OFFICE (724) 591-8900
FAX: (724) 591-5129

NEW PATIENT DEMOGRAPHICS SHEET

Welcome to Our Practice!

Please help us serve you better by providing all of the following information.

Title **Last Name** **First Name** **MI** **Email**

Street Address **Apartment Number**

City **State** **Zip Code**

Home Phone: ☐ **Primary** **Cell Phone:** ☐ **Primary** **Primary Doctor (full name)**

Age **DOB** **Sex (M, F)** **Referring Doctor (full name)**

Employer **Employer Phone Number**

Emergency Contact Name **Emergency Contact Number**

Marital
☐ Married
☐ Widowed
☐ Single
☐ Divorced
☐ Separated

Employment
☐ Full
☐ Part
☐ Retired
☐ None

Living Status
☐ Rent
☐ Own
☐ Other:_____

Relationship to Insured
☐ Self
☐ Spouse
☐ Other
☐ Child

COMPLETE IF INSURANCE IS IN ANOTHER PERSONS NAME: Spouse / Parent / Caregiver

Last Name **First Name** **MI** **Social Security #**

Home Phone: **Cell Phone:**

Age **DOB** **Sex (M, F)** **Relationship to Insured:**

ACCIDENT DETAILS

Employment Related:
☐ Yes ☐ No

Accident Related:
☐ Auto ☐ Other ☐ No

State Accident Occurred In:

Date of Accident:

Give Details of Accident:

Patient / Guardian Signature

Print Name

Date

OFFICE (724) 591-8900
FAX: (724) 591-5129

CONSENT TO TREAT AND CONDITIONS OF ADMISSION

1. CONSENT TO REHABILITATION PROCEDURES: The undersigned consents to the procedures which may be performed during this and future outpatient physical therapy visits that are performed at Holland and Kelley PT.

2. LEGAL RELATIONSHIP BETWEEN HOLLAND AND KELLEY PT PHYSICAL THERAPISTS: All Physical Therapists, and Physical Therapist assistants are employed by Kelley and Kelley Enterprises LLC.

3. RELEASE OF INFORMATION: Upon inquiry and to the extent allowed by law, Holland and Kelley PT may make available certain basic information about the patient in accordance with HIPAA regulations, including name, address, age, sex, general description of the reason for treatment (whether an injury, burn, poisoning or other condition) general nature of the injury, burn, poisoning or other condition, and general condition. If the patient's representative does not want such information to be released, he/she must make a written request for said information to be withheld. The patient or his/her representative may present a written request to Holland and Kelley PT for this purpose. The undersigned agrees that, to the extent necessary to determine liability for payment and to obtain reimbursement, Holland and Kelley PT may disclose portions of the patients record including his/her medical record, to any person or entity which is or may be liable for all or any portion of Holland and Kelley PT's charges, including but not limited to government agencies (e.g., Medicare, Medicaid, insurance companies, health care service plans, or workers compensation carriers). By signing below, I acknowledge that I have received Holland and Kelley PT's Notice of Privacy Practices.

4. FINANCIAL AGREEMENT: The undersigned agrees whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she hereby individually obligates himself/herself to pay the account of Holland and Kelley PT in accordance with the regular rates and terms of Holland and Kelley PT. All accounts are handled in house, including billing, collections and all other matters relating to the account.

5. ASSIGNMENT OF INSURANCE BENEFITS: The undersigned authorizes, whether he/she signs as agent or as patient, direct payment to Holland and Kelley PT of any insurance or other applicable (e.g., Medicare, Medicaid) benefits otherwise payable to or on behalf of the undersigned or patient for these outpatient services, at rate not to exceed Holland and Kelley PT's regular charges. It is agreed that payment to Holland and Kelley PT, pursuant to the authorization, by an insurance company shall discharge said insurance company of any and all obligations under a policy to the extent of such payment. Any pre-certification of insurance benefits is the patient's sole responsibility. The undersigned authorizes payment of Medicare/Medicaid benefits to be made on behalf of the patient for all services furnished by Holland and Kelley PT. It is further understood by the undersigned that he/she is financially responsible for charges not collected by this agreement, unless otherwise stated by applicable written contract or law.

6. AUTHORIZATION FOR RELEASE OF INFORMATION AND FOR PAYMENT: I hereby authorize the release of all information from the patient's medical record that may be necessary to make reimbursement or payment for any or all the services rendered by the Therapist involved in my care with Holland and Kelley PT. I hereby authorize my Insurer or any third party responsible for the payment of covered medical/surgical benefits on my behalf to make payment directly to Holland and Kelley PT. As a patient I understand that I am responsible for my insurance benefits and understand my in network and out of network coverage.

The undersigned certifies that he/she has read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute this document and accept and agree to its terms.

Patient / Guardian Signature	Print Name	Date

OFFICE (724) 591-8900
FAX: (724) 591-5129

FINANCIAL POLICY

AS A COURTESY TO OUR PATIENTS, WE CHECK THE INSURANCE COVERAGE AND BENEFITS FOR THERAPY SERVICES; HOWEVER, IT IS THE PATIENT'S RESPONSIBILITY TO VERIFY COVERAGE, UNDERSTAND THEIR PARTICULAR INSURANCE AND ENSURE THAT PAYMENT IS MADE.

In the information below, we are ESTIMATING the amount of money you will need to pay after your insurance has been filed. **The information below does not guarantee insurance coverage or insurance payment. When insurance benefits are verified, the insurance company does not guarantee payment. If the insurance company denies coverage, you will receive a bill for those services.**

Holland and Kelley PT does not accept third party liability insurance. If you have been involved in an accident where there is third party coverage, you will be responsible for paying for therapy services rendered by Holland and Kelley PT at the time that services are rendered.

The amount not covered by the primary insurance company is ESTIMATED below. That amount is payable on the date that services are rendered. This estimate is determined by benefits from your plan or from a predetermination from your insurance company. Please understand that this is only an estimate and that insurance companies have their own schedule of what they consider to be "usual and customary". These fees often vary between plans. Our charges are based solely on the amount of time, skill and care that is provided by your therapist for each individual treatment session. Therefore, it is not uncommon to find a difference in our charges and the insurance payment. If we are in network for your insurance carrier, you will be responsible for the insurance allowable. If we are not in network for your insurance, you will be responsible for the difference between the allowable and the charge. Please understand that your insurance is an agreement between you, your employer and the insurance carrier.

PAYMENT IS DUE AT THE TIME THAT SERVICES ARE RENDERED.
If you have NOT met your deductible, we will take a deposit from you towards your deductible at each visit until you meet the deductible. You will receive a bill for the difference between the deposit and the insurance allowable after the insurance has communicated the allowable. *If you have had a recent procedure that should apply to your deductible, it may not have been billed by the hospital or physician's office and therefore, may not be listed when we checked your benefits.* If you have a co-insurance percentage that you are expected to pay, we will collect an estimated amount on that co-insurance and you will receive a bill for the difference between what you paid and what the insurance company allows.

If Medicare denies payment, you will be notified that payment has been denied. If Medicare assignment is accepted, at no time will the charges on those items be more than the yearly deductible plus the 20% that Medicare does not pay. In many cases, the deductible amount and the 20% is paid by other insurances. We will follow through with the appeal process on Medicare claims that are denied.

IT IS THE CUSTOMER'S RESPONSIBILITY TO:

- Provide us with all insurance information necessary to file your claim and notify our office of any changes or loss of insurance coverage
- Pay all deductible and balance remaining after secondary insurance is filed
- Payment in full of all claims not covered by your insurance carrier.
- Any arrangement or agreement for payment other than those described above must have approval from the manager.

It is your obligation to pay any and all charges related to the collection of the bill if Holland and Kelley PT deems it necessary or appropriate to retain a collection agency and/or attorney for the collection of this bill. These charges may include, but are not limited to, collection costs of forty (40%) percent of the obligated debt plus other expenses such as court cost, reasonable attorney fees, and past due interest.

WE ENCOURAGE YOU TO CONTACT YOUR INSURANCE COMPANY TO BETTER UNDERSTAND YOUR BENEFIT FOR THERAPY SERVICES.

☐ You have satisfied your deductible and your out of pocket.

☐ Your individual deductible is $_____

☐ You have met $_____ of your individual deductible

☐ Your family deductible is $_____

☐ You have met $_____ of your family deductible

☐ We require a payment of $_____ towards your deductible

☐ Your co-pay for each visit is $_____

☐ You are responsible for a co-ins of $_____

☐ We require a payment of $_____ per visit for co-ins after deductible

☐ Your total out of pocket is $_____

☐ Your total family out of pocket is $_____

☐ You have met $_____ of your total out of pocket expenses

☐ Your insurance allows $_____ for therapy each benefit year. We estimate that to be _____ visits. **This does not guarantee the number of visits.**

☐ Your benefits allow you _____ PT/OT visits each benefit year.

☐ Your Workers Compensation Ins. has approved _____ visits. **In the event they do not pay; you are ultimately responsible for payment.**

☐ Your benefits are pending because: _____

THIS QUOTE OF BENEFITS AND/OR AUTHORIZATION DOES NOT GUARANTEE PAYMENT OR VERIFY ELIGIBILITY. PAYMENTS ARE SUBJECT TO ALL TERMS, CONDITIONS, LIMITATIONS, AND EXCLUSIONS OF THE MEMBERS' INSURANCE CONTRACT AT THE TIME OF SERVICE. SECONDARY INSURANCES ARE NO DIFFERENT AND HAVE THE SAME STIPULATIONS AS PRIMARY INSURANCES AND MAY NOT COVER THE SERVICES PROVIDED.

I HAVE READ THE INFORMATION ABOVE AND UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT.

Patient / Guardian Signature	Print Name	Date

OFFICE (724) 591-8900
FAX: (724) 591-5129

PATIENT HISTORY QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Have you had TWO or more falls in the past year or ANY fall WITH injury in the past year? YES NO

Are you currently receiving or in the past calendar year received Home Health Services of any kind? YES NO

Date of Injury or Surgery_____ Body Part Affected _____

What do you think caused your symptoms? _____

Have you ever had this problem before? YES NO When _____ Treatment received YES NO

How long did it take for you to feel better? _____

Are you on a work restriction from your doctor? YES NO

Have you had any of the following for your current problem: X-Ray Injection MRI CT Scan

Do you smoke? YES NO

Are you latex sensitive? YES NO

Do you have a pacemaker? YES NO

Are you currently pregnant or think you might be pregnant? YES NO N/A

During the past month have you been feeling down, depressed or hopeless? YES NO

During the past month have you been bothered by having little interest or pleasure in doing things? YES NO

Have you RECENTLY noted any of the following symptoms during you current episode? (check all that apply)

- ☐ fatigue
- ☐ fever/chills/sweats
- ☐ nausea/vomiting
- ☐ weight loss/gain
- ☐ falls
- ☐ difficulty maintaining balance while walking
- ☐ numbness or tingling
- ☐ muscle weakness
- ☐ headaches
- ☐ dizziness/lightheadedness
- ☐ heartburn/indigestion
- ☐ difficulty swallowing
- ☐ changes in bowel or bladder function
- ☐ constipation
- ☐ diarrhea
- ☐ shortness of breath
- ☐ fainting
- ☐ cough

Have you EVER been diagnosed with any of the following conditions? (check all that apply)

- □ Cancer
- □ Heart problems
- □ Chest pain/angina
- □ High blood pressure
- □ Circulation problems
- □ Blood clots
- □ Stroke
- □ Anemia
- □ Chemical dependency
- □ Recent Infection
- □ Depression
- □ Lung problems
- □ Tuberculosis
- □ Asthma
- □ Rheumatoid arthritis
- □ Other arthritic condition
- □ Bladder/urinary tract infection
- □ Eye irritation/infection
- □ Sexually transmitted disease/HIV
- □ Incontinence
- □ Thyroid problems
- □ Diabetes
- □ Osteoporosis
- □ Multiple sclerosis
- □ Epilepsy
- □ Kidney problems
- □ Ulcers
- □ Liver problems
- □ Hepatitis

ALLERGIES: List any medication, food, or other substances you are allergic to: _____

_

OFFICE (724) 591-8900
FAX: (724) 591-5129

Aggravating Factors: Identify up to 3 important positions or activities that make your symptoms worse

1. _____
2. _____
3. _____

Easing Factors: Identify up to 3 important positions or activities that make your symptoms better

1. _____
2. _____
3. _____

How are you currently able to sleep at night due to your symptoms?

☐ No problem sleeping ☐ Difficulty falling asleep ☐ Awakened by pain ☐ Sleep only with medication

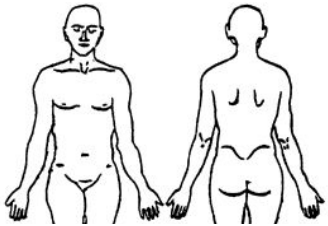
When are your symptoms worst? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

When are your symptoms the best? ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ After exercise

---

Body Chart: Please mark the areas where you feel symptoms on the chart to the right with the following symbols to describe your symptoms: (you may also use this space to describe your pain in your own words)

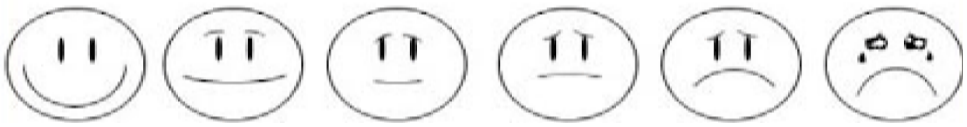
X Shooting/sharp pain
O Dull/aching pain



/ Numbness
= Tingling

My symptoms currently: ☐ Come and go ☐ Are Constant ☐ Are constant, but change with activity

Using the 0 to 10 scale, with 0 being “no pain” and 10 being the “worst pain imaginable” please describe:



1 2 3 4 5 6 7 8 9 10

Your **CURRENT** level of pain while completing this survey: _____

The **BEST** your pain has been during the past 24 hours: _____

The **WORST** your pain has been during the past 24 hours: _____

OFFICE (724) 591-8900
FAX: (724) 591-5129

MEDICATION LIST

Include all prescription, over the counter, and supplements currently taking

Name: _____ **DOB:** _____ **Date:**_____

□ Please see attached Medication list provided by patient.

1: _____

Dosage: _____ Frequency: _____ Administered: _____

2: _____

Dosage: _____ Frequency: _____ Administered: _____

3: _____

Dosage: _____ Frequency: _____ Administered: _____

4: _____

Dosage: _____ Frequency: _____ Administered: _____

5: _____

Dosage: _____ Frequency: _____ Administered: _____

6: _____

Dosage: _____ Frequency: _____ Administered: _____

7: _____

Dosage: _____ Frequency: _____ Administered: _____

8: _____

Dosage: _____ Frequency: _____ Administered: _____

9: _____

Dosage: _____ Frequency: _____ Administered: _____