

Patient Functional Assessment Questionnaire

Patient Name: _____ Date: _____

INSTRUCTIONS: Circle the level of difficulty for each activity		0 = Absolutely no difficulty	1 = Able to do w/ little difficulty	2 = Able to do w/ little to moderate difficulty	3 = Able to do w/ moderate difficulty	4 = Able to do w/ moderate to significant difficulty	5 = Able to do w/ significant difficulty	6 = Unable to do at all	Not Applicable
Mobility/Walking	Walking short distances	0	1	2	3	4	5	6	n/a
	Walking long distances	0	1	2	3	4	5	6	n/a
	Walking outdoors	0	1	2	3	4	5	6	n/a
	Climbing Stairs	0	1	2	3	4	5	6	n/a
	Hopping	0	1	2	3	4	5	6	n/a
	Running	0	1	2	3	4	5	6	n/a
Change/Maintain Body Position	Rolling over	0	1	2	3	4	5	6	n/a
	Moving – lying to sitting	0	1	2	3	4	5	6	n/a
	Sitting	0	1	2	3	4	5	6	n/a
	Bending/ Stooping	0	1	2	3	4	5	6	n/a
	Kneeling	0	1	2	3	4	5	6	n/a
	Standing	0	1	2	3	4	5	6	n/a
Carry / Move / Handle Objects	Pushing	0	1	2	3	4	5	6	n/a
	Pulling	0	1	2	3	4	5	6	n/a
	Reaching	0	1	2	3	4	5	6	n/a
	Grasping	0	1	2	3	4	5	6	n/a
	Lifting	0	1	2	3	4	5	6	n/a
	Carrying	0	1	2	3	4	5	6	n/a
Self Care	Dressing/ Clasp b/h back	0	1	2	3	4	5	6	n/a
	Doing light housework	0	1	2	3	4	5	6	n/a
	Prep meals/kitchen tasks	0	1	2	3	4	5	6	n/a
	Bathroom activities	0	1	2	3	4	5	6	n/a
	Sleeping Ability	0	1	2	3	4	5	6	n/a
	Hygiene (comb hair/brush teeth)	0	1	2	3	4	5	6	n/a

Patient Signature: _____ Date: _____
Reviewed by Therapist/Credentials: _____ Date: _____



The Physical Therapy Connection Patient information

Date: _____

Patient's Name: _____

Date of Birth: _____ Age: _____

Address: _____

Phone: _____ Email: _____

Any restriction to contact you? Yes No

Is your condition related to: (please circle) work auto neither

Referring doctor: _____

Patient's Employer: _____

Occupation: _____

Employment: (please circle) full-time part-time retired unemployed

Contact person (if work related): _____

Contact phone: _____

Work status: (please circle) no restrictions restrictions off work

Goal date to return to work, if applicable: _____

Primary Health Insurance: _____

Insured's name: _____ Date of birth: _____

Policy number: _____

Group number: _____

Do you have a co-pay? _____

*Secondary Health Insurance: _____

Insured's name: _____ Date of birth: _____

Policy number: _____ Group number: _____

Emergency Contact: _____

Phone number: _____

Relationship to patient: _____

Date of follow-up appointment with your doctor? _____

How did you hear about us?

___ Doctor recommended

___ Web site

___ Family or friend

___ TV

___ Walk-in

___ Other-Please specify:

___ Conquest Fitness

___ Internet/Facebook



Health Information

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Height: _____ Weight: _____
Date of injury: _____ Date of Surgery: _____
How did your problem occur? _____
Location of pain: _____
Chief complaint: _____
Diagnostic Tests:(please circle) X-rays MRI CT Scan EMG Other _____
Results: _____
Related treatments:(example: injections, chiropractor) _____

List previous injury or surgery that may affect treatment: _____

List any serious illnesses that may affect treatment: _____

Do you have any of the following? (please check)

- | | |
|--|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hyperthyroidism |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Irritable bowel/Crohn's |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Metal Implants |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Dizziness/Vertigo | <input type="checkbox"/> Pregnancy(currently) |
| <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Sinus Infections |
| <input type="checkbox"/> Facial Pain | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Headaches/Migraine | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> High Cholesterol |

Additional Comments:

Do you have heart issues/surgery? Please specify _____



Kidney Issues? Please specify _____

Cancer? Please specify? _____

Have you fallen in the past year? _____ If so, how many times? _____
When was your last fall? _____

Pain rating:

- Please circle your pain level with activity.
- Please place an X over your pain level at rest.

0 1 2 3 4 5 6 7 8 9 10
Mild Moderate Severe

Do you have difficulty sleeping? yes no

Pain is increased by: _____

Pain is decreased by: _____

Please list any medications that you are presently taking: _____

Please list any allergies or sensitivities (Example: meds, latex, adhesives): _____

Have you received previous physical therapy services this year? yes no
If so, how many visits and when? _____

Are you currently receiving any type of home health services? yes no
If so, what type of services? _____



Appointment Cancellation/No-Show Policy Agreement

The Physical Therapy Connection is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (517)668-0000 by 3:00 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a Monday appointment, please call our office by 3:00 p.m. on Friday.** If prior notification is not given, you will be charged \$75.00 for the missed appointment. This charge will not be billed to your insurance company; it will be billed to you directly. Thank you for your understanding regarding this matter.

INITIAL: _____

Billing/Payment Policy

As a courtesy, The Physical Therapy Connection, Inc., verifies your benefits with your insurance company. A quote of benefits is not a guarantee of benefits or payment. Your claim will process according to your plan, if your claim processes differently from the benefits we quoted, the insurance company will side with the plan and will not honor the benefit quote we received.

It is the policy of The Physical Therapy Connection, Inc. that payment is due at the time of service unless financial arrangements are made in advance. We require all patients to pay deductible, copay and/or coinsurance payment at the beginning of each visit. After your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund promptly.

If you are covered by health insurance with physical therapy benefits, we will be happy to bill your insurance. Please provide your insurance information to the front office staff and we will verify your coverage as a courtesy. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our clinic by another physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100 percent responsible for all charges incurred: your physician's referral and our verification of your insurance benefits are not a guarantee of payment.

We highly recommend you also contact your insurance carrier and check into your coverage for physical therapy. Do not assume that you will not owe anything if you have more than one insurance policy.

Worker's Comp/Auto: Please let us know at your first appointment if this injury is a Worker's Compensation or Auto claim. We will need a claim number, point of contact name and phone number at your first visit. If we are not notified at your first visit we will bill your health insurance company and it is your responsibility to get it covered and paid for by worker's comp or auto insurance.

Payment Methods: We accept cash, check, Visa, MasterCard, Discover, and American Express.



Payment Policy/Collection Fees: We will bill you twice and if no payment is received we will add a finance charge of 20% to your bill each month you are late. After three billing cycle's we will refer your account to collections or small claims court. In the event your account is placed in collection status or sent to small claims court, any additional fees incurred due to this, will be added to your outstanding balance.

Credit Card on File: We do require a credit card on file for any patients with deductibles and copays. Your credit card will **ONLY** be charged the full amount owed if we have billed you twice with no payments made.

Divorced Parents of Patients: By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I am authorizing The Physical Therapy Connection, Inc. to bill my insurance company for all services. I also understand and agree that such terms may be amended by the practice from time to time.

INITIAL: _____

I authorize The Physical Therapy Connection to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

Amex Visa Mastercard Discover

Credit Card Number _____

Expiration Date ____ / ____ / ____

Csv _____

Cardholder Name _____

Billing Address _____

City _____ **State** _____ **Zip** _____

I (we), the undersigned, authorize and request The Physical Therapy Connection to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by The Physical Therapy Connection.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to The Physical Therapy Connection in writing and the account must be in good standing.

Patient Name (Print): _____

Patient Signature: _____

Date: ____ / ____ / ____



Consent For Treatment:

I hereby give consent to The Physical Therapy Connection, Inc and its designated agents to provide evaluative and treatment services as necessary and reasonable for my care.

INITIAL: _____

Signature

Date