GREENBERG PHYSICAL & HAND THERAPY ASSOCIATES

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____ P.O Box:_____

City: _____ State: _____ Zip Code: _____

Alternate Address: _____

Home Phone: _____Cell Phone: _____

Work Phone: _____ Email Address: _____

Referring Physician: _____ Phone #: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact: Name:_____ Relationship:_____ Phone:_____

How did you hear about us? _____

INSURANCE INFORMATION

Primary Insurance: (Policy Name and #): _____

Subscriber: Self_____, Other: _____

Secondary Insurance: (Name and #): _____

****If you have MEDICARE, are you also receiving care from a Home Health Agency? YES_____ NO_____**
Medicare will NOT cover outpatient therapy services if you are currently receiving any services from a home health agency.

NOTICE TO ALL PATIENTS

Medicare: *Greenberg Physical and Hand Therapy Associates accepts assignment on all covered services. Medicare pays 80% of its allowed rate. If you have a supplementary policy it may cover the remaining 20%. Medicare does not cover general fitness programs, massage, or services that do not meet guidelines of "reasonable and medically necessary". Please note there is a yearly monetary cap for Medicare Part B Services.*

Blue Shield and other insurance companies: *Greenberg Physical and Hand Therapy Associates is considered an "out of network" provider. You will be responsible for payment at the time of service. As a courtesy, we will submit claims to your insurance company, and will reimburse you if/when the claim is paid.*

Missed Appointments: *Appointments cancelled with less than 24 hours' notice or failure to show for an appointment will be subject to a full visit charge.*

I authorize Greenberg Physical and Hand Therapy Associates to administer treatment as necessary, and to release my medical records required for insurance processing. I understand I am financially responsible for charges not covered by my insurance carrier.

Signature authorizing understanding of treatment, benefit assignment, and payment responsibility

Sign X:_____ Date: _____

Name:_____ Date: _____

MEDICAL QUESTIONNAIRE

Thank you for taking the time to fill out this questionnaire in regards to your past and current medical history. Please answer as accurately and completely as possible. The answers you provide will help us to determine the best course of treatment for you. All information will remain confidential. We appreciate your cooperation.

Injury/Condition: _____If injury, where it occured_____

Date of Injury: _____ Date of Surgery (if applicable): _____

Have you had recent diagnostic testing for this injury/condition?: (X-ray, MRI, CT scan)_____

Are your symptoms (check one) _____getting worse, _____the same, _____improving

Pain level: minimal_____, moderate _____, severe _____ Does pain interfere with your sleep?_____

Have you had PT or OT for this problem before? Yes___, No___, If yes, how many visits this year_____

Are you presently working? Occupation:_____

What types of activities/exercise/sports do you enjoy?_____

How often? _____1-2x per week, _____3-4x per week, _____5+ per week

Please indicate all the following conditions that apply, either presently or in the past:

_____ Heart Disease
_____ Diabetes
_____ High Blood Pressure
_____ Stroke
_____ Dizziness or fainting
_____ Headaches
_____Cancer (specify)
_____Lung Disease
_____ Pacemaker
_____ Allergies
_____ Osteoarthritis
_____ Osteoporosis
_____ Rheumatoid Arthritis
_____ Tick borne illness
_____ Autoimmune disorder, specify _____
_____ Depression
_____ Cognitive Impairment
_____ Hearing loss
_____Vision impairment
_____ Other, specify_____

Please list any prior surgeries:_____

Please list any medications, vitamins, or supplements you are taking: _____
_____
_____

Do you, or have you in the past smoked tobacco? Yes____, No_____, If yes,____Packs x _____years
Last tobacco use _____

Do you drink alcohol? ____Yes, _____No, If yes, # of drinks per week:_____

Have you had any falls in the past year? Yes_____, No_____ If yes, how many?_____, With Injury?_____

What goals do you hope to achieve from PT/OT program? _____

_____