NEW PATIENT QUESTIONNAIRE

DATE:________________

PATIENT INFORMATION

PATIENT NAME:__________________________________ **DOB:**_______________ **SOCIAL SECURITY NO.:** __________________

SEX:☐M ☐F **RACE:**☐ASIAN ☐AFRICAN AMERICAN ☐CAUCASIAN ☐HISPANIC/LATINO ☐NATIVE AMERICAN ☐OTHER

STREET ADDRESS:_____________________________________ **CITY/STATE/ZIP CODE:**_________________________________

HOME PHONE:______________________ **CELL PHONE:**_______________________ **EMAIL:**______________________________

CURRENTLY EMPLOYED?:☐YES ☐NO ☐RETIRED ☐DISABLED **IF EMPLOYED, OCCUPATION:**________________________

JOB DUTIES:____

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

REFERRING PHYSICIAN:____ **PHONE:**______________________________

PRIMARY CARE PHYSICIAN:____ **PHONE:**______________________________

PRIMARY INSURANCE INFORMATION

INSURANCE:____________________________ **POLICY HOLDER'S NAME:**______________________ **RELATION:**_____________

MEMBER ID:_______________________ **GROUP NO.:**_______________________ **POLICY HOLDER BIRTHDATE:**____________

SECONDARY INSURANCE INFORMATION

INSURANCE:____________________________ **POLICY HOLDER'S NAME:**______________________ **RELATION:**_____________

MEMBER ID:_______________________ **GROUP NO.:**_______________________ **POLICY HOLDER BIRTHDATE:**____________

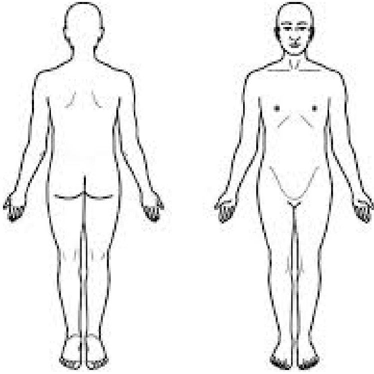
EMERGENCY CONTACTS

NAME:____________________________________ **RELATION:**______________________ **PHONE:**__________________________

NAME:____________________________________ **RELATION:**______________________ **PHONE:**__________________________

INSIGHT
COMPREHENSIVE THERAPY CENTER

INJURY INFORMATION



DATE OF INJURY:____________________ **DID YOU GO TO HOSPITAL?:** ☐YES ☐NO

WHICH HOSPITAL?:______________________ **WAS IMAGING TAKEN?:** ☐YES ☐NO

WHICH TYPE?: ☐X-RAY ☐MRI ☐CT SCAN ☐EMG ☐MYELOGRAM

TYPE OF CLAIM: ☐AUTO ☐WORKERS COMP ☐ OTHER_____________________

LAWSUIT FILED?: ☐YES ☐NO **WAS THERE A REPORT OF INJURY?:** ☐YES ☐NO

NAME OF INSURANCE:______________________**CLAIM NO.:**___________________

CLAIMS ADJUSTER:__________________________**PHONE:**____________________

DO YOU HAVE AN ATTORNEY?: ☐YES ☐NO

IF SO, ATTORNEY:____________________________ **PHONE**:____________________

DESCRIBE INCIDENT:____

CHIEF COMPLAINT

CHIEF COMPLAINT (i.e. back pain, neck pain, etc.):____

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

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

WHAT MAKES THE PROBLEM WORSE? (i.e. walking, standing, squatting, etc):_______________________________________

WHAT MAKES THE PROBLEM BETTER? (i.e. pain meds, rest, ice, heat, etc.):_______________________________________

HAVE YOU TRIED: ☐PHYSICAL THERAPY ☐INJECTIONS ☐SPLINTING ☐CHIROPRACTIC ☐MEDICATION(S)

DO YOU UTILIZE: ☐CRUTCHES ☐WHEELCHAIR ☐BRACE ☐CAST ☐SPLINT

MEDICAL INFORMATION

HEIGHT:______________ **WEIGHT:**_______________ **DOMINANT HAND:** ☐LEFT ☐RIGHT

PLEASE SELECT ALL THAT APPLY:: ☐HIGH BLOOD PRESSURE ☐DIABETES ☐HIGH CHOLESTEROL ☐STROKE ☐BLOOD CLOT ☐ASTHMA ☐COPD ☐SEIZURES ☐ULCERS ☐ARTHRITIS ☐OSTEOPOROSIS ☐PACEMAKER ☐CANCER_______________________________________ ☐OTHER____

ARE YOU ON BLOOD THINNERS?: ☐YES ☐NO **IF YES, WHICH ONE?:**___________________ **WHY?:**____________________

DO YOU HAVE ANY METAL IN YOUR BODY?: ☐YES ☐NO **IF YES, WHERE?:**__________________________________

ARE YOU ABLE TO WORK?: ☐YES ☐NO **IF NOT, IS IT DUE TO THIS PROBLEM?:** ☐YES ☐NO

WHEN WAS THE LAST TIME YOU WORKED?:____________________

MEDICAL HISTORY

DRUG ALLERGIES?:☐YES ☐NO **IF YES, WHAT?:**___________________________

ANESTHETIC ALLERGIES?:☐YES ☐NO **IF YES, WHAT?:**___________________________

FOOD ALLERGIES?:☐YES ☐NO **IF YES, WHAT?:**___________________________

OTHER:___________________________

CURRENT MEDICATIONS (Please circle any you feel you have become addicted to):

____

____

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

____

____

SOCIAL HISTORY

DO YOU SMOKE CIGARETTES?:☐YES ☐NO **IF YES, _______ PACKS PER** ☐DAY ☐WEEK

RECREATIONAL DRUG USER?:☐YES ☐NO **IF YES, WHAT TYPE?:**_____________________ **AMOUNT?:**__________________

DO YOU CONSUME ALCOHOL?:☐YES ☐NO **IF YES, _______ DRINKS PER** ☐DAY ☐WEEK

DO YOU CONSUME CAFFEINE?:☐YES ☐NO **IF YES, _______ DRINKS PER** ☐DAY ☐WEEK

DO YOU TRAVEL?:☐YES ☐NO **IF YES, WHERE?:**☐LOCAL ☐STATE ☐NATIONAL ☐INTERNATIONAL

MARITAL STATUS:☐SINGLE ☐MARRIED ☐WIDOW ☐WIDOWER ☐DIVORCED

INSIGHT
COMPREHENSIVE THERAPY CENTER

REVIEW OF SYSTEMS

(Please check all that apply)

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 JOINTS

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 VAGINAL BLEEDING ☐PREGNANCY ☐HORMONE THERAPY

HEENT:
☐DECREASED ABILITY TO SEE ☐BLURRED VISION ☐PAIN IN 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

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage and assign directly to Insight Comprehensive Center all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____

Patient Signature

____

Printed name, if signature is other than patient

____

If minor, parent/guardian signature

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, and/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.

____

Patient Signature or responsible party

____

Date

PATIENT FINANCIAL RESPONSIBILITY POLICY

At Insight Comprehensive Therapy Center, our goal is to provide the best service possible. Please call us before your appointment if you need to make special financial arrangements to pay your bill.

General

a. The patient's insurance policy is a contract between the patient and his or her insurance company. However, all charges regardless of the insurance coverage are the patient's responsibility and the patient is ultimately responsible for any unpaid balances. As a courtesy to our patients, Insight Comprehensive Therapy Center bills the patient's insurance and makes every effort to ensure that claims are promptly and correctly processed. Insight Comprehensive Therapy Center also bills patients' secondary insurance when patients provide complete insurance information.

b. Patient co-pays are expected at the time of service, and any remaining payment is due in full within 30 days of receiving the first bill from Insight Comprehensive Therapy Center. We accept cash, checks, money orders. If you can't pay your balance within 30 days, please contact us at P: 810-275-9610. There are several ways you can pay your bill, including possible payment plans, and an Insurance Department representative will help find the right one for your financial needs. We will also work with you to determine if you are eligible for financial assistance.

Waiver of Copays and Deductibles

a. It is the policy of this practice to bill all applicable out-of-pocket amounts and to make reasonable efforts to collect such amounts in accordance with our collection practices and procedures. Insight Comprehensive Therapy Center will not waive co-pay, coinsurance, or deductible amounts for insured patients, except in the limited circumstances set forth in this Patient Financial Responsibility Policy. Such determinations may be made only after sufficient investigation has been made and it is expected that such waivers will be rare.

b. If Insight Comprehensive Therapy Center does waive co-pays or deductibles for a patient based on the patient's financial status, we will maintain a record of the information upon which we based this decision. Waivers of co-pays and deductibles may also be made after reasonable collection efforts have failed to result in the collection of the fees. Insight Comprehensive Therapy Center will maintain records of what collection efforts have been made for fees waived in these instances.

____ ________________

Signature of Patient or Personal Representative | Date

____ ___________________________________

Name of patient or Personal Representative | Description of personal representative's Authority

NOTICE OF PRIVACY PRACTICES

Our office's Notice of Privacy Practice explains your rights and our policies regarding the protection of your personal health information. It is always kept here posted at the front desk. We are required by federal law to show it to you and get your signature to acknowledge that we have done so. If you would like, you may read it before you sign this or we can give you a copy to take home. Please sign below.

ACKNOWLEDGEMENT OF RECEIPT OF OFFICE PRIVACY POLICY

I acknowledge that Insight Comprehensive Therapy Center's "Notice of Privacy Practices" has been provided to me. I understand that I have the right to review Insight Comprehensive Therapy Center's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of bills, or in the performance of health care operations with Insight Comprehensive Therapy Center. It describes my rights as they concern the limited use of health information--including my demographic information collected from me and created or received by my physician. The Notice of Privacy Practices for Insight Comprehensive Therapy Center is also provided on request at the main administration desk of the facility.

Insight Comprehensive Therapy Center reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a copy of the revised Notice of Privacy Practices by calling the facility and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

____ ________________

Signature of Patient or Personal Representative Date

____ ____

Name of patient or Personal Representative Description of personal representative's Authority

HIPAA AUTHORIZATION/RELEASE OF RECORDS/TRANSFER REQUEST

TO: ____

____

I, ____________________________ hereby authorize/request the release of my protected health information (PHI) i.e., all medical records including but not limited to diagnosis, records of treatment, examinations, x-rays, specialists seen, and disability date (if applicable) to:

Insight Comprehensive Therapy Center
4800 S. Saginaw Street
Suite 1625
Flint, MI 48507
P: 810-275-9610 F: 810-963-0908

I understand that I may inspect or copy the PHI described by this authorization. I understand that, at any time, this authorization may be revoked by me, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Patient Signature:____

Patient Date of Birth:____

Today's Date:____