NEW PATIENT QUESTIONAIRE

RETURNING PATIENTS NEED ONLY TO FULL OUT CHANGED OR UPDATED INFORMATION

PATIENT INFORMATION (Please Print) DATE:

PATIENT'S NAME FIRST	MIDDLE	LAST	SEX ☐ M ☐ F	RACE	DATE OF BIRTH	SOCIAL SECURITY NO.

STREET ADDRESS	CITY AND STATE	ZIP CODE	HOME PHONE NO. ( )

E-MAIL	CELL PHONE NO. ( )

PATIENT'S EMPLOYER (NAME & ADDRESS)	WORK PHONE NO. (INCLUDE EXT.) ( )

OCCUPATION (DESCRIBE YOUR JOB DUTIES)	ACTIVE RETIRED DISABLED DATE

ARE YOU ON DISABILITY? ☐YES ☐NO	ARE YOU IN THE PROCESS OF OBTAINING DISABILITY? ☐YES ☐NO

PERSON TO CONTACT (OTHER THAN YOUR HOME PHONE NO.)	RELATIONSHIP	PHONE NO. ( )

REFERRING DOCTOR (NAME AND PHONE NUMBER)	FAMILY DOCTOR (NAME AND PHONE NUMBER)

HOW DID YOU HEAR ABOUT US?	PHARMACY NAME	PHONE NO. ( )

INSURANCE INFORMATION

PRIMARY	INSURANCE COMPANY/CARRIER		
	POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
	CONTRACT / ID NUMBER		GROUP
SECONDARY	INSURANCE COMPANY/CARRIER		
	POLICY HOLDER'S NAME	POLICY HOLDER'S RELATIONSHIP TO PATIENT	POLICY HOLDER'S BIRTHDATE
	CONTRACT / ID NUMBER		GROUP

INJURY INFORMATION

WAS THIS AN INJURY?	INJURY DATE OR BEGAN AS AN ISSUE	TYPE OF CLAIM ☐ INSURANCE CLAIM ☐ WORKER'S COMP ☐ AUTO CLAIM ☐ OTHER _____

WERE ANY OF THE FOLLOWING TAKEN OF THE ISSUE ☐ X-RAYS ☐ MRI ☐ CT SCAN ☐ EMG ☐ MYELOGRAM	WHERE WERE THEY TAKEN	DATE TAKEN

EXPLAIN HOW INJURY OR PROBLEM OCCURRED	LAWSUIT FILED ☐ YES ☐ NO

NAME OF CARRIER		

CARRIER ADDRESS	CITY AND STATE	ZIP CODE

POLICY HOLDER NAME	CLAIM NO.	NAME OF CLAIM REPRESENTATIVE/ATTORNEY	PHONE # ( )

I AUTHORIZE INSIGHT ORTHOPEDICAL SPECIALIST'S THE REQUSET TO RELEASE ANY OF MY MEDICAL RECORDS FROM ANY HOSPITAL OR OTHER FACILITY I HAVE BEEN TREATED. I ALSO AUTHORIZE THE FOLLOWING PEOPLE TO BE SPOKEN TO IN REGARDS TO MY MEDICAL CARE:

NAME	RELATIONSHIP	NAME	RELATIONSHIP
NAME	RELATIONSHIP	NAME	RELATIONSHIP

SIGNATURE DATE

CHIEF COMPLAINT: *(Please describe why you are here i.e. "My right knee hurts")*

_____

_____

ON A SCALE OF 1-10, PLEASE RATE YOUR PAIN WITH 10 BEING THE MOST SEVERE: _____

WHAT MAKES THE PROBLEM WORSE *(i.e. walking or squatting):* _____

WHAT MAKES THE PROBLEM BETTER *(i.e. pain med, rest, ice, heat):* _____

WHEN DID YOU START HAVING THIS PROBLEM: *(Date of injury or duration in weeks/months):* _____

HAVE YOU TRIED: ❑ Physical Therapy ❑ Injections ❑ Splinting ❑ Medication(s)

DO YOU UTILIZE: ❑ Crutches ❑ Wheelchair ❑ Brace ❑ Cast ❑ Splint

PAST MEDICAL: *(Please select all those that apply to you)*

❑ **None** ❑ High Blood Pressure ❑ Diabetes ❑ High Cholesterol ❑ Stroke ❑ Blood Clot
❑ Asthma ❑ COPD ❑ Seizures ❑ Ulcers ❑ Arthritis ❑ Osteoporosis ❑ Pacemaker
❑ Diabetes ❑ Cancer _____ ❑ Other _____

ARE YOU ON BLOOD THINNERS: ❑ No ❑ Yes: Name _____ Why? _____

DO YOU HAVE ANY METAL IN YOUR BODY: ❑ No ❑ Yes: Where? _____

DOMINATE HAND: ❑ Left ❑ Right

CURRENTLY ABLE TO WORK? ❑ Yes ❑ No, is it due to this problem? ❑ Yes ❑ No Last time you worked _____

Height:
Weight:

ALLERGIES:

DRUG	ANESTHETICS	FOOD	OTHER
❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO	❑ YES ❑ NO

SOCIAL HISTORY:

❑ YES ❑ NO	**Do you smoke cigarettes?** If yes, _____ packs per Day/Week
❑ YES ❑ NO	**Recreational Drugs?** If yes, what type & amount? _____
❑ YES ❑ NO	**Alcohol?** If yes, _____drinks per Day/Week
❑ YES ❑ NO	**Caffeine?** If yes, _____drinks per Day/Week

Do you travel? ❑ Local ❑ State ❑ Nation ❑ International

Marital Status: ❑ Single ❑ Married ❑ Widow ❑ Divorced

MEDICATION(S): *(Please list your current medications)* **Circle any medications you feel you have become addicted to.**

PAST SURGICAL HISTORY: *(Please list your surgeries with approximate dates)*

FAMILY HISTORY: *(Serious illness for example bleeding, blood clot, heart attack)*

FATHER	ALIVE / DECEASED	
MOTHER	ALIVE / DECEASED	
PATERNAL GRANDFATHER	ALIVE / DECEASED	
PATERNAL GRANDMOTHER	ALIVE / DECEASED	
MATERNAL GRANDFATHER	ALIVE / DECEASED	
MATERNAL GRANDMOTHER	ALIVE / DECEASED	

Insight Institute of Neurosurgery & Neuroscience (IINN)
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Phone: (810) 732-8336
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FINANCIAL POLICY

The following Financial Policy has been set forth by Dr. J. Shah M.D., Dr. B. Mehta M.D. as well as the other providers employed by IINN (hereinafter referred to as "we" or "us"). It is required that the patient and/or responsible party (hereinafter referred to as "you") read and sign this statement prior to any treatment.

SELF PAY - A mandatory payment is due prior to treatment from all uninsured patients. Monthly payments are required until your balance is paid in full. We accept cash, check, money orders and MasterCard, Visa, Discover and American Express card payments.

INSURANCE - We reserve the right to accept or deny assignment of insurance benefits. if we accept assignment of benefits, it is your responsibility to supply our office with a copy of your current insurance card. Please remember that your insurance policy is a contract between you and your insurance company. The balance on your account is your responsibility. Please keep in mind that some, and perhaps all, of the services provided may be non-covered services. Also be aware that some services may not be considered reasonable and/or medically necessary by Medicare or other medical insurance. Regarding insurance plans where we are participating providers, **all co-pays are due at time of service.** In the event that your insurance coverage changes to a plan where we do not participate, please refer to the information in the above paragraph.

WORKER'S COMPENSATION - You must complete and sign a "Worker's Compensation Case" form. It is your responsibility to bring this completed form with you along with all billing information for your account (carrier name and address, contact person, telephone number and claim number). This information must be provided to us prior to treatment. We will not accept a delay in payment due to a worker's compensation dispute and/or litigation. If that is the case, we require a payment plan until a decision is reached. At that time, if the decision is favorable to you, we will attempt to collect payment from them for any outstanding bills that pertain to the treatment of your injury. We will reimburse you for any payments made that your Worker's Comp claim backdates. If the decision is not favorable, we will bill your medical insurance. In the case that you do not have medical insurance or it is past the time limit to file a claim with your medical insurance, you will be held accountable for your full balance.

AUTO/LIABILITY INJURY - If you are being seen due to a liability injury you must provide the following information for billing and verification of payment prior to treatment:

***Auto Accident:** if you were injured in an auto accident, you must complete and sign an "Auto Case" form and provide us with the name and address of the auto insurance company responsible, your agent/adjuster's name, telephone number, your claim number and date of accident. You must also state whether the auto insurance is primary to your medical insurance or not and the litigation status of your claim.

***Slip and fall, etc.:** you will be required to submit the info pertaining to your case i.e. lawyer's contact info, insurance company responsible and their contact info.

For any case, we will not accept a delay in payment due to a claim that is in dispute and/or litigation. If that is the case, we reserve the right to bill your medical insurance until a decision is reached. If your medical insurance denies payment due to an open Auto/Liability claim, you will be required to set up a payment plan and make payments until a decision is reached. If the decision is favorable, we will attempt to collect payment from them for any outstanding bills that pertain to the treatment of your injury. We will reimburse you for any payments made that your Auto claim backdates. Your medical insurance will be reimbursed, if they have made payments, once your Auto/Liability insurance has paid. If the decision is not favorable, we will bill your medical insurance if we have not already. In the case that you do not have medical insurance or it is past the time limit to file a claim with your medical insurance, you will be held accountable for your full balance.

MINOR PATIENTS - The following parties are responsible for payment of the minor's account balance: the adult accompanying the minor and/or the parents (or guardians of the minor). A minor that is not accompanied by an adult will be denied any non-emergency treatment unless charges for the treatment have been preauthorized.

ASSIGNMENT OF BENEFITS AND RELEASE OF RECORDS - You do hereby assign to us, the medical benefits to which you, or your dependents, are entitled. You also authorize us to furnish to your insurance company all of your patient information, including but not limited to, any and all medical records, notes, test results, x-ray reports, MRI reports or other documents related to your treatment (including itemization of any charges and payments on your account) that is deemed necessary to process this claim. You also authorize us to release any and all patient information and medical records, necessary to collect this debt. Similarly, you authorize us to contact your insurance company, lawyer, or anyone else directly affiliated with your claim in order to collect this debt.

DISABILITY PAPERWORK FEES - There is a charge of $25 for each disability document filled out. The paperwork will be completed within 7 business days. Your paperwork will not be released to you, or otherwise appropriate party, until the $25 fee is received.

RETURN CHECK FEES - There is a $20.00 service charge on all return checks that will be your responsibility to pay in addition to the *original* charges the check was for.

COLLECTION COSTS AND PROCEDURES – If your account becomes delinquent, you agree to pay any additional charges to collect your unpaid bills, including but not limited to, reasonable attorney fees, court costs and collection agency fees. By signing this policy you do acknowledge that we reserve the right to release any patient information and any medical records to our collection agency that are deemed necessary to assist their staff and their attorneys in the collection of this debt.

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FINANCIAL POLICY SIGNATURE PAGE

By signing below you confirm that you have read and understood our Financial Policy on the previous page, and that you agree to its contents.

Signature of patient or responsible party

Date

ATTENDANCE POLICY:

Your regular attendance and participation in Physical Therapy is important. Without your participation, physical therapy will not be effective.

As a courtesy to other patients, we may refuse treatments for patients that arrive more than 15 minutes past their scheduled appointment time. Those who are late may be rescheduled for the next available appointment time.

Missing or canceling 3 or more appointments, within 2 weeks, without making up the missed appointments in a timely manner, will result in discharge from physical therapy for non-compliance.

Your doctor and insurance company will be notified of your poor attendance and noncompliance.

***We request 24 hours advance notice of any cancelled or rescheduled appointments.**

Worker's Compensation Patients:

Please be advised in the event that you miss a schedule appointment and fail to notify us, we are obligated to notify your worker's comp adjustor of poor attendance (missed appointments or tardiness).

I agree to actively participate in physical therapy including the following:

- Obtaining current prescriptions and referrals from my doctor, nurse, or medical practitioner.
- Check with my insurance company regarding my individual coverage for physical therapy.
- Ask questions if you do not understand any treatment, care, or instructions the therapist is giving you during physical therapy.
- Performing exercises at therapy as well as at home on a regular basis.
- Payment of any co-payments prior to services, deductibles, or co-insurance.

I understand that I am responsible for my own health care and will actively participate in Physical Therapy. My signature below indicates I have read and agree to the policy.

Patient's Signature_____ Date:_____

Staff Initials: _____

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PATIENT RESPONSIBILITIES

To help us provide you with quality healthcare, you have the following responsibilities:

1. To provide us with complete and accurate information about your health, including illnesses you have now or have had in the past, pain, medications, allergies, vitamin, and home remedies you use.
2. To follow your recommended treatment plan and instructions.
3. To ask questions when you have them and to tell your therapist if you do not understand any part of the care provided or your care plan.
4. To respect the rights, property and privacy of other patients and their families.
5. To respect our property and facilities.
6. To conduct all your interactions with our staff, patients and visitors in a respectful and polite manner. Inappropriate, harmful, threatening, rude, harassing, abusive, violent or discriminatory language and behavior will not be tolerated
7. To accept the consequences resulting from not following the recommended plan of care.

If you are discharged from therapy due to non-compliance of the responsibilities listed above, we reserve the right to refer you to another qualified provider for care.

_____ _____

Signature of patient or responsible party Date

REVIEW OF SYSTEMS (please check if applicable)

General:

☐Weakness ☐Tiredness ☐Excess appetite

☐Weight loss ☐Chills ☐Fever

☐Difficulty sleeping

Cardiovascular:

☐Chest Pain or Tightness ☐Heart racing

☐Need to sit up to breathe ☐Irregular heartbeat

☐Heart murmur ☐Swelling of the legs

☐Varicose veins ☐Leg pain at rest ☐Leg pain with exertion

Respiratory:

☐Cough ☐Wheezing ☐Shortness of breath

☐Bloody sputum ☐Pain with breathing

Musculoskeletal:

☐Muscle pain ☐Neck pain ☐Back pain

☐Arm pain ☐Pain down legs

☐Painful or still joints ☐Redness of any joint

Neurologic/Psychiatric

☐Seizures ☐Headaches ☐Blackouts ☐Dizziness

☐Double vision ☐Weakness of limbs

☐Loss of balance ☐Loss of sensation

☐Loss of coordination ☐Speech problems

☐Depression ☐Problems with memory

Male Reproductive:

☐Lump in testicles ☐Discharge from penis

☐Decreased sex drive ☐Erection problems

Female Reproductive:

☐Decreased sex drive ☐Unusual vagina bleeding

☐Pregnancy ☐Hormone therapy

HEENT:

☐Decreased ability to see ☐Blurred vision

☐Pain in the eyes ☐Difficulty hearing

☐Ringing in ears ☐Frequent nasal discharge

Gastrointestinal:

☐Nausea ☐Vomiting ☐Diarrhea ☐Constipation

☐Heartburn ☐Abdominal pain

☐Bright red blood in stools ☐Black stools

☐Change in bowel habits

Urinary:

☐Difficulty with urination ☐Pain with urination

☐Urinary tract infection ☐Loss of bladder control

☐Frequent urination

Endocrine:

☐Goiter ☐Heat intolerance ☐Cold intolerance

☐Increased thirst ☐Change in voice

☐Change in hand/ foot size

☐Change in breast size

Skin:

☐Change in mole ☐Breast lumps ☐Itching

☐Rash ☐Redness or infection

Hematologic:

☐Easy bruising ☐Prolonged bleeding