Courcier Clinic
Physical Therapy

Assessment Screening Tool

Name: _____ DOB:_____

We want to create a personalized treatment plan for you! To do so, we need to know how you're feeling! Please mark your symptoms below. If there are multiple options, please circle or list what applies to you. We may also use this to determine appropriate diagnostic tests*.

	Low Back Pain		Neck Pain		Diabetes
	Dizziness/Vertigo		Headaches/Migraines		Neuropathy
	Blurred Vision		Hearing loss/Tinnitus		High or Low Blood Pressure
	History of Falls		Overall muscle weakness		Sensation of Pins and Needles
	Numbness/Tingling/Weakness in **hands**		Radiating pain in arms		Radiating pain in legs
	Numbness/Tingling/Weakness in **arms**		Burning sensation		Joint pain (joint?)
	Numbness/Tingling/Weakness in **legs**		Unsteady Gait/Walking		Degenerative Disc Disease
	Numbness/Tingling/Weakness in **feet**		Pinched Nerve		Nerve entrapment/compression

Signature:_____ Date: _____

*Tests that may be suggested are Electromyography, Nerve Conduction Velocity, and/or Musculoskeletal Ultrasound.

Courcier Clinic

Today's Date: _____

Name: _____ Date of Birth: _____

Address: _____
& street City State Zip

Social Security #: _____-_____-_____ Name of Parent (if minor) or Spouse: _____

Email address: _____ May we email you? Yes or No

Home Phone: _____ Cell Phone: _____ May we text you? Yes or No

Which phone do you prefer we call? _____

Physician Name and Phone #: _____

Employer Name and Phone #: _____

Emergency Contact Name and Phone #: _____

Person Responsible for Bill: _____

Relationship: _____ Employer: _____

Address and phone (if different): _____

Social Security #: _____-_____-_____ Date of Birth: _____

Patient's Responsibility:

- **To be aware of benefit coverage including deductibles and co-pays.**
- **To pay co-pay at the time of service.**
- **To pay any amounts not covered by Medicare or supplemental.**
- **To contact insurance carrier concerning unpaid claims.**

Financial Policy Acknowledgement:

I have read and understand the above financial policy. I understand that regardless of my insurance coverage, I am ultimately responsible for the balance on my account for any services rendered. I authorize the release of medical information necessary for filing health insurance claims for me by Courcier Clinic. I authorize my insurance carrier(s) to make payment directly to Jeff Courcier, PT.

Signature: _____ Date: _____

Courcier Clinic

Adult Intake Assessment

Date:_____

**Note: If you are currently receiving any type of Home Health Care service, please see the receptionist before completing this form.

Patient's Name: _____ Date of Birth: _____

How did you hear about Courcier Clinic?/Who referred you?: _____

What is your time allowance for a physical therapy appointment?: ☐ 30 mins ☐ 1 Hour ☐ 1.5 hours ☐ 2 Hours

Medical History

Hospitalizations/Surgeries: _____

When did this injury/condition begin?:_____

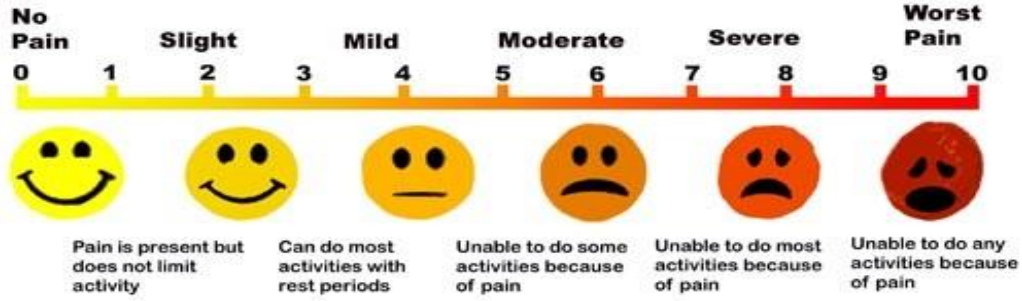
Do you have any medical issues/concerns?_____

Current Medications/Dosages: _____

Current Medical Condition/Injury

Using the numerical scale below, indicate your present level of pain _____, the worst your pain gets _____,

and the best your pain gets _____. When/if you have pain, do you take anything for it? _____



Please Indicate where you are having pain using the symbols below:

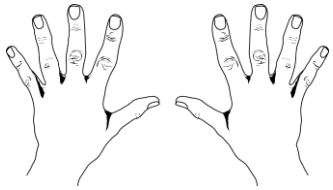
X – Sharp Sensations

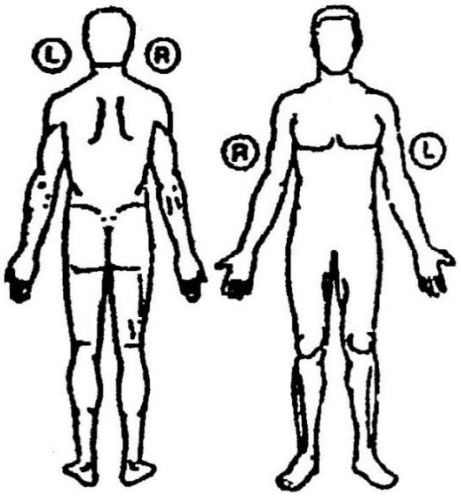
O – Numbness or Tingling

 # - Dull Aching

+ - Burning Sensations

> - Radiating





What happened when your injury/condition occurred?

Have your symptoms changed since the incident? How?

What makes the symptoms better? Worse?

Have you had any tests for this condition/injury (i.e. MRI, CT scan, x-ray, etc)? When?

Have you had therapy or other treatment for this condition/injury? When/Where?

In what position do you normally sleep?

Are you currently employed? Where? _____

What type of work do you do? _____

Have you missed work? How much? _____

Are you able to work now? _____

Education Level: _____

Has your pain/symptoms interfered with work/sports/recreational activities? _____

What is your current support system at home for treatment? _____

**Note: If you are being threatened or hurt physically, emotionally, or sexually please talk to your therapist. We can help you.

Patient/Family Goals

Please list your major concerns and/or goals with seeking treatment. List them in order of importance to you.

1. _____
2. _____
3. _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice takes effect on April 1, 2003 and remains in effect until we replace it.

OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. Your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive with our organization. We need this record to provide you with quality care and to comply with certain legal requirements. We are required by local, federal, and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your medical information.

OUR LEGAL DUTY

Law Requires us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We have the right to:

1. Change our privacy practices and the terms of this notice, as permitted by law.
2. Make changes in our privacy practices and the new terms of our notices effective for all health information that we maintained, including health information we created or received before we made changes.

Notice of Change to Privacy Practices:

1. Before we make a significant change in our privacy practices, we will change this notice and make the new Notice available upon request.

USE AND DISCLOSURE OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose health information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, review competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, and licensing for credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment for health care operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure that was permitted by your authorization while it was in effect. Unless you give us a written notice, we cannot use or disclose health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Persons Involved With Care: We may use or disclose health information to notify, or assist in the notification of a family member (including identifying or locating), your personal representative or another person responsible for your care, of your location, and your general condition. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interests in allowing a person to pick up medical supplies, x-rays, or other similar forms of health information.

Marketing Health Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information to appropriate authorities when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of an inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

You have a Right to:

(1) Look at or get copies of your medical information. (You must make your request in writing.) You may request that we provide copies in a format other than photocopies – and we will comply, unless it is not practical for us to do so. You may obtain the form for access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you $0.25 for each page, and postage, if you want the copies mailed to you.

(2) Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and heath care operations and other specified exceptions.

(3) Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).

(4) You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or locations and provide a satisfactory explanation how payments will be handled under the alternative means or locations you request.

(5) You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

(6) If you have received this notice electronically, and wish to receive a paper copy, you have the right to obtain a paper copy by making a request in writing to the Privacy or Contact Officer at our office.

QUESTIONS AND COMPLAINTS

If you have any questions about this notice, or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the US Department of Health and Human Services. We will provide you with the address to file your complaint with that entity. We will not retaliate in any way if you choose to file a complaint.

Privacy Officer: Jeff Courcier, PT

Contact Officer: Jeff Courcier, PT

Phone: (405) 478-5333

Fax: (405) 478-5334

Courcier Clinic
13512 N Eastern Avenue Suite A
Oklahoma City, OK 73131

I HAVE RECEIVED THE NOTICE OF PRIVACY PRACTICES

PRINT NAME _____

BIRTHDATE: _____

SIGNATURE: _____

TODAY'S DATE: _____

Courcier Clinic

13512 N Eastern Ave. Suite A

Oklahoma City, OK 73131

Phone: (405) 478-5333

Fax: (405) 478-5334

Cancel Policy

Effective: January 1, 2016

Failure to cancel your appointment **24 hours prior** will result in an **$80.00 charge** to your account. This fee cannot be billed to your insurance.

We have several patients on a cancellation list on a daily basis and when patients fail to cancel or no-show, it is unfair to those waiting on an appointment.

If you are more than 15 minutes late, your treatment may be abbreviated in order to accommodate our patients whom arrived on time.

In the event you are unable to call during regular business hours, our voicemail system is on 24 hours a day. **Please leave us a message.**

I have read and understand the above policy.

Signature

Date

Courcier Clinic

GENERAL OFFICE BILLING INFORMATION

1. **COURCIER CLINIC MAY NOT BE A NETWORK PROVIDER FOR YOUR INSURANCE PLAN.** If you have not met your deductible at the time physical therapy is performed, you will be responsible for this amount. You will also be responsible for the balance not covered by your insurance (i.e. your copayment and other charges of procedures your insurance doesn't cover) as determined by your insurance plan.
2. If your deductible has not been met, a $150 payment is expected upon initial evaluation. We will collect $100 per visit thereafter until the deductible has been met.
3. Medicare's deductible is $185 per year with a 20% coinsurance per visit thereafter, which is the patient's responsibility unless secondary insurance covers this.
4. Payment is due at the time services are rendered. Payment for therapy will be according to your insurance plan. If you do not have insurance or your deductible has not been met, payment is due at the time of therapy services. We will estimate your amount due based on your insurance.
5. Collections: If your account has to be sent to a collection agency, additional fees will be incurred. Due to the costs associated with setting up this account, we will add an additional 35% fee to the balance being turned to collections. These charges, along with the balance, will be your responsibility in full. Any resulting legal fees will also be your responsibility.
6. Your insurance company may require you to complete an accident information form. It is important you fill out this form as soon as possible and return to your insurance company. Failure to supply this information to your insurance company may result in you being responsible for the balance of your account.
7. If there is an attorney involved (litigation), you will be required to make monthly payments while the case is pending. Cases that go to litigation rarely settle in less than 6 months. All accounts not settled after one year will be subject to a 9.25% annum interest charge.
8. IF YOU HAVE THIRD PARTY LIABILITY INSURANCE (e.g. homeowner's, motor vehicle, etc.)as well as health insurance, both insurances will be filed, however the liability insurance will be primary. When the liability insurance settles and pays the clinic, the appropriate health insurance reimbursement will be made directly to the health insurance company. If a THIRD PARTY is involved, a Clinic Lien will be placed on the account.
9. **There will be a $25.00 fee added to your account for any returned checks.**
10. **No show/cancel fees are patient's responsibility.**

****Effective 7/23/2018** Insurance Balances that are 120+ days old will be placed to patient responsibility.**

I HAVE READ THE ABOVE. I UNDERSTAND I AM RESPONSIBLE FOR PAYMENT OF MY MEDICAL SERVICES AND AGREE TO THE APPLICABLE TERMS AS STATED ABOVE.

_____ _____

Patient/Parent/Guardian Signature Date

_____ _____

Office Staff Signature Date