



HEALTH QUESTIONNAIRE

1. Name: _____ Date of Birth: _____

2. Have you had physical, occupational or speech therapy this year? [] Yes [] No If yes, please provide date and location _____

3. With whom do you live?

- [] Alone [] Spouse only [] Spouse and other(s) [] Child (not spouse)
[] Other relative(s) [] Group setting [] Personal Care Attendant [] Other: _____

4. GENERAL HEALTH STATUS

- a. Please rate your health: [] Excellent [] Good [] Fair [] Poor
b. Have you had any major life changes during the past year? (e.g., new baby, job change, death of a family member) [] Yes [] No
c. Are you pregnant? Yes [] No [] Unsure []

5. SOCIAL/HEALTH HABITS

Do you currently smoke tobacco? [] Yes [] No If yes, how many packs or cigarettes/cigars per day _____

6. MEDICAL/SURGICAL HISTORY - Please check if you have ever had:

- [] Arthritis [] Broken bones/fractures [] Osteoporosis
[] Circulation/vascular problems [] Heart problems [] Depression
[] High blood pressure [] Stroke [] Head injury
[] Diabetes/high blood sugar [] Low blood sugar/hypoglycemia [] Repeated infections
[] Multiple sclerosis [] Parkinson disease [] Cancer
[] Seizures/epilepsy [] Infectious disease [] Other: _____

Within the past year, have you had any of the following symptoms? (Check all that apply)

- [] Chest pain [] Joint pain or swelling [] Bowel problems [] Other: _____
[] Hoarseness [] Shortness of breath [] Dizziness or blackouts
[] Coordination problems [] Weakness in arms or legs [] Urinary problems
[] Pain at night [] Weight loss/gain [] Nausea/vomiting

Have you ever had surgery? [] Yes [] No If yes, please describe, and include date:

Month _____ Year _____
Month _____ Year _____
Month _____ Year _____

Do you have any electrical implanted devices? (i.e. pacemaker, bone stimulator, urinary control stimulator, etc...) Yes [] No []
Are you allergic to any medication or substances? Yes [] No [] If yes, please list: _____

7. MEDICATIONS

- a. Do you take any prescription medications? [] Yes [] No
If yes, please list: _____
b. Do you take any non-prescription medications? [] Yes [] No
If yes, please list: _____

8. OTHER CLINICAL TESTS- Within the past year, have you had any of the following tests? (Check all that apply)

- [] Arthroscopy [] Biopsy [] EKG (electrocardiogram) [] EMG (electromyogram)
[] Bone scan [] CT scan [] Echocardiogram [] MRI
[] X-rays [] Myelogram [] NCV (nerve conduction velocity) [] Stress test (e.g., treadmill, bicycle)
[] Other: _____

I hereby certify that I have personally answered all of the questions on this form and that my answers are true and complete to the best of my knowledge and belief.

Patient's Signature: _____ Date: _____



FINANCIAL POLICY

BILLING

As a courtesy to you, we will bill your primary and secondary health insurance companies. Please provide us with complete and accurate insurance information, as well as any change of address, telephone number of employer

THIRD PARTY BILLING/RESPONSIBILITY

Regardless of the cause of your injury, as the patient, you are responsible for your bill (this includes car accidents). Your insurance coverage is a contract between you and your insurance company. You are responsible for payment of your account. If your deductible has not been met, full payment of your office visit is required. If your deductible has been met, and your insurance covers a percentage of your therapy, you will be billed your part once insurance payment is received. If you have a set co-pay, it is due the day your treatment is rendered. We offer two payment options: Cash or Check. If you have a question regarding insurance payments or the extent of services covered under your insurance plan, please contact your carrier regarding coverage.

PRIVATE PAY

If you do not have insurance, you will be considered private pay. You will be required to pay each visit in full at the time of treatment.

FINANCIAL DECISION

Which method of payment do you prefer in order to meet your financial responsibility?

Cash, Check, ? _____ **(You must select at least one.)**

(please ask our receptionist for a receipt of your payment)

CANCELLATIONS

A **24-hour** notice must be given when canceling an appointment, or charges may be added to your account.

CONSENT/ASSIGNMENT

I hereby consent to examination and treatment by MedCare Therapy Center, LLC and authorize the release of any and all information acquired in the course of my treatment or dealing in any manner with my treatment, including, but not limited to medical records, electronic media, oral communications to my insurance company, PCP or referring physician, employer or third party payor. I agree to hold MedCare Therapy, LLC Center harmless from the above information. I realize I have the right to refuse any procedure after having the risks and benefits explained to me. I authorize payment to be made directly to MedCare Therapy Center, LLC, including Medicare, Medicaid or other benefits payable from any source, for all services rendered. I understand I am ultimately responsible for payment of my account, and accept full responsibility for the cost of all services. I have read the above information and I fully understand that I am ultimately responsible for the fees.

Thank you.

Patient's Name: _____ Date: _____
(Please Print Name and Sign)

Guarantor's Name: _____ Date: _____
(Please Print Name and Sign)

Facility Representative: _____ Date: _____
(Please Print Name and Sign)



BILL OF RIGHTS

ACCESS TO CARE

- ❖ Regardless of race, creed, national origin, or source of payment, you have the right to receive medical treatment and care.

RIGHT TO PRIVACY AND CONFIDENTIALITY

- ❖ You have the right to privacy regarding your medical care program including case discussion, consultation, examination and treatment.
- ❖ Your treatment and care shall be conducted discreetly and those not involved with your care must have permission to be present.
- ❖ All records pertaining to your care shall be treated as confidential and read only by the individuals directly involved in your care.
- ❖ You have the right to have a person of your own sex present during certain exams, procedures and treatments.

PERSONAL SAFETY

- ❖ You have the right to expect that reasonable safety standards be followed within the center practices and environment.

INFORMATION

- ❖ You have the right to know the identity and professional status of those providing you care.
- ❖ You have the right to be informed if your care is to be delivered under the auspices of any clinical training programs.
- ❖ You have the right to obtain complete and current information concerning your diagnosis, treatment and prognoses in terms you can readily understand. When it is not medically advisable to give this information to you, it should be made available to an appropriate individual on your behalf.
- ❖ You have the right to sufficient information to enable you to give informed consent prior to any procedure or treatment.
- ❖ You have the right to be informed by the practitioner responsible for your care of any continuing health care requirements following discharge.
- ❖ You have the right to be informed when a significant change in your medical status or psychological status has occurred altering treatment significantly.
- ❖ You have the right to voice grievances with respect to treatment of care. Patient/Family complaint forms are available and resolutions to grievances will be resolved promptly.

Patient's COPY

OUTPATIENT REHAB PROGRAM

SCHEDULING

Appointment times are not standing. Please stop at the front desk after your visit to schedule your next appointment.

LATE POLICY

Please contact the receptionist if you're going to be late. If you are late 20 minutes or more for your scheduled appointment:

- Your session may have to be rescheduled
- Your treatment time may be rescheduled
- You may wait to be seen

CANCELLATION POLICY

Appointments may be cancelled by calling (304) 776-5031. To cancel, please call at least one day (24 hours) in advance when possible (or as soon as you know you are unable to make your scheduled appointment), so your therapist's schedule can be adjusted. The receptionist can reschedule your appointment. You may need to talk to your therapist if clinical matter is involved.

If you have (3) or more cancellations, your physician will be notified to assess if therapy is appropriate at this time. A new physician's order may be required.

INSURANCE COVERAGE

Patient is responsible for checking to see if therapy is a covered service under their insurance. Each individual's policy is different. We will make every effort to assist you with checking your insurance coverage, but the ultimate responsibility for verification is yours.

Thank You.