Physical Therapy Screening Questionnaire

Name: _____ Date: _____
Date of Birth: _____ SSN: _____
Address: _____
City_____State_____ Zip Code_____
Phone Number (best place to reach you): _____
Email: _____
Referring doctor: _____

Answering the following questions will help us to manage your care better. Please complete both sides prior to our appointment.

Do you now or have you had a history of the following? Explain yes responses and include dates.

Y/N	Bladder infections	Y/N	Pelvic Pain
Y/N	Painful intercourse	Y/N	Constipation
Y/N	Low back pain	Y/N	Bone/joint problems
Y/N	Diabetes	Y/N	Abdominal pain
Y/N	Multiple sclerosis	Y/N	Stroke
Y/N	Asthma	Y/N	Heart Disease
Y/N	Allergies	Y/N	Emphysema/Bronchitis
Y/N	Menopause	Y/N	Smoking habit
Y/N	Sexually transmitted disease	Y/N	Other (list) _____

Explain the above responses: _____
_____
_____

	Always	Sometimes	Never
1. Do you have trouble making it to the toilet in time?	_____	_____	_____
2. Do you leak when you have a strong urge to urinate?	_____	_____	_____
3. Do you lose urine with any of the following?			
Coughing or sneezing	_____	_____	_____
Laughing	_____	_____	_____
Lifting	_____	_____	_____
Active exercise (running, etc.)	_____	_____	_____
Minimal exercise (walking, light housework)	_____	_____	_____
Sleeping	_____	_____	_____
Nervousness	_____	_____	_____
Leakage unrelated to any specific cause	_____	_____	_____
Other, please explain _____			
4. Is your clothing wet a few drops __, wet underwear __, wet clothes __, wet floor __?			

5. Do you use sanitary pads __, tissue paper __, or diapers __ for protection?
   Name Brand _____
   How many protective pads do you use per day? _____
   Are they damp ___, wet ___, or saturated ___ at each change?
6. How often do you urinate each day? _____ night? _____
7. Is the volume of urine you usually pass large__, average__, small__, or very small__?
8. Do you empty your bladder frequently, before you have the desire to pass urine just so you can stay dry? Yes _____ No _____
9. How many glasses of fluid do you drink per day? _____
10. How many have caffeine? (coffee, tea, soda) _____
11. Any bowel or gas control problems? _____ Please explain _____
_____

Rocky Mountain Osteopathic Medicine and Physical Therapy
8158 E. 5th Ave., Suite 220, Denver, CO 80230
Office: 303-856-3568 Fax: 303-648-5709

Women's Health Treatment Informed consent:

I understand that I am consenting for physical therapy care by a licensed clinical provider for internal evaluation of pelvic floor muscles. I consent to care for any musculoskeletal dysfunctions I may have, as well as an internal assessment of my musculature. I understand that it is my choice to proceed with and/or terminate care at any time, and will maintain communications with my therapist to this accord.

_____ _____

Patient's Name (printed) (date)

_____

Patient's Signature

Patient Billing Agreement

Medical Services Billing–If we are in-network with your insurance company, we will submit the charges directly to your primary insurance. After your insurance(s) complete(s) payment to us you are responsible for payment of any allowable remaining patient balance.

Co-pays -are always collected at check-in. The amount is usually listed on your insurance card.
Deductibles – if your plan has a deductible, you are required to pay a portion of it at check in. After insurance processes the claim, you will be billed for any remaining balance. Please see deductible page and sign.
Self-Pay Patients- If you are "self-pay" for any routine visit you must pay $100 in advance at check-in. At the end of your visit you can:

1. Pay the total charges (less the pre-paid $100) for services and tests done during the visit; OR
2. Sign a Payment Agreement stating you will have the balance paid in full within 3 months. You will be billed monthly. If you would like to set up a payment plan, please discuss with our office manager.

Billing Process - Once we have received the final payment statement from your insurance, we will mail you a statement requesting the remaining allowable patient amount. You will receive a second bill 30 days later for remaining balances. If you are unable to make payment in full before 60 days, you may call our office manager and make installment payment arrangements to avoid having your account go to the collection agency. If your account is not paid 30 days after we send you the second statement, your account will be turned over to our collection agency without further notice from us. After your account has been turned over to our collection agency, you will be responsible for the outstanding balance you have with us as well as any agency fees, legal/attorney fees, and court costs. This could be placed on your credit record and may affect your ability to make any credit purchases.

Other Billing Policies:

Cancellations / 'No-shows' – You are expected at your scheduled appointment time because that time slot has been reserved for you to see the Doctor. Not showing up for a scheduled appointment interrupts the scheduled patient flow, does not allow the Doctor to see other patients in need, and does not allow RMOM staff to use our time effectively. Accordingly, we handle "no-shows" as follows: If you do not call us to cancel or reschedule at least 24 hours in advance of your scheduled appointment, this may be considered a "no-show". The first time there is a "no show," the patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment. If there is a second "no show," within 1 year, a fee of $40.00 will be billed to the patient, not the insurance company and this fee is required to be paid prior to scheduling the patients next appointment. Three "no shows," in 1 year, may result in the termination from our practice.

Auto Accident Patients - If you are being seen for an auto accident, you will be responsible for paying the full balance on the day of your appointment. We will give you a summary of your office visit charges for you to submit to the auto-insurance company. We cannot bill your insurance company for this type of visit.

Workers Compensation Visits - If you are being seen under a Workers Compensation claim you must have a completed injury form from your employer for billing and reporting purposes prior to being seen or you will be treated as a "Self-pay" patient. We cannot bill your regular medical insurance for these claims. If you have been referred by another physician to our office this has already been taken care of for you.

Physical Therapy, Routine Physicals and Preventive Services - It is your responsibility to know the benefits covered by your insurance. Please find out in advance if your insurance will pay for the Physical Therapy or other preventive services.

Payment methods accepted - For your convenience, we accept Visa, MasterCard, American Express, Debit Cards linked to your credit card account, money orders, cash or personal checks with proper ID.

Insufficient funds - If your check is returned due to insufficient funds, you will be charged a $20 fee by us in addition to whatever your bank charges you. You will receive a statement for amounts due in this case. Also, you will not be allowed to pay us by check for the next 6 months following the returned check.

Patients in Collections - Patients with unpaid balances in collections will not be scheduled for appointments unless approved by the Billing Dept. Generally “Collections” balances must be paid in full before you can be seen here again.

I hereby assign RMOM the right to bill and receive payment from my health insurances and authorize RMOM to release information to them for payment and audit purposes and provide access to my records to the necessary parties to accomplish this task and acknowledge understanding the above policies and procedures as a patient of Rocky Mountain Osteopathic Medicine (RMOM).

_____ _____

Printed Patient Name Patient or Guardian Signature

Date

If you have a High Deductible Plan please read below and sign:

DEDUCTIBLE

Your health insurance **deductible** is the amount that you will have to pay annually for your healthcare (such as specialist office visits, physical therapy, surgical procedures, blood tests, or hospitalizations) *before* the health insurance pays anything.

In order for a patient to meet their deductible claims must be submitted and processed by the patient's insurance carrier. When the claims are processed, the amount that is applied to the deductible is the allowed amount for the services being billed. For example, if the claim is for an office visit, 99213 for $80, and the insurance allows $55 for a 99213, then $55 will be applied to the patients' deductible, not $80. You are responsible for payment of the amount applied to your deductible. Depending on your plan, after your deductible is met, you will most likely be responsible for a percentage at that time. This is separate from your co-pay amount. Co-pay's do not apply towards your deductible, they are in addition to.

Your deductible is:_____

I understand my deductible plan and agree to pay my medical bills according to my plan

Signed:_____

Date:_____

In order to meet the financial needs of all of our patients we do offer payment plans. Our billing specialist must approve payment plans.

If you have any questions about our billing policies or a statement that you have received, please contact our billing specialist at 303-856-3568.

Mark C. Winslow D.O.
Rocky Mountain Osteopathic Medicine
8158 E. 5th Ave., Suite 220, Denver, CO 80230
Office: 303-856-3568 Fax: 303-648-5709

_____ _____
Name of Patient (please print) **Date of Birth**

Acknowledgment of Notice of Privacy Practices

I hereby acknowledge that I received Rocky Mountain Osteopathic Medicine's Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date

Documentation of Good Faith Efforts
To obtain patient's acknowledgment that they received provider's Notice of Privacy Practices

(For use when acknowledgment cannot be obtained from the patient.)

The patient presented to the office/hospital on [insert date] and was provided with a copy of Covered Entity's Notice of Privacy Practices. A good faith effort was made to obtain from the patient a written acknowledgment of his/her receipt of the Notice. However, such acknowledgement was not obtained because:

☐ Patient refused to sign.

☐ Patient was unable to sign or initial because:
_____
_____

☐ The patient had a medical emergency, and an attempt to obtain the

acknowledgment will be made at the next available opportunity.

☐ Other reason (describe below):
_____
_____

_____ _____
Signature of Employee Completing Form Date

[Note: Providers are required to make good faith efforts to obtain acknowledgement that each patient has received their Notice of Privacy Practices. Should the individual refuse to acknowledge receipt of provider's Notice of Privacy Practices, the provider should document the "Good Faith Efforts" taken to obtain such acknowledgement. The regulation does not specific how those "Good Faith Efforts" should be documented. This example form is meant to serve as an example of one way that a provider could satisfy this requirement.]