____

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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.

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 therapy benefits.

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.

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.

SELF -PAY: Payment for out-of-pocket patients is due immediately after services are rendered. We do offer a discounted rate of $85 for 1-30 minutes, $170 for 31-60 minutes and so on. If you have insurance coverage that we are out of network with we can provide you with necessary information to submit the insurance claim on your own.

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

Summary of Notice of Privacy Practices

Our complete Notice of Privacy Practices contains a detailed description of how our office will protect your health information, your rights as a patient and our common practices in dealing with patient health information. Please refer to that Notice for further information.

Uses and Disclosures of Health Information. We will use and disclose your health information in order to treat you or to assist other health care providers in treating you. We will also use and disclose your health information in order to obtain payment for our services or to allow insurance companies to process insurance claims for services rendered to you by us or other health care providers. Finally, we may disclose your health information for certain limited operational activities such as quality assessment, licensing, accreditation, and training students.

Uses and Disclosures Based on Your Authorization. Except as stated in more detail in the Notice of Privacy Practices, we will not use or disclose your health information without your written authorization.

Uses and Disclosures Not Requiring Your Authorization. In the following circumstances, we may disclose your health information without your written authorization:

- To family members or close friends who are involved in your health care;
- For certain limited research purposes;
- For purposes of public health and safety;
- To Government agencies for purposes of their audits, investigations & other oversight activities;
- To Government authorities to prevent child abuse or domestic violence;
- To the FDA to report product defects or incidents;
- To law enforcement authorities to protect public safety or to assist in apprehending criminal offenders;
- When required by court orders, search warrants, subpoenas & as otherwise required by law.

Patient Rights. As our patient, you have the following rights:

- To have access to and/or a copy of your health information;
- To receive an accounting of certain disclosures we have made of your health information;
- To request restrictions as to how your health information is used or disclosed;
- To request that we communicate with you in confidence;
- To request that we amend your health information;
- To receive notices of our privacy practices.

If you have a question, concern, or complaint regarding our privacy practices, please refer to our complete Notice of Privacy Practices for the person or persons whom you may contact.