AgeWell
Physical Therapy & Wellness, P.C.

Phone: (516) 488-8808
Fax: (516) 488-8818
www.agewellpt.com

AgeWell Physical Therapy Pre-evaluation Questionnaire

Name _____ Age _____ Today's Date _____

Why are you seeking therapy? _____

How long have you had this problem? _____

Have you had therapy for this problem before? _____ If so, when? _____

Have you recently been in the hospital or in-patient rehab: _____ If so, when? _____

How has this problem affected your life? _____

What activities is it making difficult for you? _____

Do you have anay specific goals for therapy? _____

Please circle those that apply:

I live with (alone / spouse or partner / son or daughter / live-in aide / other: _____.)

I presently live in a: (private house / apartment / condo / other: _____.)

There are (stairs / no stairs / elevator) to enter , and (stairs / no stairs) to my bedroom.

I have changes in sensation in my (hands / feet.)

These changes in sensation are accompanied by (numbness / tingling / no feeling at all.)

I walk with: (no device / cane / walker / rollator / holding someone / can't walk.)

How long have you been using a walking device? _____

If you have an aide, what is the schedule ? _____

What does the aide provide assistance with?_____

Have you experienced 2 or more falls in the last year? _____ -OR- Have you had at least one fall with an injury in the past year? _____

If yes, please describe the falll or injury, if any. _____

Please provide a detailed medical history, including past and present conditions and surgeries. Use reverse side if necessary. _____

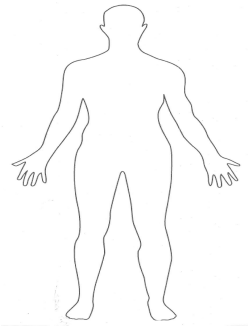
Are you coming to therapy, at least in part, to address pain? Yes / No

Please rate your pain from 0 – 10 and indicate where on your body it is.
Describe the pain in your own words and indicate what activities make it worse of better.

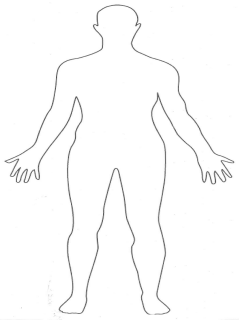
I I I I I I I I I I 1

0 1 2 3 4 5 6 7 8 9 10

No Pain Moderate Worst Possible



Front



Back

To the best of your ability, please list all medications you are currently taking.

Prescription Medication	For What Condition	Dosage	Freq.	Oral, Inject, Patch, etc.
Vitamins, supplements, herbs, over-the counter, etc.				

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PROVIDING QUALITY CARE FOR OUR PATIENTS IN OURS OUR PRIMARY CONCERN.

Your responsibility as a patient/insured is to be aware of all HOME HEALTH CARE services you are currently receiving. This includes:

- Nurses
- Aides
- Anyone who comes to the home to perform a service and is being paid through Medicare, privately, or another insurance company.

It is your duty to inform us.

Medicare does not allow a patient to receive homecare and outpatient physical therapy simultaneously. Therefore you must produce a letter of discharge if you were receiving homecare within a month of starting your physical therapy here.

If Medicare determines that your home health care overlaps with your outpatient physical therapy, you will be financially responsible for any services Medicare denies.

Please select one below and sign:

I am currently receiving home care: _____

I was receiving home care, which ended on : _____

I have never received home care: _____

_____ _____

Patient Signature **Date**

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By way of my signature, I provide AgeWell Physical Therapy & Wellness, P.C. with my authorization and consent to use and disclose my Protected Healthcare Information (PHI,) for the purpose of treatment, payment, and healthcare operations as described in the Privacy Notice.

____ I have received copy of AgeWell PT's Notice of Privacy Practices. (Updated 9/23/2013)

____ I was provided with a copy of AgeWell PT's Notice of Privacy Practices but declined it.

_____
Patient Name (PRINT)

_____ _____
Patient Signature Date

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1999 Marcus Avenue Suite M15 Lake Success, NY 11042

SECONDARY INSURANCE RESPONSIBILITY

If my secondary insurance company: _____does not pick up payment for services rendered, I, _____am responsible to pay AgeWell Physical Therapy for any co-payments or deductibles.

_____ _____

Signature **Date**

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TRANSPORTATION POLICY

It is the mission of AgeWell Physical Therapy and Wellness to provide outpatient physical therapy services to the geriatric population. AgeWell recognizes that not all patients seeking treatment have transportation available to get them there. It is the policy of AgeWell to provide transportation FREE OF CHARGE to those individuals who qualify for this service.

Conditions:

In order to qualify for free transportation, riders must:

- Meet age requirement be 75 years of age or older
- Demonstrate that they do not drive nor have someone in the home to drive them.

If the patient does not meet this criterion, he/she may still be able to inquire about transportation with AgeWell for a fee.

Limitations:

AgeWell will accommodate all patients' transportation needs to the best of its ability; however, riders MUST be aware of the following limitations:

- Riders must understand that appointment times will be limited by the vehicles availability
- Riders must understand that their appointments may have to be changed due to the changes in the driving schedule.
- Riders must understand that pick-up and drop-off times may vary due to traffic conditions or other unforeseen delays.
- Riders must understand that the vehicle may stop to pick-up or drop-off other riders while they are in the vehicle.
- Riders must understand that transportation may become unavailable for an unknown period of time and without warning (e.: driver unavailable, mechanical problems, etc.)

PLEASE NOTE: All persons in vehicles, front and back seats, must wear seatbelts. Drivers are instructed not to proceed until all comply with this safety law.

Gratuity:

Gratuities are not required or even expected. If you choose to tip the driver, a gratuity should only be considered if you feel you have been provided with excellent service.

_____ _____

Patient Signature **Date**

Assignment of Benefits to AgeWell Physical Therapy & Wellness, P.C.

Patient Name: _____ Insured Name: _____
SS Number: _____

I request that payment of authorized benefits be made on my behalf to:

AGEWELL PHYSICAL THERAPY & WELLNESS, P.C.
1999 MARCUS AVENUE, STE. M15
LAKE SUCCESS, NY 11042

For services furnished to me by the providers of AgeWell Physical Therapy & Wellness, P.C., I authorize AgeWell Physical Therapy & Wellness to release appropriate information, medical or otherwise, as provided by HIPAA Privacy Rule, to my insurance carrier and/or centers for Medicare services and its agents as needed to determine those benefits payable for related services.

THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay in the current manner, any balance of said professional service charges over and above this insurance payment.

(Check each line below and sign at the bottom of the page.)

___ A philosophy of this assignment shall be considered as effective and valid as the original.

___ I authorize the release of any medical information pertinent to my case to any insurance company, adjuster, or attorney involved in this case for the purpose of processing claims and securing payment benefits.

___ I authorize the use of this signature on all insurance submissions.

___ I authorize AgeWell Physical Therapy & Wellness, P.C. to deposit checks made in my name.

___ I authorize AgeWell Physical Therapy & Wellness, P.C. to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

____ I understand that it is my responsibility to provide AgeWell Physical Therapy & Wellness, P.C. with current and accurate information regarding my medical insurance coverage and referrals when necessary from my primary care physician. I understand failure to do so could result in non-payment by the insurance carrier and that any such balances are my responsibility. I understand that I am financially responsible for all charges if not paid by the insurance company.

___ I UNDERSTAND THAT I DO NOT HAVE A SECONDARY INSURANCE AND WILL BE RESPONSIBLE FOR ALL MONIES NOT PAID BY PRIMARY INSURANCE COMPANY.

_____ PLEASE INITIAL FOR VERIFICATION

I understand that AgeWell Physical Therapy & Wellness, P.C. is compliant with HIPAA's Privacy Rule and that they adhere to the rules and regulations with regard to my medical records, or Protected Health information (PHI.) I consent to my PHI being used, disclosed and obtained as described on the Notice of Privacy Practices currently in effect.

I authorize AgeWell Physical Therapy and Wellness, P.C. to leave messages on my answering machine at home as needed to notify me of appointments or changes in and of my upcoming visits.

_____ _____

Signature of Policyholder **Date**

PATIENT CONDITION QUESTIONNAIRE

Patient Name: _____ Date: _____

If you currently feel or have felt any of the following Symptoms within the past several months or if you have been diagnosed with any of the following conditions, please check the appropriate boxes.

Please check all that apply:

Low Back Pain	Numbness, Tingling in Legs
Neck Pain	Numbness, Tingling in Feet
Burning Sensation	Numbness, Tingling in Hands
Weakness in the Arms	Weakness in the Legs
Joint Instability	Muscle Cramping
You are Diabetic	Loss of Sensation in Hands
Thyroid Dysfunction	Neurological Condition
Muscle Weakness	Loss of Sensation in Feet
Radiating Pain to the Arm	Radiating Pain to the Leg
You have Neuropathy	Pins and Needles Sensation
Blurred Vision	Hearing Problems
Hypertension	Hypotension
Dizziness or Vertigo	Headaches
Unsteady Gait	Any Fall Due to Dizziness

Please note any other condition or symptom you feel is important:

_____

_____

_____

_____ _____

Patient Signature **Date**