Medicare Packet

PATIENT HEALTH HISTORY & QUESTIONNAIRE

Patient Name:
Occupation: _____ Sex: ☐ Male ☐ Female ☐ Gender Diverse Height: _____ Weight: _____

Please list current medications (Including prescription, over the counter, and herbal). You can also provide our office staff a list to copy.

Medication	Dosage	Freq	Please indicate route by checking box:
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐
			Oral ☐ Patch ☐ Topical ☐ Other ☐

If you are currently not taking any medications, please indicate NO by checking the box: ☐

Surgery / Hospitalization, please include date and reason.
Date: _____ Reason: _____

Please list any known allergies (including medications, latex, etc.) _____

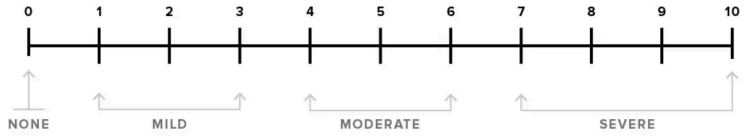
Any **significant** weight gain or loss in the last year? ☐ Yes ☐ No (+/-) _____ lbs

Are you currently experiencing any of the following?			
Nausea or vomiting	☐ Yes ☐ No	Chest Pains (Angina)	☐ Yes ☐ No
Productive/chronic cough	☐ Yes ☐ No	Pain wakes me at night	☐ Yes ☐ No
Difficulty Swallowing	☐ Yes ☐ No	Recent fever, chills, sweats	☐ Yes ☐ No
Dizzy Spells	☐ Yes ☐ No	Difficulty sleeping	☐ Yes ☐ No

Headaches	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No
Visual problems	☐ Yes ☐ No	Heart palpitations	☐ Yes ☐ No
Hearing loss/ringing in ears	☐ Yes ☐ No	Loss of appetite	☐ Yes ☐ No
Difficulty walking	☐ Yes ☐ No	Incontinence	☐ Yes ☐ No
Unusual weakness	☐ Yes ☐ No	Fatigue or myalgia	☐ Yes ☐ No
Joint pain or swelling	☐ Yes ☐ No	Falls	☐ Yes ☐ No

Please indicate the body part(s) in which you are experiencing pain: _____

I would rate my current pain (please indicate appropriate number): _____



I will advise my treating therapist if there is any change in my physical condition which will alter my response to any of the questions on this form.

Signature:_____ Date: _____

Patient Name/Responsible Party: _____ Guardian (if applicable): _____

Consent to Treat

Full Name: _____ Phone Number: _____

Address: _____ Apt: _____ City: _____ State:_____ Zip: _____

INTRODUCTION:
The purpose of physical therapy is to rehabilitate individuals following injury, surgery or disease with the goal of achieving maximal patient potential and accelerate recovery. Treatment is patient specific, and will include careful evaluation followed by intervention. Intervention may include, but is not limited to manual techniques, functional stretching, strengthening, home exercise prescription as well as the use of modalities.

POTENTIAL BENEFITS:
I understand that my physical therapist cannot make any promises nor guarantees regarding a cure for, or improvements in my condition. My physical therapist will educate me on potential results of treatment for my condition and will discuss treatment options with me before I consent to care.

POTENTIAL RISKS:
As with any health care procedure complications may arise during the course of treatment. Adverse effects may include but are not limited to possible increase in my current level of pain discomfort, or aggravation with an existing injury. This discomfort is usually temporary, but if it persists or if I do not tolerate any part of my prescribed interventions I agree to inform my physical therapist. I am aware that every precaution is taken to deliver modalities safely, there is a small risk of skin irritation or burning with the use of electrical modalities, ice, heat or tape.

I acknowledge I have discussed the potential risks and benefits of physical therapy with my referring provider. _____ (Initials)

COMMUNICATION:
It is my responsibility to notify my physical therapist of any known physical conditions, including pregnancy, the intent to become pregnant, and any changes to my health or medication(s). I will also notify a member of the physical therapy team if I experience any discomfort during therapy so that treatment can be adjusted.

INFORMED CONSENT FOR TREATMENT:
The term “Informed Consent” means that the potential risks, benefits and alternatives of physical therapy treatment have been explained to me. I understand all procedures will be thoroughly explained to me before they are performed and any questions will be addressed to my satisfaction. I allow this consent form to cover the entire course of treatment for my present condition and for future conditions for which I seek treatment, with its validity extending for 1 year from the date of endorsement. I give permission for Quinn Orthopedic to leave a detailed voicemail at the phone number provided. By consenting below, I acknowledge that I have weighed the risks involved in undergoing treatment, determined it is in my best interest to proceed with the recommended treatment, and understand that I can decline any part of my therapy program at any time.

If you agree to allow access to your or your dependent’s medical records by another individual, please check the box:

YES _____ or NO _____. The ‘QOPT Authorization for the Release of Protected Health Information’ form will follow.

I have read the above consent for Quinn Orthopedic Physical Therapy. My signature below acknowledges that I have understood and will abide by the conditions and policies noted on this consent form.

Signature: _____ Date: _____

Patient Name/Responsible Party: _____ Parent/Guardian (if applicable): _____

Emergency Contact: _____ Relation: _____ Phone Number: _____

QOPT Authorization for the Release of Protected Health Information

Patient Information

Patient Name:_____ Date of Birth: _____ Phone Number: _____

Address: _____City: _____ State: _____ ZIP Code: _____

Individual/Organization Authorized to Release PHI

Patient Name:_____ Organization: Quinn Orthopedic Physical Therapy

Part III: Individual/Organization Authorized to Receive PHI

Name/Organization: _____ E-mail: _____

Address: _____City: _____State: _____ ZIP Code: _____

Phone Number:_____ Fax Number(if applicable): _____

Patient Authorization

I, _____, hereby authorize the use or disclosure of my health information as described above for the purposes listed. I understand that this authorization is voluntary and valid for one year from the date of my signature unless I revoke it in writing or indicate otherwise.

I understand that I have the right to revoke this authorization at any time by providing written notification to the party named in Part II. The revocation will take effect upon receipt and will prevent further release of my health information from that date forward. However, I understand that actions taken in reliance on this authorization before the revocation will not be affected.

I acknowledge that I am signing this authorization voluntarily and that my healthcare treatment, payment, or eligibility for benefits will not be impacted whether I choose to sign this authorization or not.

I also understand that the party named in Part III is prohibited from re-disclosing my health information unless I provide written authorization or as specifically permitted by law, such as under California Code §56.10.

If the party named in Part III is not a HIPAA-covered entity or business associate as defined in 45 CFR §160.103, I understand that the health information disclosed may no longer be protected under federal and state privacy regulations.

I acknowledge that I have the right to receive a copy of this authorization and that fees may be charged to cover the cost of releasing my health information.

Additionally, I understand that my substance use disorder records are protected under federal regulations governing the Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written authorization.

Patient or Personal Representative

Signature:_____ Date: _____

Name:_____Relationship to Patient: _____

If Signed by Representative (Signature of Witness): _____

For Office Use Only

Received by:_____Date Received: _____ Date Completed:_____

Quinn Orthopedic Physical Therapy
Financial Agreement

Before starting care, Quinn Orthopedic Physical Therapy will verify your insurance coverage as a courtesy. Please note that your financial responsibility is determined by how your insurance processes each claim, including any applicable deductibles, coinsurance, or adjustments. For the most accurate and up-to-date information about your benefits, coverage limits, and claim processing, we encourage you to contact your insurance provider directly.

DISCLAIMER:

Please review the financial policy outlined below, which must be signed before treatment can begin. All patients are required to provide a valid photo ID. To ensure accuracy in the health care record and proper insurance verification, we will also request to make copies of your ID and insurance card for our records.

As a courtesy, Quinn Orthopedic Physical Therapy will bill your insurance company directly; however, it is your responsibility to know your benefits, including network status, covered services, exclusions, and any pre-authorization requirements. If you are uninsured or out of network, you may pay our discounted cash rate of $200 for the initial evaluation and $100 for follow-up visits. Upon request, we can provide a statement for you to submit to your insurer for possible reimbursement. We will verify your coverage before starting care, but final payment responsibility depends on how your insurer processes claims, including deductibles, coinsurance, and adjustments. For details on your coverage or claim processing, please contact your insurance provider. Pursuant to **California Civil Code §1785.27,** a holder of this medical debt contract is prohibited from furnishing any information related to this debt to a consumer credit reporting agency.

You are responsible for providing current and accurate insurance information, including any updates or changes in coverage. Failure to do so may result in you being held financially responsible. After 60 days, any balance not paid by the insurance company will become your liability.

You are responsible for any costs not covered by insurance, including co-pays, deductibles, denied claims, non-medically necessary charges, and any amounts exceeding your visit limit. Uncovered visits will be billed at a cash rate of $200 for evaluations and $100 for follow-up appointments. While we will assist in tracking your visits and confirming pre-authorizations, you remain ultimately responsible for these costs. Payments are due at the time of service. If payment is not received within 60 days, or if the outstanding balance exceeds $300, services may be suspended until a reasonable payment arrangement is made. If you are experiencing financial hardship, please contact our billing manager to discuss possible accommodations.

CANCELATION & NO SHOW POLICY:

Your appointment with us is a professional engagement with a licensed medical provider. In fairness to our providers, our practice and to our other patients, we must insist that you take responsibility to keep and attend your appointments as scheduled. If you are unable to keep a scheduled appointment, we ask that you give us the courtesy of 24 hours notice of cancellation so that we may offer the appointment to other patients. Appointments can be adjusted via email (reception@quinnpt.com) or phone. Please be sure to leave a message, should you not connect with a team member directly. Failure to give 24 hours advance notice of a missed appointment will be considered a no-show. We will waive the first no-show as a courtesy, but subsequent no-shows will each result in a $50 charge to your account balance.

Signature:_____ Date: _____

Patient Name/Responsible Party:_____Parent/Guardian (if applicable): _____

Acknowledgement of Receipt of Notice of Privacy Practices

As part of my health care, **Quinn Orthopedic Physical Therapy** creates and stores information about me. This includes records concerning my health history, symptoms, examinations, test results and plans for future care.

I understand that this information serves as a basis for my continuing care. I understand that this information is used as a means of communication among the company's personnel, and with medical personnel outside of this practice. I understand that this information serves as a source of information for applying my diagnoses and surgical information to my bill. I understand that this information is a way for third party insurance companies to assure that a service we billed for was actually performed.

I understand that this information can be used as a tool to assess the quality of care provided to patients. I have been provided an opportunity to review the Notice of Privacy Practices for the company that provides a more complete review of information uses and disclosures. I understand that I have the right to review this Notice of Privacy Practices before signing this consent.

I understand that the company may change its Notice of Privacy Practices at any time and that a current copy will be available for my inspection during regular business hours at each of our clinics and on the company website.

I understand that I have the right to request restrictions as to how my information may be disclosed to carry out treatment, payment or other healthcare operations and that the company is not required to agree to the restrictions requested. The procedure to request restriction on information use and disclosure is contained in the Notice of Privacy Practices.

My signature below acknowledges that I have received a copy of the Notice of Privacy Practices of Quinn and agree to the liability limitations explained therein.

Signature: _____Date: _____

Patient Name/Responsible Party: _____Parent/Guardian (if applicable): _____