

Medical Questionnaire

Patient Name: _____ Type of injury/problem: _____
Do you currently have any Home Health Services? No Yes, check all that apply - Therapist Nurse Aide
If so, what agency is coming to your home? _____
Have you had ANY therapy this calendar year at: No Yes, check all that apply - Chiropractor MD Other
Have you had treatment for this condition in the past? No Yes, where? _____
How many times have you tripped or fallen (either against an object or to the floor) in the past year: 0 1 2 or more
Have you had an injury due to a fall? No Yes
Are you allergic to latex? No Yes
Are you currently taking any medications? No Yes, list medications or attach a copy: _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS:

I hereby authorize you to pay directly to the below named Therapy Company any and all benefits due out of indemnity under the terms of my policy by your company.

**Professional Therapy Services, Inc.
2810 Frank Scott Parkway West
Suite 824
Belleville, IL 62223**

Payment is authorized upon your receipt of any and all of our itemized statements for services rendered to us. This policy was in full force and in effect at the time the services were rendered. Payment of this amount is herein directed in whole or part, and shall be considered the same as if paid by your company directly to me.

I also hereby certify that all information is correct and complete, that I hereby give my consent for treatment with therapy to be administered by persons with acceptable professional licensure. I hereby authorize release of any medical information necessary to process this claim. I am responsible for payment of any sum due upon demand for goods and services rendered. If litigation is required to collect any amounts due under this contract, I consent to St. Clair County, Illinois as being the proper venue for the filing of any action. In the event, after reasonable demand, I fail to pay any sum due and my account is placed in the hands of a collection agency, I agree to pay reasonable collection fees incurred in the collection of any such sum due or in part thereof and interest to 1.5% per month on any unpaid balance past 30 days.

SIGNATURE: _____ DATE: _____

FOR OFFICE STAFF ONLY

Onset: _____ Body part to be treated: _____
V57.1-PT V57.21-OT V57.3-SLP V57.81-Orthotic Training V57.89-Other Specified Rehab Procedure
Dx: _____ Other Dx: _____
Is Medicare Cap Exempt? No Yes
Medicare: CPT II 1100F: 2 or more falls in the past year or any fall with injury in the past year
CPT II 1101F: No falls in past year or only one fall without injury in the past year
Pain Assessment: G8440-Pain Assessment on outcome scale and/or on evaluation (location, intensity & description)
G8442-Documented that patient is not eligible for pain assessment
G8441-Pain assessment not documented and no reason listed
Patient Co-Dev. Plan of Care: G8437-yes, patient notified and helped dev POC with documentation on evaluation
G8439-active participation not documented due to patient not eligible
G8438-no documentation and no reason

Physician: _____ Therapist: _____