Groschan and Associates PA

Patient Information Form

Patient Information

Last Name _____ First Name _____ MI _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Date of Birth _____ Gender _____ Marital Status _____ Email _____

Emergency Contact

Last Name _____ Relationship _____

First Name _____ Phone _____

Employer

Name _____ Phone _____

Address _____

Address2 _____ City _____ State _____ Zip _____

Problem

Problem Description _____ Date of Injury _____

Referred By _____

Latest Referral Information _____ Motor Vehicle Accident _____

That occurred in: _____

Notes: _____

Primary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoPay _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

Secondary Insurance

Insurance _____ Deductible _____

ID _____ Max Benefit _____

Group # _____ CoInsurance _____

Subscriber

Name _____

Relationship _____

Date of Birth _____

I authorize release of information requested by my insurance plan for payment.
I understand that I am financially responsible for any balance due.
I agree to comply with the terms and conditions as outlined on the Patient Registration form.

I hereby acknowledge that I have received a copy of the Notice of Privacy Practices.

(You have the right to refuse to sign this acknowledgement if you so choose.)

Signature: _____ Date: _____

Patient Health Questionnaire - PHQ

ACN Group, Inc. - Form PHQ-202

ACN Group, Inc. Use Only rev 7/18/05

Patient Name _____ ***Date*** _____

1. Describe your symptoms _____

_____

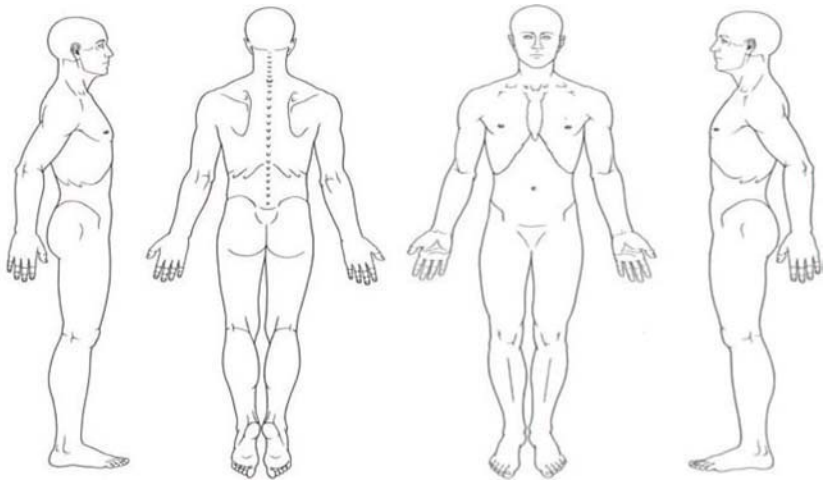
a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms?

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

Indicate where you have pain or other symptoms



3. What describes the nature of your symptoms?

① Sharp ④ Shooting
② Dull ache ⑤ Burning
③ Numb ⑥ Tingling

4. How are your symptoms changing?

① Getting Better
② Not Changing
③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ *Unbearable*

b. How much has pain interfered with your normal work (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. During the past 4 weeks how much of the time has your condition interfered with your social activities?
(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

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

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

① No One
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

① Xrays *date:* _____ ③ CT Scan *date:* _____
② MRI *date:* _____ ④ Other *date:* _____

9. Have you had similar symptoms in the past? ① Yes ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

① This Office
② Chiropractor
③ Medical Doctor
④ Physical Therapist
⑤ Other

10. What is your occupation?

_____

① Professional/Executive
② White Collar/Secretarial
③ Tradesperson
④ Laborer
⑤ Homemaker
⑥ FT Student
⑦ Retired
⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

① Full-time
② Part-time
③ Self-employed
④ Unemployed
⑤ Off work
⑥ Other

Patient Signature _____ ***Date*** _____

Patient Health Questionnaire - page 2

ACN Group, Inc PHQ-102

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ ***Date*** _____

What type of regular exercise do you perform? ① None ② Light ③ Moderate ④ Strenuous

What is your height and weight? Height [ ][ ][ ] *Feet Inches* Weight [ ][ ][ ] lbs.

For each of the conditions listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
○	○	Headaches	○	○	High Blood Pressure	○	○	Diabetes
○	○	Neck Pain	○	○	Heart Attack	○	○	Excessive Thirst
○	○	Upper Back Pain	○	○	Chest Pains	○	○	Frequent Urination
○	○	Mid Back Pain	○	○	Stroke			
○	○	Low Back Pain	○	○	Angina	○	○	Smoking/Use Tobacco Products
						○	○	Drug/Alcohol Dependence
○	○	Shoulder Pain	○	○	Kidney Stones			
○	○	Elbow/Upper Arm Pain	○	○	Kidney Disorders	○	○	Allergies
○	○	Wrist Pain	○	○	Bladder Infection	○	○	Depression
○	○	Hand Pain	○	○	Painful Urination	○	○	Systemic Lupus
			○	○	Loss of Bladder Control	○	○	Epilepsy
○	○	Hip/Upper Leg Pain	○	○	Prostate Problems	○	○	Dermatitis/Eczema/Rash
○	○	Knee/Lower Leg Pain				○	○	HIV/AIDS
○	○	Ankle/Foot Pain	○	○	Abnormal Weight Gain/Loss			
			○	○	Loss of Appetite	***Females Only***		
○	○	Jaw Pain	○	○	Abdominal Pain	○	○	Birth Control Pills
						○	○	Hormonal Replacement
○	○	Joint Swelling/Stiffness	○	○	Ulcer	○	○	Pregnancy
○	○	Arthritis	○	○	Hepatitis	○	○	
○	○	Rheumatoid Arthritis	○	○	Liver/Gall Bladder Disorder			
						Other Health Problems/Issues		
○	○	General Fatigue	○	○	Cancer	○	○	
○	○	Muscular Incoordination	○	○	Tumor	○	○	
○	○	Visual Disturbances	○	○	Asthma	○	○	
○	○	Dizziness	○	○	Chronic Sinusitis			

Indicate if an immediate family member has had any of the following:

○ Rheumatoid Arthritis ○ Heart Problems ○ Diabetes ○ Cancer ○ Lupus ○ _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

_____ _____ _____

_____ _____ _____

List all the surgical procedures you have had and times you have been hospitalized:

_____ _____ _____

_____ _____ _____

Patient Signature _____ ***Date*** _____

Doctor's Additional Comments

_____

_____

_____

Doctors Signature _____ ***Date*** _____

Groschan & Associates
Physical Therapy
www.GroschanPT.com

2328 W. Joppa Rd., Suite 300
Lutherville, MD 21093
Phone: (410) 938-8660
Fax: (410) 938-8664

Medications List

Patients Name: _____ **Date:_____**

Prescription name:	Dosage amount:	Frequency:

Update your Medications list above and sign and date below. If it is the same, please sign and date below:

Sign:_____ Date:_____ **Sign:_____ Date: _____**

Sign:_____ Date:_____ **Sign:_____ Date:_____**

Sign:_____ Date:_____ **Sign:_____ Date: _____**

Sign:_____ Date:_____ **Sign:_____ Date:_____**

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PAYMENT POLICY

****Please keep this page for your records****

COMMERCIAL INSURANCE – Even as a non-participating provider we will bill your primary insurance as a courtesy to you. We expect to be paid our full charged amount. Charges outstanding for more than sixty days will be due in full from you regardless of the type of insurance involved. Be aware of the fact that your insurance company may pay you directly. We expect that when you receive payment from your insurance carrier that you will in return remit your remaining balance to us immediately. Any remaining balance after your primary coverage has paid, including items classified as "above usual and customary", is due from you upon receipt of the explanation of benefits from your primary insurance carrier. You will be responsible for any item not paid in full by your insurance carrier. Prior to beginning treatment, we will also verify your insurance benefits as a courtesy. While we will take all reasonable action to provide accurate therapy benefit information for your specific plan, be aware that verification of benefits is not a guarantee of payment from your insurance carrier. Secondary insurance will be your responsibility to file and collect.

MEDICARE INSURANCE – We will bill Medicare for you. In most cases, Medicare will pay 80% of allowable charges. We will bill your secondary insurance for you, if you have one, or the balance will be billed to you.

AUTOMOBILE PIP – We will bill your Auto carrier for you until your PIP has been exhausted. You will be responsible for all dates of service in full after PIP is exhausted upon time of service. We may bill your commercial insurance as an out-of-network provider once your PIP is exhausted. If there is a legal case settlement pending you will still be responsible for payment at the time of service.

WORKERS COMPENSATION – We will bill your Workers Compensation carrier for you. You will be responsible for all dates of service in full if your Workers Compensation insurance does not pay. We will bill your commercial insurance as an out-of-network provider if your workers compensation is exhausted. However, you must pay in full at time of service or choose another physical therapy office to attend. If there is a legal case settlement pending you will still be responsible for payment at the time of service.

LIABILITY INSURANCE - We will bill your Liability insurance carrier for you. You will be responsible for all dates of service in full if your Liability insurance does not pay. We will bill your commercial insurance as an out-of-network provider if your Liability insurance is exhausted. However, you must pay in full at time of service or choose another physical therapy office to attend. If there is a legal case settlement pending you will still be responsible for payment at the time of service.

SELF PAY – Please pay the balance in full at the time of service or upon the receipt of a monthly statement or notice. In the event that you are unable to pay the balance in full, we are willing to make reasonable payment arrangements. Please be advised that Groschan & Associates is not a credit grantor, and therefore, failure to maintain these arrangements may result in the placement of your account with a collection agency or attorney for collection. Credit cards (MasterCard, Visa and Discover) are accepted for payment on account.

LEGAL SUIT – You will be responsible for our full fees at time of service you will be reimbursed by your case settlement.

All above policies must be followed unless other arrangements have been negotiated with Groschan and Associates prior to treatment.

Please be aware that you will be financially responsible for services rendered regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principal amount owing, and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, and all court costs and additional legal expenses associated with the recovery of this debt. We reserve the right to charge interest on balances over thirty days old, charge returned check fees as allowed by state law, and charge a no-show fee for missed appointments when adequate notice of cancellation is not provided.

Thank you for allowing us this opportunity to serve you. If you have any questions about the above information or any uncertainty regarding your insurance coverage, please ask for our assistance. Kindly sign and date this document to indicate that you understand and agree to the terms of this payment policy.

PLEASE NOTE THE FOLLOWING CANCELLATION POLICY: To keep appointment times available for all of our patients, there is a charge of $50.00, BILLED TO THE PATIENT, for each instance whereby a patient does not show for a scheduled appointment or does not give at least 24 hour notice of cancellation.

Groschan & Associates Physical Therapy Notice of Privacy Practices

******Please keep this page for your records******

This notice describes how your medical information is used and disclosed. Please review it carefully.

Our Responsibilities:

We, at Groschan & Associates, are committed to excellence in the physical therapy field and in achieving the highest standards for ethical conduct. It is our goal to help you understand our commitment to compliance with our legal duties and obligations.

We are required to keep your health information private and give you notice of our legal commitment and privacy practices with respect to the information you give us. We will abide by this and notify you if we are unable to keep this commitment to you.

The purpose of this notice is to help you in making informed decisions before authorizing the disclosure of your health information to others.

Understanding Your Rights As A Patient:

You have a right to review and obtain a copy of your records and be given an account of all disclosures of information sent to other health care professionals at any time.

You may request in writing that we not use or disclose your health information for treatment, payment, and administrative purposes except if required by law or emergency circumstances.

Your record will only be accessible to those at this facility that are directly related to your treatment and/or account.

Your health information may not be removed, mailed or sent from our facility except for the purpose of treatment and/or collecting an account.

Your written permission will be obtained for specifying a particular access and/or disclosure if not directly related to treatment or collection of an account.

In accordance with the provision of HIPAA (Health Insurance Portability and Accountability Act), a patient or provider on behalf of the patient may request an account of where health information has been disclosed. We at Groschan & Associates will compile and provide such listing upon written request.

Understanding Your Record/Chart:

Documentation is made each visit to our office. This may include signs and symptoms, examination findings and response to treatment. This information helps us to plan your continued care and treatment. It also helps other health care professionals involved in your care to communicate with each other in providing the best possible care for you. Understanding what information is kept in your record will help you understand its value to the health care professionals who may need access to your records.

Problems/Concerns/Questions:

If you have any problems, concerns or questions about this notice please do not hesitate to call upon us here at Groschan & Associates. If you feel your privacy rights have been violated or if you disagree with any decisions we have made regarding access or disclosure of your health information, you have the right to file a complaint by contacting us or the secretary of Health and Human Services.

GROSCHAN & ASSOCIATES
PATIENT INFORMATION CONSENT FORM

Please read and initial each section below:

We require payment for supplies or equipment at the time it is issued. Groschan and Associates, P.A. is not a Durable Medical Supplier; therefore equipment issued is not covered by your insurance company. You are welcome to purchase equipment elsewhere. We provide supplies as a convenience to our patients.

ALL DEDUCTIBLES, CO-PAYS AND CO-INSURANCES ARE DUE AT TIME OF SERVICE. VISA, DISCOVER, MASTERCARD, AND SUPPLIMENTAL HEALTH INSUANCE CARDS (HSA'S OR FSA'S) ARE ACCEPTED FOR YOUR CONVENIENCE. A RECEIPT IS AVAILABLE UPON REQUEST.
WE APPRECIATE YOUR COOPERATION

_____ I have read and understood Groschan & Associates Payment Policy

_____I hereby assign all medical benefits to which I am entitled to Groschan and Associates, P.A. in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance company. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owning as well as all reasonable costs associates with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1.5% per month (18% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all medical information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Groschan & Associates as may be dictated by prudent medical practice by my illness, injury or condition. This consent is intended as a waiver of liability for such treatment excepting acts of negligence.

_____I have read and understood Groschan & Associates Notice of Privacy Practices outlined by H.I.P.A.A. (Health Insurance Portability and Accountability Act). I understand my rights as stated on the form. Any questions about my rights were explained to me.

_____I consent to the use and disclosure of my health information for purposes as noted in the Notice of Privacy Practices. I understand that I have the right to revoke this consent by notifying the company in writing at any time.

Date: _____

_____
Patient's Name (please print)

_____
Patient's Signature / Other legally responsible person