PT3

UnityPoint Health
Des Moines

Date of Next Physician Visit ______________________

Date of injury or onset of problem[3] ____________ How were you injured? ______________________

Age ______ Date of Birth[4] __________ Employer[6] ______________________ Occupation[7] ______________

Phone: Home ____________________ Cell ______________________ Work ______________

Describe current problem/body area involved ____

At the present time, would you say that your health is: ☐ Excellent ☐ Very good ☐ Fair ☐ Poor

Have you had any treatment or test for this injury/problem (Xray, MRI, EMG, etc) ______________________

Have you ever had any previous therapy visits at home or as an outpatient this year? ______________________

If Worker's Compensation: Contact name(s) ______________________

Phone ______________________ Fax ______________________

Case Manager or Company Nurse ______________________

Work related: ☐ Yes ☐ No Currently working: ☐ Yes ☐ No Restrictions: ☐ Yes ☐ No Describe ________

Medical History *(Please check all illnesses that apply):*

Blood pressure: ☐ High ☐ Low Abnormal weight: ☐ Loss ☐ Gain ☐ Heart disease/problems ☐ Diabetes

☐ Osteoporosis ☐ Pacemaker Year ________ ☐ Current/past pregnancy(ies) ☐ Bowel/bladder changes ☐ Seizures

☐ Cancer Type ______________ ☐ Other ______________________

Prior surgery(ies) ______________________

Please list any allergies: ______________________

Does your injury affect any of the following activities? *(please check all that apply)*

☐ Exercise ☐ Sitting ☐ Sleeping ☐ Stairs/curbs ☐ Standing ☐ Walking ☐ Driving ☐ Bathing ☐ Dressing

☐ Housework ☐ Cooking ☐ Other ______________________

What other symptoms have been associated with this condition?

☐ Grinding ☐ Giving away ☐ Tingling ☐ Nausea ☐ Dizziness

☐ Weakness ☐ Numbness ☐ Swelling

Circle pain now: 0 1 2 3 4 5 6 7 8 9 10

How often does it hurt? ______________________

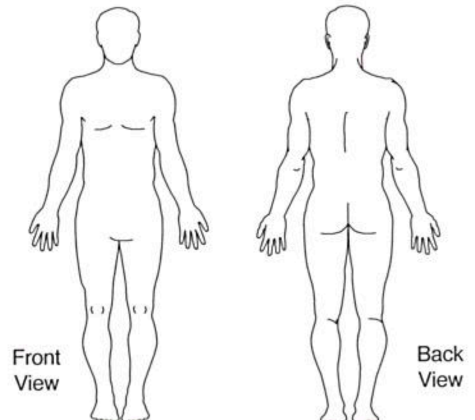
What makes your symptoms worse? ______________________

What makes your symptoms better? ______________________

What are your goals for Therapy? ______________________

What do you do for exercise (frequency)? ______________________

Please shade your area(s) of greatest discomfort



PATIENT LABEL

4-2013 OM
THER 1002

Outpatient Questionnaire

ORD1

UnityPoint Health
Des Moines

Home Med. List: Outpatient Therapies *(Medication Reconciliation Form)*

Source of Medication list: (check all that apply). Include all prescription & non-prescription meds.

☐ Patient medication list ☐ Patient/family recall Other ____________________

Medication Name Include ALL Prescription & Non-Prescription Medications (include herbals, nutraceuticals, & OTCs)	**Dose**	**Route**	**Frequency**
☐ **Takes NO home medications**			
☐ **See attached medication list**			

Home Med. List: Outpatient Therapies *(Medication Reconciliation Form)*

Date & Name of Person Completing Information

____

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Patient Label

Distribution: White/Chart

Page 1 of 1

Home Medication List: Outpatient Therapies

(Medication Reconciliation Form)

Content Review: 06/2007

4-2013 OM
ORD 0257
O/PTherapies

INSURANCE AND BILLING INFORMATION

Services received at UnityPoint Health Des Moines Outpatient Therapy Services will be billed by Iowa Methodist Medical Center and/or Iowa Lutheran Hospital as "**outpatient therapy**" rather than a "clinic visit". Therefore, many insurance plans require the patient to pay the insurance deductible before therapy charges are covered.

Patients are responsible for all deductible and/or co-insurance charges.

Many insurance plans require prior approval before therapy will be paid. Due to the many types of health insurance plans, the patient is responsible to assure that pre-approval has been obtained by the physician's office, if needed.

I understand the above information and will contact my insurance company with any questions concerning my coverage of the services provided by Iowa Health Des Moines Outpatient Therapy.

For Medicare Beneficiaries, the typical allowed charges for therapy are in the range of $10.00 to $30.00 per fifteen minute unit of service based on the physician fee schedule. Medicare Part B pays 80% of the allowed charges. Your coinsurance payment charges, which are your responsibility and may be covered by a secondary insurance provider, are estimated to be in the range of $1.00 to $13.00 per unit of service after meeting your annual deductible. If additional services need to be provided during your visit, these charges, and your co-insurance liability, may increase based on the actual services that you receive. Please direct any questions you have regarding your financial liability to your therapist.

KEEPING YOUR APPOINTMENTS

Please notify us if you are unable to attend your scheduled appointment. We will notify your physician and employer, if appropriate, of all cancellations and missed appointments. If you are more than 15 minutes late for your appointment, we may have to reschedule your appointment. If you miss three consecutive appointments without contacting us, we will discharge you from therapy and notify your physician.

By signing this agreement, I acknowledge that I have read and understand all of the preceding information and all of my questions have been answered to my satisfaction.

________________________________ ____________________

Signature Date