Patient Summary Form

PSF-750 (Rev:12/11/2013)

Instructions
Please complete this form within the specified timeframe. All PSF submissions should be completed online at www.myoptumhealthphysicalhealth.com unless otherwise instructed.

Please review the Plan Summary for more information.

Patient Information

Patient name: Last | First | MI

○ Female ○ Male

Patient date of birth

Patient address | City | State | Zip code

Patient insurance ID# | Health plan | Group number

Referring physician (if applicable) | Date referral issued (if applicable) | Referral number (if applicable)

Provider Information

1. Name of the billing provider or facility (as it will appear on the claim form)

2. Federal tax ID(TIN) of entity in box #1

1 MD/DO 2 DC 3 PT 4 OT 5 Both PT and OT 6 Home Care 7 ATC 8 MT 9 Other ____

3. Name and credentials of the individual performing the service(s)

4. Alternate name (if any) of entity in box #1

5. NPI of entity in box #1

6. Phone number

7. Address of the billing provider or facility indicated in box #1

8. City

9. State

10. Zip code

Provider Completes This Section:

Date you want *THIS* submission to begin:

Cause of Current Episode

1 Traumatic
2 Unspecified
3 Repetitive
4 Post-surgical
5 Work related
6 Motor vehicle

Date of Surgery

Type of Surgery

1 ACL Reconstruction
2 Rotator Cuff/Labral Repair
3 Tendon Repair
4 Spinal Fusion
5 Joint Replacement
6 Other _____

Diagnosis (ICD code)
Please ensure all digits are entered accurately

1° ____.____
2° ____.____
3° ____.____
4° ____.____

Patient Type

1 New to your office
2 Est'd, new injury
3 Est'd, new episode
4 Est'd, continuing care

Nature of Condition

1 Initial onset (within last 3 months)
2 Recurrent (multiple episodes of < 3 months)
3 Chronic (continuous duration > 3 months)

DC ONLY
Anticipated CMT Level

○ 98940 ○ 98942
○ 98941 ○ 98943

Current Functional Measure Score

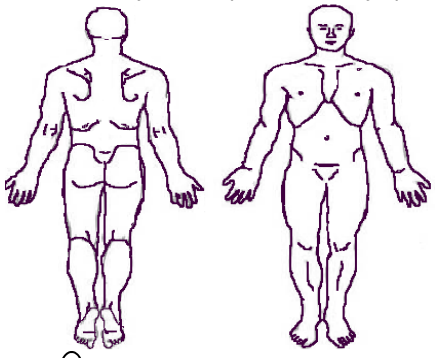
Neck Index | DASH | ____ (other)
Back Index | LEFS

Patient Completes This Section:

(Please fill in selections completely)

Symptoms began on:

Indicate where you have pain or other symptoms:



1. Briefly describe your symptoms:

2. How did your symptoms start?

3. Average pain intensity:

Last 24 hours: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

Past week: **no pain** 0 1 2 3 4 5 6 7 8 9 10 **worst pain**

4. How often do you experience your symptoms?

1 Constantly (76%-100% of the time) 2 Frequently (51%-75% of the time) 3 Occasionally (26% - 50% of the time) 4 Intermittently (0%-25% of the time)

5. How much have your symptoms interfered with your usual daily activities? (including both work outside the home and housework)

1 Not at all 2 A little bit 3 Moderately 4 Quite a bit 5 Extremely

6. How is your condition changing, since care began at *this* facility?

0 **N/A — This is the initial visit** 1 Much worse 2 Worse 3 A little worse 4 No change 5 A little better 6 Better 7 Much better

7. In general, would you say your overall health right now is...

1 Excellent 2 Very good 3 Good 4 Fair 5 Poor

Patient Signature: X _____ **Date:** _____

OPTUM™

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The STarT Back Musculoskeletal Screening Tool

Patient name: _____ Date: _____

Thinking about the **last 2 weeks** tick your response to the following questions:

		Disagree 0	**Agree** 1
1	My pain has **spread** at some time in the past 2 weeks	☐	☐
2	In addition to my main pain, I have had **pain elsewhere** in the last 2 weeks	☐	☐
3	In the last 2 weeks, I have only **walked short distances** because of my pain	☐	☐
4	In the last 2 weeks, I have **dressed more slowly** than usual because of my pain	☐	☐
5	It's really not safe for a person with a condition like mine to be physically active	☐	☐
6	**Worrying thoughts** have been going through my mind a lot of the time in the last 2 weeks	☐	☐
7	I feel that **my pain is terrible** and that **it's never going to get any better**	☐	☐
8	In general in the last 2 weeks, I have **not enjoyed** all the things I used to enjoy	☐	☐

9. Overall, how **bothersome** has your pain been in the last 2 weeks?

Not at all	Slightly	Moderately	Very much	Extremely
☐	☐	☐	☐	☐
0	0	0	1	1

Originally developed by:
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Funded by Arthritis Research UK

INTEGRATED PHYSICAL THERAPY, LLC
Phone 1-608-658-5352
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Patient Information

Last Name_____First Name_____MI___

Date of Birth_____sex_____male_____female

Address_____

City_____State_____Zip Code_____

Home Phone_____Work/Cell Phone_____

e-mail address_____

Employer_____Phone_____

Referring Physician _____Phone #_____

Are you currently receiving Home Health Services_____

Have you received Physical Therapy or Speech Therapy this year YES_____NO_____

Primary Insurance Information

Name of Subscriber_____DOB_____

Insurance Company_____

Address_____

Phone _____Group Number_____

Subscriber Number_____Relation to Subscriber_____

Second Insurance Information

Name of Insured_____ DOB_____

Insurance Company_____

Address_____

Phone _____Group Number_____

Subscriber Number_____ Relation to Subscriber_____

Is this a workcomp claim _____yes _____No Claim #_____

Contact_____Phone_____Date of Injury_____

Is this a personal injury or motor vehicle claim _____yes _____no

Attorney Name_____Phone_____

HEALTH HISTORY

To ensure you receive a complete and thorough evaluation, please answer the following questions the best you can. Ask your therapist to assist if you need help of do not understand a question.

Name:_____

Circle YES or NO…

Have you or any immediate family member ever been told you have:.....

	Self	Family
Cancer ….....	Yes...No	Yes.....No
Diabetes	Yes ..No	Yes.....No
High blood pressure	Yes ..No	Yes.....No
Heart disease	Yes...No	Yes.....No
Angina/chest pain	Yes...No	Yes.....No
Stroke	Yes...No	Yes.....No
Osteoporosis	Yes ..No	Yes.....No
Osteoarthritis	Yes...No	Yes.....No
Rheumatoid arthritis	Yes...No	Yes.....No

Do YOU have a history of:

Allergies/Asthma ..... Yes....No
Headaches ..... Yes....No
Bronchitis ..... Yes....No
Kidney disease ..... Yes....No
Rheumatic fever ..... Yes....No
Ulcers ..... Yes....No
Multiple Sclerosis ..... Yes....No
Seizures ..... Yes....No
Head Injury..... Yes…No
Chemical Dependency..... Yes…No
Parkinsons..... Yes…No
Lymphedema……. Yes…No

In the past 3 months have you had or do you experience:

A change in <u>your</u> health?..... Yes.....No
Nausea/Vomiting ?..... Yes.....No
Fever/chills/sweats ?..... Yes.....No
Unexplained weight change ?..... Yes.....No
Numbness or
tingling ?.....Yes.....No
Changes in appetite ?..... Yes.....No
Difficulty swallowing ?..... Yes.....No
Changes in bowel/bladder function... Yes.....No
Shortness of breath ?..... Yes ....No
Dizziness ?..... Yes.....No
Upper respiratory infection ?..... Yes.....No
Urinary tract infection ?..... Yes.....No

Are you currently:

Pregnant ?.....Yes....No
Depressed ?.....Yes....No
Under Stress ?.....Yes....No

Are your symptoms: (check one)

Getting worse The same Improving

How are you able to sleep at night? (check one)

Fine
Moderate difficulty
Only with medication

Check all that apply…

Do you have a problem with ... (check all that apply)

Hearing Vision
Speech Communication

Do you or have you in the past smoked tobacco?

YES NO

If yes, _____Packs **X** _____Years.
Last tobacco use _____

Do you drink alcoholic beverages? YES NO

If yes, how many drinks do you routinely have per week? _____/week

Do you have a cardiac pacemaker? YES NO

If yes, inserted when? _____

Please check if you are allergic to:

Latex Tapes/adhesives
Cortisone
Food/
Other:_____

Have you ever been in a relation ship where you have been hurt or threatened?

YES NO

Do you feel safe at home?

YES NO

Are you currently seeing chiropractor?

YES NO

Are you currently receiving home health services?

YES NO

HEALTH HISTORY

To ensure you receive a complete and thorough evaluation, please answer the following questions the best you can. Ask your therapist to assist if you need help of do not understand a question.

Have you had any physical or occupational therapy visits in the past year?..... YES NO

About how many? _____

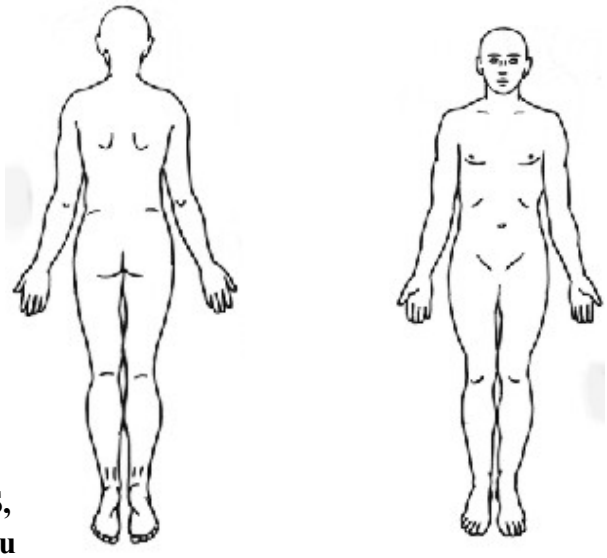
When (Approximate)? _____

Do you have an advanced directive?

YES NO

Please use the diagram below to indicate where you feel symptoms right now. Use the following key to indicate the different types of symptoms.

KEY:
Pins & Needles = 000
Stabbing = /////
Burning = XXX
Deep Ache = zzz



Please list any SURGERIES, INJURIES, or OTHER CONDITIONS for which you have received medical care and approximate date:

_____
_____
_____
_____
_____
_____

MEDICATIONS:

Please list or check current medications you are taking?

Prescribed pain medication
Over the counter pain pills
Muscle relaxants
Anti-inflammatory
Blood pressure medication
Blood thinner
Heart medication
Cholesterol medication
Diabetic medication
Thyroid medication
Inhalers

Other:

_____
_____
_____
_____
_____
_____
_____

INTEGRATED PHYSICAL THERAPY, LLC
Phone 1-608-658-5352
Fax 1-888-965-4018

SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES INTEGRATED PHYSICAL THERAPY, LLC

EFFECTIVE 2008, THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW THE FULL NOTICE OF PRIVACY PRACTICES, WHICH IS ATTACHED. All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share health information with each other for treatment, payment, or health care operation purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION:

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We created a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all your records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

*make sure that health information that identifies you is kept private

*give you this notice of our legal duties and privacy practices with respect to health information about you and

*follow the terms of the notice that is now in effect.

THIS IS HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION

ABOUT YOU. The following categories describe the ways that we use and disclose health information. By coming in for care, you give us the right to use your information for treatment, sharing with your physician or other related health care professionals as necessary to carry out treatment, to get reimbursed for your care, and to operate IPT. There are also various other ways in which we may use or disclose information: Use and disclose medical information about you for treatment. To allow oversight of the quality of the healthcare we provide. To allow Worker's Compensation Claims. To allow payment from your insurance company. As required by subpoena in law or disputes Various uses as required by law, or to avert a serious threat to health or safety.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding health information we maintain about you: The right to inspect and copy, amend, request restrictions, paper copy of this notice, request confidential communications and an account of disclosers, if you so desire. WE RESERVE THE RIGHT TO CHANGE THIS NOTICE, or revise or changed notice effective for health information we already have about you as well as any information we receive in the future. In addition, each time you register for treatment or health care services we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Dee Aussprung 608-658-5352. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care we provided to you. You may receive patient satisfaction surveys or cards of kindness in the mail. You may also choose to communicate via email or phone with your physical therapist.

Integrated Physical Therapy
Phone 1-608-658-5352
Fax 1-888-965-4018

Treatment Agreement

General Consent to Care

I consent to and authorize the medical staff of Integrated Physical Therapy, LLC who may be involved in my care, to provide care and treatment prescribed by and/or considered necessary or advisable by my clinician(s), physician(s) or other health care provider(s). (If patient is a minor under the age of 18, a parent or legal guardian must sign this agreement and authorizes care.) I agree and give my consent for Physical Therapy Services or Consult/Wellness to be provided by Integrated Physical Therapy Staff. I acknowledge that no guarantees have been made to me about the results of this treatment.

Appointment Attendance Agreement

I understand the importance of attending therapy consistently and arriving promptly for my appointment. I understand that my physical therapist may discharge therapy due to two (2) unexcused or missed appointments. We appreciate your full cooperation in attending all scheduled therapy sessions. We are required to inform your Worker's Compensation Adjuster and/or Rehabilitation Manager of all missed or canceled appointments.

Responsibility for Payment

I acknowledge that in consideration of the services provided to me by Integrated Physical Therapy, LLC, I am financially responsible for payment of my bill. I acknowledge that it is my responsibility to provide Integrated Physical Therapy, LLC with current insurance information and to familiarize myself with my insurance plan and its policies. While many insurance plans will typically cover services provided by Integrated Physical Therapy, LLC, insurance coverage varies between plans and the patient is ultimately responsible for charges for services rendered to the patient. Deductibles, co-payments, and other restrictions for services or fees not specifically covered according to policy may limit your insurance coverage. All known co-payments or deductibles will be collected at time of service. Any questions I have regarding my health insurance coverage or benefit levels should be directed to my health plan. We strongly advise that you check with your insurance company to fully understand the coverage provided through your insurance plan and any limitations in therapy services.

Assignment of Insurance Benefits

I assign all my rights and claims for reimbursement under my health insurance policy to be paid directly to Integrated Physical Therapy, LLC. I agree to provide information as needed to establish my eligibility for such benefits. I understand that insurance may not pay for all the services I receive and that I am responsible to pay for services or materials provided to me that are not paid by the insurance.

Release of Information

I understand that Integrated Physical Therapy, LLC may document medical and other information related to my treatment in electronic and other forms, and that such information will be used in the course of my treatment, for payment purposes, and to support those who are caring for me. I authorize my clinician(s) and Integrated Physical Therapy, LLC administrative staff to contact other healthcare professionals that may have information related to my prior and current health conditions and treatment. I acknowledge that I have had the opportunity to read and/or received Integrated Physical Therapy, LLC Notice of Privacy Practices. I authorize Integrated Physical Therapy, LLC to release any information necessary to process my claims and to inform my primary provider or physician, Lawyer, Insurance (or if work injury then also Employer, case manager) of my status. I have been informed that Integrated Physical Therapy, LLC will protect all information from unauthorized use or release other than that used to process my claim and manage my care. I also authorize the release of appointment information left in a voice-mail, answering machine, email or text message, and understand that there is some level of privacy risk associated with these forms of communication.

Consent for Emergency Contact Information

Person to contact in case of an emergency:

_____ _____ _____

Name Relationship Phone number

I certify that I have read and understand the contents of this document.

_____ _____

Signature of Patient or Legally Responsible Person Date

_____

Printed Name of Above

Integrated Physical Therapy
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Optional form, to help you understand your insurance better

PATIENT NAME: _____

Health Insurance has become very complicated over the past few years. Our office staff will help you as much as we can but **it is ultimately your responsibility to understand your particular plan. Often insurance companies limit visits for Physical Therapy Treatment**. It is important to both of us to know as soon as possible about any limits on your insurance coverage. This information helps your physical therapy treatment flow smoothly without interruption.

Please contact your insurance company directly and ask the following questions with regards to Physical Therapy treatment or call our Billing/insurance office at 414.434.8523 and speak with Maria directly.

1. Does my insurance cover Physical Therapy treatment? Yes____ No____

2. How many visits does my plan allow? # Visits_____

3. If more visits are needed, what do I need to do?

_____

_____

4. Does my plan stop coverage after a period of time or # Visits_____

after a certain number of visits? # Weeks_____

5. How much is the deductible on my plan and how much Deductible $_____

have I met this year? Amount Met $_____

6. What is my out of pocket per year? Out of Pocket $_____

7. Do I have any co-payments? Yes____ No____

If so, is the co-pay per visit? Per Visit Amount $_____

Or one time only? One time Amount $_____

8. Does my insurance mandate physician referral for Physical Therapy?

Yes____ No____

PLEASE RETURN THIS FORM AT YOUR NEXT VISIT