Oncology Rehab and Wellness Resources, LLC

Please complete all registration forms prior to your first visit.

Medical History and Activity Questionnaire

Name: _____ Date: _____

Referring Physician: _____

Current diagnosis: _____

Date of first cancer diagnosis: ____/____/____ Subsequent cancer diagnosis(es): ____/____/____

Please describe your current symptoms/problems:

☐ **Fatigue**

Do you have significant fatigue? (circle) Yes No

Do you have diminished energy? (circle) Yes No

Do you have increased need to rest, disproportionate to any recent change in activity level? (circle) Yes No

If "Yes" to any of the above, please complete:

A. Rate how severe your fatigue is **right now**

0 1 2 3 4 5 6 7 8 9 10

(no fatigue) (unbearable)

B. Rate how severe your fatigue is **on your worst day**

0 1 2 3 4 5 6 7 8 9 10

(no fatigue) (unbearable)

C. Rate how severe your fatigue is **on average**

0 1 2 3 4 5 6 7 8 9 10

(no fatigue)

☐ **Distress**

A. Rate how severe your distress is **right now**

0 1 2 3 4 5 6 7 8 9 10

(no distress) (unbearable)

B. Rate how severe your distress is **on your worst day**

0 1 2 3 4 5 6 7 8 9 10

(no distress) (unbearable)

C. Rate how severe your distress is **on average**

0 1 2 3 4 5 6 7 8 9 10

(no distress) (unbearable)

☐ **Pain** – location(s): _____

A. Rate how severe your pain is **right now**

0 1 2 3 4 5 6 7 8 9 10
(no pain) (unbearable)

B. Rate how severe your pain is **on your worst day**

0 1 2 3 4 5 6 7 8 9 10
(no pain) (unbearable)

C. Rate how severe your pain is **on average**

0 1 2 3 4 5 6 7 8 9 10
(no pain) (unbearable)

Please describe your current symptoms/problems (continued):

☐ Joint stiffness – location(s): _____
☐ Numbness/Tingling/Burning (circle) – location(s): _____
☐ Swelling – location(s): _____
☐ Unsteadiness or difficulty walking
☐ Dizziness or fainting
☐ Change in bowel or bladder functions
☐ Unexplained muscle weakness
☐ Headaches
☐ Other (explain): _____

Medications - please list any medications you are currently taking, including prescription, over the counter and herbal medications, vitamins/mineral/dietary/nutritional supplements. You may continue on back if necessary. This information is required by some insurance companies. If your doctor has this information, please ask him/her to fax this to us at 703-870-3668 . Thank you!

Name of medication or supplement	How taken (by mouth, inhaled, injection, infusion patch, etc.)	Dose	Frequency	Comments

Please list any allergies you have to medications or environmental irritants: _____

_____

Medical History
Have you ever had any of the following conditions or diagnoses? Circle all that apply and describe below.

Cancer	Stroke	Emphysema/chronic bronchitis
Heart problems	Epilepsy/seizures	Asthma
High Blood Pressure	Multiple sclerosis	Allergies-list below
Neuropathy	Head Injury	Latex sensitivity
Anemia	Osteoporosis	Hypothyroid/ Hyperthyroid
Back pain /neck pain	Chronic Fatigue Syndrome	Headaches
Sacroiliac/Tailbone pain	Fibromyalgia	Diabetes
Alcoholism/Drug problem	Arthritic conditions	Kidney disease
Smoking history	Stress fracture/fracture	Irritable Bowel Syndrome
Depression or anxiety	Rheumatoid Arthritis	Hepatitis HIV/AIDS
Anorexia/bulimia	Joint Replacement/surgery	Sexually transmitted disease
Childhood bladder problems	Bone Fracture	Swelling (ankles/ legs, arms/ generalized)
Vision/eye problems	Sports Injuries	Raynaud's (cold hands and feet)
Hearing loss/problems	TMJ	Pelvic pain

Other/Describe:_____

Surgical /Procedure History
Have you ever had any of the following surgical procedures? Circle all that apply and describe below.

Y/N	Back/spine surgery	Y/N	Breast surgery
Y/N	Bladder/prostate/kidney surgery	Y/N	Surgery for your abdomen/stomach/intestines
Y/N	Bone /joints surgery	Y/N	Brain surgery
Y/N	Uterine/ovarian/female organ surgery	Y /N	Head or neck surgery

Other/describe: _____

General Health and Activity: (circle)

	Prior to your illness (circle)	**Currently (circle)**
General Health	Excellent Good Average Fair Poor	Excellent Good Average Fair Poor
Activity/Exercise	None 1-2 days/wk 3-4 days/wk 5+ days/wk	None 1-2 days/wk 3-4 days/wk 5+ days/wk
Work	None less than 10 hrs/wk 11-20 hrs/wk 21-40 hrs/wk >40 hrs/wk	None less than 10 hrs/wk 11-20 hrs/wk 21-40 hrs/wk >40 hrs/wk
Hobbies/Interests	List:	**List:**
Has your doctor advised you on any activity or work restrictions?	No / Yes: (indicate restrictions below)	No / Yes: (indicate restrictions below)

Are you currently having any difficulty with daily tasks? Circle all that apply and describe below.

Y/N	Driving	Y/N	Grooming
Y/N	Laundry/housekeeping	Y/N	Toileting
Y/N	Dressing/bathing	Y/N	Grocery shopping
Y/N	Driving	Y/N	Cooking

Patient signature: _____ Date: _____

PATIENT INSURANCE INFORMATION

Patient Information

Last: _____ First: _____ MI: _____ Age: _____
Street Address: _____ Apt: _____
City: _____State: _____ Zip: _____ DOB: ____/____/____ SS# _____
Primary Phone: _____ Alternate Phone(s): _____

Emergency Contact: _____ Relationship: _____
Phone: _____ Alternate Phone(s): _____

Insurance Information

Primary Insurance: _____ ID #_____ Group # _____
Primary Holder of Insurance:_____
Provider Contact/Benefits Verification Phone Number: (on back of card)_____
Secondary Insurance _____ ID #_____ Group # _____
Primary Holder of Insurance:_____

Medical Information

Current Diagnosis: _____
Medical History: _____
Surgery: Y / N: (type and date)_____
Chemotherapy: Y / N: (type)_____ Date(s): _____- _____
Radiation: Y / N: (type)_____ Date(s): _____- _____

Physician Information

Ordering MD: _____ Phone: _____ Fax: _____
Oncologist: _____Phone: _____ Fax: _____
PCP/Other: _____Phone: _____ Fax: _____

Prior/Current Therapy Services: Are you currently receiving any type of home health care, including physical therapy, occupational therapy, speech therapy or nursing care? (circle) Y / N

Have you received any physical therapy, occupational therapy or speech therapy for any condition this year? (circle) Y / N If yes, please indicate the condition and duration of care:

_____
_____

For office use only

Services Requested/Ordered: (circle) PT OT ST

☐ Evaluate and Treat
☐ Specific Orders: (freq/dur) _____
☐ Specific Requests Ordered: _____ _____

Insurance Verification:

Date of verification: _____ By whom: _____

Deductible: $_____ Met? Y / N Co-pay amt: $_____ Benefit or visit limit: _____

Intake information entered to database Date: _____/_____/_____ Entered by: _____

FINANCIAL AGREEMENT AND SERVICES POLICY

Patient's Name: _____ Date: _____

I understand that my insurance company will be sent an itemized bill for each session in accordance to reasonable and customary charges. I agree to assign benefits directly to **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** for all therapy services rendered. I also agree to remit any monies sent to me in error from my insurance company for services rendered by **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC**. It is understood that the insurance is filed as a courtesy to the patient and does not relieve the patient of financial responsibility.

I agree to pay for all services rendered should my insurance company deny payment for services, and will be responsible for **any deductible, co-insurance or co-payment, to be paid at the time of my visit.**

Note: Not all insurance plans cover all services. In the event your insurance plan determines a service "not to be covered," you will be responsible for those charges. While **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** *will complete an initial verification of benefits as a courtesy to our patients,* ***it is the patients' responsibility to know their therapy benefits. Therefore patients will need to check with their insurer to verify coverage. If pre-authorization is required patients will need to check with their insurer to verify coverage and follow up with our office if it was obtained & visits were approved.***

PATIENT NOTIFICATION OF CANCELLATION PROCEDURES

Your appointment time is reserved for you. This office requires 24 hours advance notice for cancellations. **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** reserves the right to determine penalty for failure to abide by above cancellation policy. Fees are as follows:

** **$30** for cancellations with less than 24 hours notice and **$50** for no show/not home for visit.

** Fees are not covered by insurance and therefore cannot be submitted for reimbursement.You are fully responsible for payment of all fees as stated.

TARDINESS: Please call if you are running late. Physical therapy treatments may need to be abbreviated for patients arriving more than 10-15 minutes late. We reserve the right to reschedule your appointment. We will deliver the same respect for your time. If we are running late, the session will be completed in its entirety. For *House Calls* patients, your therapist will call you to notify you if they are more than 15 minutes behind their scheduled timeframe.

PATIENT NOTIFICATION OF SCHEDULING AND DISCONTINUANCE PROCEDURES

Should you miss three consecutive visits/visits in excess as determined by your therapist, you will be moved to "same day scheduling" and will be offered times available for that day. Should you miss visits in excess it will be considered that you are not in adherence or compliance with your plan of care, and will be discharged from this office. Your primary/referring physician will be notified. Your therapist may, at their discretion, modify this policy.

BILLING AND COLLECTIONS FOR SERVICES RENDERED

Balances after insurance are due within 30 days of receipt of invoice unless other satisfactory payment arrangements have been made with our office. All patient invoices unpaid after 45 days will be subject to the maximum interest penalty/finance charge allowed by law. **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** reserves the right to use whatever means necessary including an attorney, small claims court, or collection agency in an attempt to secure payment.

FEE FOR SERVICE/PRIVATE PAY PATIENTS

Payment is expected at the time of service. Upon request, we will give you a paid bill to submit to your insurance company so that you can attempt to get reimbursed in part or in full. With your permission, we will cooperate fully with your insurance company if they request copies of treatment notes or other information related to the processing of your claim. Please note that we cannot make any representation that your insurance company will reimburse you in part or in full for our services, and payment to us in full is required regardless of the final determination of coverage by your carrier. *See "**FEE FOR SERVICE/NON-PARTICIPATING PROVIDER STATEMENT OF PAYMENT POLICIES" FOR FEES.**

_____ (initial) I agree to make immediate payment upon receipt of services rendered.

I HAVE READ AND UNDERSTOOD **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** FINANCIAL POLICY AND I AGREE TO BE BOUND BY ITS TERMS. I ALSO UNDERSTAND THAT SUCH TERMS MAY BE AMENDED BY THE PRACTICE FROM TIME TO TIME.

Patient / Responsible Party Signature:_____ Date: _____/_____/_____

FEES FOR NON-REIMBURSABLE SUPPLIES

Electrical stimulation is a treatment modality that may be recommended by your physical therapist. It is a modality that is used to help manage pain and increase circulation. Insurance will not cover the cost of certain supplies necessary to perform electrical stimulation as suggested by your therapist. If electrical stimulation is suggested, there will be a onetime fee charge of $7.00 billed to your account, for the supplies that will be used each time you will receive this treatment modality. Please indicate below if you accept or deny the modality.

(Patients with PACEMAKERS AND SOME FORMS OF CANCER are not eligible for Electrical stimulation)

□ Yes, I would like the physical therapist to provide this modality if recommended and understand that I will be charged a onetime fee of $7.00 for the supplies utilized in electrical stimulation.

□ No, I wish to defer the utilization of electrical stimulation and will not be charged the onetime fee.

Patient / Responsible Party Signature:_____ Date: _____/_____/_____

Iontophoresis is a treatment modality that may be recommended by your physical therapist. It is a modality that helps to significantly decrease localized inflammation. Insurance will not cover the cost of certain supplies necessary to perform iontophoresis as suggested by your therapist. If iontophoresis is suggested by your physical therapist your account will be charged an $8.00 fee for every iontophoresis patch that is utilized in your treatment. Please indicate below if you accept or deny the modality.

(Patients with PACEMAKERS AND SOME FORMS OF CANCER are not eligible for Iontophoresis)

□ Yes, I would like the physical therapist to provide this modality if recommended and understand that I will be charged a fee of $8.00 for each iontophoresis patch used.

□ No, I wish to defer the utilization of iontophoresis in my treatment.

Patient / Responsible Party Signature:_____ Date: _____/_____/_____

Other equipment/supplies:

Please be advised that some exercise equipment/supplies/adaptive equipment/assistive devices that may be recommended by your therapist may not be covered by insurance and you will be responsible for payment to receive these supplies for home/personal use. Fees will be discussed with you and payment is expected at time of provision of such supplies.

Patient / Responsible Party Signature:_____ Date: _____/_____/_____

NOTICE OF PATIENT INFORMATION/PRIVACY PRACTICES AND CONSENT

According to the Health Insurance Portability and Accountability Act, known as HIPAA, physical, occupational and speech therapists in private practices must incorporate the federal privacy standards to protect patient's medical records and other health information provided to health plans, doctors, hospitals and other health care providers. Please note that your personal health information may be used by **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** for treatment, obtaining payment, during an audit, in emergencies, or when required by law. You will be asked for written authorization to use your personal medical information for any other reason than those listed above. You have the right to review your personal health information at any time, to request that inaccurate information be corrected, or to request a list of instances when the information has been disclosed for reasons other than treatment, payment or other administrative purposes. You have the right to restrict how the information is used and disclosed for treatment, payment and administrative operations. The requests for restrictions will be considered on a case-by-case basis. You have the right to address concerns and complaints about a potential violation of their health privacy to the US Department of Health and Human Services.

For further questions, you may contact the Compliance Officer for **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC at 703-789-0367**

I hereby consent to the use and disclosure of my personal health information for purposes as noted in the Company's Notice of Patient Information/Privacy Practices. In doing so, I hereby release **ONCOLOGY REHAB AND WELLNESS RESOURCES, LLC** from any and all legal liability that may arise from the release of such information. I agree that a copy of this authorization may be used in place of the original.

I understand that I retain the right to revoke this consent by notifying the Company in writing at any time except for that action which has already been taken. It shall be effective only long enough to answer the purpose of which it is given and no further confidential information will be released without the execution of an additional written authorization.

I have read and agreed to the above policies and procedures.

Patient or Responsible Party Signature: _____Date: _____