Kenhorst Office
600 High Blvd
PO Box 676
Kenhorst, PA 19607
610.796.9687 (P)
610.796.9391 (F)

GOOD Physical Therapy
Helping you reach optimal health and peak performance

Pottsville Office
48 Tunnel Road
Evergreen Suites, Suite 202
Pottsville, PA 17901
570.622.0182 (P)
570.622.3192 (F)

PATIENT MEDICAL HISTORY QUESTIONNAIRE

Name: _____ Date: _____

DOB: _____ Age: _____ Gdr: M F Occupation: _____

Referring physician: _____ Next appt. date: _____

Primary care physician: _____ Involved body area: _____

What is the condition for which you were referred to PT? _____

Have you ever been hospitalized for this condition? Yes ☐ No ☐

If "Yes", dates hospitalized: _____ Length of Stay: _____ Hospital: _____

Have you ever had Physical Therapy or Chiropractic care? Yes ☐ No ☐

If "Yes", dates of treatment: _____ How long? _____ Location: _____

List any medications you are taking for this condition: _____

Have you ever had any diagnostic tests for this condition? (e.g. X-ray, MRI, CT scan, NCV/EMG)

Yes ☐ No ☐ If "Yes", list. _____

List any medication you are taking for any other condition: _____

List any allergies you have: _____

What was the cause of your symptoms? (e.g. work injury, car accident, sports) _____

When did your symptoms start? _____ Present pain scale (0- 10) _____

Activities that increase symptoms (e.g. sitting, standing) _____

Activities that decrease your symptoms (e.g. lying down, walking) _____

What is your goal or expectation of physical therapy? _____

Mark an "X" beside any condition you currently have or previously have had, with dates and details

X	CONDITION	DATE & DETAILS	X	CONDITION	DATE & DETAILS
	Asthma			Cancer	
	High Blood Pressure			Stroke	
	Heart Disease			Diabetes	
	Lung Disease			Fractures	
	Kidney Disease			Arthritis	
	Vascular Disease			Surgeries	
	Infectious Disease			Headaches	
	Vision/Hearing Loss			Seizures	
	Current Pregnancy			Pacemaker	

Other Medical Issues: _____

**If you have any other medical information you would like to share with us, please add on the reverse side of this questionnaire **

PATIENT INFORMATION **Continued**

Thank you for completing this form. Please know, by providing thorough information, Good PT is better able to communicate with your insurance company to ensure your receive your full healthcare benefits.

Please review the information on the reverse side of this form to ensure it is accurate to the best of your knowledge.

If *all* information on the reverse side of this form is accurate and complete, skip to 2.
If any information is incorrect or missing, proceed to 1 and then to 2, 3, and 4. Please remember to sign and date the bottom of this form. Thank you again.

1. If any information is missing or inaccurate, make correction here:

_____

_____

2. Please enter the following information:

Email address: _____ Other phone#: _____
Employer/School: _____
Employer Address: _____
Occupation: _____
Social Security No. _____
Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Minor
Emergency Contact Name: _____
Emergency Contact Phone: _____
Your relationship to Emergency Contact: _____

Within the last 60 days have you had or are you currently having any home health agency to your residence? ☐ YES ☐ NO
If "Yes", please provide agency name and reason.

_____

Have you had any physical therapy or chiropractic care this year? ☐ YES ☐ NO
If "Yes" please provide name of the practice.

_____

How were you directed to this clinic? ☐ Physician ☐ Family/Friend ☐ Insurance Co.
☐ Advertisement ☐ Health Fair/Seminar ☐ Past Patient ☐ Staff Member ☐ Other

3. I furnished my insurance card(s) to Good PT. ☐ YES ☐ NO

*** If you have more than one insurance carrier, please make sure you furnish all cards.**

4. If my insurance includes a copay, I am aware I am responsible to pay my copay at each visit.
☐ YES ☐ NO

Please include any other information you would like to share with us at this time.

_____

I have reviewed and verify that the information on both sides of this form is correct to the best of my knowledge.

Signature: _____ **Date:** _____

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Keith L. Good, LPT, P.C.
Licensed Physical Therapist

OUR PRACTICE POLICIES

Please review our practice policies and speak with a member of our staff if you have any questions. Keep a copy of this form for your records. The policies apply to you or the patient you represent as the patient representative.

After you have reviewed both sides of this handout, complete the sign-off page, to confirm that you have read and agree to our policies. Agreement with our policies is required to receive treatment.

OUR ATTENDANCE POLICY

At Good PT we strive to provide you with the best possible physical therapy care. Like you, our entire staff is deeply committed to working to restore your physical abilities as quickly as possible. That is why it is very important for you to adhere to the plan of care and the recommended treatment schedule.

If you need to reschedule an appointment, we ask that you please call our office 24 hours prior to the scheduled appointment. This will allow ample time for our staff to reschedule your appointment while maintaining your continuity of therapeutic care. It is preferable that the appointment be scheduled for the next day and if not, within the same week. Failure to cancel by 5 p.m. the day prior to the appointment will result in a Cancelation fee of $25.00.

A missed appointment or “no show” without notice is subject to a $25.00 charge, payable at the next scheduled visit.

OUR PRIVACY POLICY - HIPPA

At Good PT we strive to protect the privacy of your health records and information in accordance with all federal and state regulations. We will only use and disclose your protected health information (PHI) for treatment purposes, payment, and health care operations, as needed. We will not sell your PHI and we will notify you if there is a breach of policy.

You have the right to request that we restrict how your health information is disclosed for treatment, payment, or health care operations by submitting a written request. You may revoke the restrictions and designations by providing written notice. You have the right to designate who and where we may disclose your protected health information. You have access to your health care records, through a written authorization for Release of Information, and a fee may be assessed for copying.

You may read more about our HIPAA/Privacy Policy on our website www.goodptnow.com under the FAQ section. In addition to speaking directly to Good PT staff, you may seek additional information from the Department of Health and Human Services.

Please review Side 2 ➔

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OUR PAYMENT POLICY

At Good PT we are dedicated to providing you with the best possible physical therapy care while keeping your costs reasonable. We are a Medicare provider and participate in network with many commercial insurance companies and third party payers. Please review your insurance information so you are aware of our participation and your benefits. We will also check with your insurance company and so it is very important that the information you give us is accurate, up-to-date, and thorough.

If you have more than one carrier or a Medigap policy, please let us know. Furnish us with all insurance cards you have so we many ensure you receive your full benefits. If during the course of treatment your status changes (e.g. change insurance companies, move, etc.) please inform the staff. This is very important to ensure you receive maximum benefits.

Please note:

- **Copayments** - If your insurance company has a copay, payment is due at each visit.
- **HMO or POS** - If you participate in an HMO or POS insurance, you may require a referral for treatment. We will need the required referral *before* we can provide care.
- **Auto Accident Insurance** - We do accept auto accident insurance including your benefits under Personal Injury Protection (PIP). Make sure you provide us with your full information on the Patient Information form along with your Attorney's contact information to maximize your benefits.
- **Workers Compensation (WC**) - We do accept WC. Make sure you provide us with all the identifying information on the Patient Information form. If you have additional coverage, you must provide us with that insurance card and information, as well, to maximize your benefits.
- **Self-Payment** – For any reason you choose to self-pay, inform staff and they will provide you with information regarding our Self-Payment Agreement.

Our Billing Department will submit claims to your insurance company. Please understand if there is a balance after the claim has been settled, you will be responsible for payment within 30 days.

- **Deductibles/Coinsurance** - If you have a deductible or coinsurance, you will be responsible for payment after we receive payment from your insurance carrier.
- **Medicare** - If you have Medicare and are over the therapy cap, you will be responsible for the payment balance over the limit.
- **Out of Network -** If we do not participate in your insurance company network, as a courtesy we will submit your claims and you will be responsible for payment.
- **Claim Denial -** If any claim is denied by your insurance company(s), including WC or Auto Accident, you will be responsible for the balance.

We accept Visa and MasterCard as well as checks and cash. Returned checks are subject to a $50.00 fee. Should you have questions regarding billing or options we have available, please contact our Billing Director at 610.741.6331 or wmugar@goodptnow.com.

Good PT has the right to amend these policies with proper notice in accordance with federal and state laws.

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Licensed Physical Therapist

Now that you have reviewed our practice policies please complete this sign-off page, to confirm that you have read and agree to our practice policies. By your initials, you acknowledge understanding and agreement either as the patient or as the patient for whom you represent. Please be aware that it is required that each of the following practice policy statements be initialed and adhered to in order to receive treatment.

Thank you for choosing Good Physical Therapy.

1. Consent for Treatment
I consent for physical therapy treatment and authorize Good PT to provide treatment which is considered necessary and proper to treat my condition. **Initials _____**

2. Attendance Requirement
I am aware of Good PT's Attendance Policy and the need to follow the treatment schedule. To the best of my ability, I will provide GoodPT a 24 hour cancellation notice and reschedule my appointment as soon as possible. Failure to do so may result in a $25.00 fee. **Initials _____**

3. Financial Responsibility
I am aware of the Good PT's Payment Policy and I will be financially responsible for the physical therapy treatment. **Initials _____**

If my insurance has a copay, I will pay at the time of each physical therapy appointment. **Initials _____**

4. Assignment of Benefits
I assign and authorize payment directly to Good PT (Keith L. Good, PC) from my insurance company(s) for physical therapy treatment. **Initials _____**

5. Consent for Release for Information
I understand that Good PT may need to disclose certain protected health information about me to carry out treatment, payment, and healthcare operations and I authorize such release. **Initials _____**

I also give Good PT permission to:
Leave a voice mail on the following phone number _____
Speak with the follow person(s) (other than my health care provider) about my treatment:
_____

6. Privacy Policy/HIPAA
I have reviewed and am aware of Good PT's Privacy Policy. **Initials _____**

I _____(print name) have read and understand the above and have provided Good PT with accurate information, to the best of my knowledge.

_____ _____
Signature Date

I am the patient representative for: _____(print patient name)
My address is: _____
My relationship to patient is:_____