Dear Patient:
Hello and thank you for choosing Health Quest Therapy, Inc. and our many fine therapists to get you back to your life.

Enclosed in this packet are forms that need to be completed prior to your visit. They include patient and insurance information as well as patient policies. Please take the time to fill them out as completely as possible and bring them to your first visit along with your patient referral from your physician.

Our Providers are very conscientious of your valuable time, and make a strong effort to run on time with their appointment schedule. The time spent during your initial visit (evaluation) is best utilized when the necessary paperwork is filled out prior to your arrival. To optimize your time during this very crucial appointment, we ask that you arrive 15 minutes early if your paperwork is already filled out. If you cannot fill the paperwork out prior to your appointment please come 25 minutes early.

Please remember to bring valid ID., updated insurance card or info, as well as your physician referral slip with you to your first appointment.

We ask that you take time to contact your insurance carrier, workman's comp case adjuster, or MDCD/MDCR office prior to your visit to find out if they cover the services you'll be receiving in our facility. If your insurance company does not cover these services, or you are a self-pay patient then you are responsible for the fee at the time of service. Insurance billing is provided by Onpoint Medical Solutions. Questions concerning your bill should be addressed directly to Onpoint Medical Solutions, contact by phone at 360.334.5292. We encourage you to be fully aware and educated about your insurance coverage and your responsibility to pay any remaining fees.

We serve the entire Mat-Su Valley, Talkeetna, Willow, Eagle River as well as portions of Anchorage, which is a very large population. If you are unable to keep your appointment, please call us 24-hours in advance of appointment.

We look forward to meeting you and getting you back to your life.

Health Quest Therapy Staff,

650 North Shoreline Drive, Wasilla, AK 99654 | phone 907.376.6363 fax 907.376.6366
www.healthquesttherapy.com

Insurance Billing and Collection Guidelines

Here are some very important things for you to know about Health Quest Therapy, Inc. and our insurance billing policies:

Insurance Benefits: It is important for you to know your coverage ***before*** coming to your first appointment. Please contact your insurance company or case manager prior to your visit and fill out the answers to the questions on the following pages. **This information will be required at check in.**

Health Quest Therapy, Inc. cannot guarantee the accuracy of the benefits quoted to our office therefore, we will not be responsible if the insurance carrier processes your claim differently than expected. This is another reason why you are required to contact your insurance company prior to your visit.

Appointment: Please come to your appointment with a valid ID., your insurance card and with the Insurance Billing Information sheet completely filled out as well as all other papers filled out and signed. After your appointment we will collect any outstanding deductibles, co-pay, and/or coinsurance for covered services. All non-billable services will require payment in full at the time of service. Please be advised that all wound care supplies including splinting materials used during your therapy session may not be covered by your insurance company. Health Quest Therapy, Inc. will provide you with a receipt for these charges so that you may bill your insurance company direct. Each appointment will be approximately 45 minutes and you will be contacted by one of our receptionists the previous day as a reminder of your appointment. Health Quest Therapy, Inc. requests a 24-hour cancellation notice. A $25.00 fee will be charged directly to you, the patient, if notice is not given or a "no show" is made. Please be aware that insurance companies do not pay these fees. The patient is responsible to make every scheduled appointment and to pay all associated fees with that appointment including cancellation and "no-show" fees. **THREE "NO SHOWS" OR CANCELLATIONS WILL RESULT IN A DISCONTINUATION OF PATIENT CARE.**

Patient Agreement: You must understand that you are responsible for all fees regardless of insurance coverage and that all charges are due at the time of services.

If your insurance company denies your claim or pays less than expected, you will be responsible for paying the balance, in full, within 60 days of date of service. In the event of patient nonpayment and/or a delinquent account you will be sent to collections and charged the associated fees and interest. In the event your account is sent to collections please review our collections policy.

Health Quest Therapy, Inc.
Physical, Occupational and Pediatric Therapy

Medicaid / Medicare

COMPLETION OF THIS SHEET IS REQUIRED ~ THANK YOU

Patient Information:

Today's date_______________________________

Last name_________________________________ First_________________________ MI______________

SSN#____________________________ DOB____________________________ Age________ Sex_______

Mailing address____

City/State____ Zip________________

Marital status: Single____________________ Married___________________ Widowed______________

Home phone #______________________________ Cell Phone#_________________________________

Employer name____ Phone#____________________

Email____

Emergency Contact

Emergency contact name____Phone#__________________

Relationship to the patient ____

Responsible Party (if patient is a minor)

Last name__________________________________ First___________________________ MI__________

Relationship to patient_____________________ SSN#______________________ DOB_______________

Mailing address____

City/State____ Zip________________

Continued on next page

Health Quest Therapy, Inc.
Physical, Occupational and Pediatric Therapy

Home Phone #_______________________________ Cell phone#__________________________________

Is another therapy provider currently treating you? (PT, OT or SLP) Yes _______ No_______

If yes, please list therapy provider and reason for treatment.

Is this visit linked to a work related accident, or motor vehicle incident? Yes _______ No_______

If yes, please ask the front desk personnel for a Workers Comp-MVA packet.

Primary Insurance Information

Company Name ____

Policy Holder: Last ______________________________ First____________________________ MI_______

SSN#_______________________ DOB_____________ Relationship to patient_______________________

Employer name____

Policy#____ Group#___________________________

Do you have a Co-pay?________ Co-pay amount $_________

Secondary Insurance Information (do you have another type of insurance?)

Company Name ____

Policy Holder: Last ______________________________ First____________________________ MI_______

SSN#_______________________ DOB_____________ Relationship to patient_______________________

Employer name____

Policy#____ Group#___________________________

Do you have a Co-pay?________ Co-pay amount $_________

Doctor & Referral Source

Doctor name____ Phone#_______________________

Whom may we thank for your visit today?____

Health Quest Therapy, Inc.
Physical, Occupational and Pediatric Therapy

Medicare Authorization

COMPLETION OF THIS SHEET IS REQUIRED ~ THANK YOU

I request that payment of authorized Medicare benefits be made to either me or on my behalf to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere in other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and not covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.
NOTICE: Medicare/Medicaid will not cover any supplies; they will be billed to you individually.

Payment Release and Assignment
I, the undersigned assign directly to Health Quest Therapy, Inc. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by insurance. I herby authorize the provider to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature____ Date_________________________

Missed Appointments & Credit Card Authorization

SIGN & DATE AT THE BOTTOM, COMPLETION OF THIS SHEET IS REQUIRED ~ THANK YOU

Health Quest Therapy, Inc. has a 2-step process for missed appointments and cancellations received less than 24 hours **prior** to appointment time, except for cases of medical emergency. If you are sick and unable to make your appointment and do not have 24 hours prior to your appointment we ***may*** be able to waive any fees if you reschedule within the same week, however you must understand that we cannot guarantee you an appointment. Please be aware that insurance companies do not pay this fee because the patient is responsible for all appointments.

1) Missed appointments and/or cancellations less than 24 hours prior to an appointment will be assessed a $25.00 charge that will be directly billed to the patient.
2) After 3 No Shows or cancellations where less than 24 hours notice was given the Patient will be discharged and notification of non-compliance will be sent to Physician.

At Health Quest Therapy, we strive to perform the best care and service to our patients, we work very hard to care for you and your records, as well as respect your time and needs. We thank you in advance for your assistance in supporting our office staff and providers with this signed agreement.

Signature____________________________________ Date_________________________

Health Quest Therapy, Inc.
Physical, Occupational and Pediatric Therapy

HIPPA COMPLIANCE

SIGN & DATE AT THE BOTTOM, COMPLETION OF THIS SHEET IS REQUIRED ~ THANK YOU

Health Quest Therapy, Inc. is fully committed to compliance of HIPPA by

- Providing appropriate security for our patient records
- Protecting the privacy of our patients medical records
- Providing our patients with proper access to their medical records
- Maintaining our patient information and billing process in compliance with National HIPPA standards

CONSENT FOR TREATMENT

I hereby authorize Health Quest Therapy, Inc. and its staff to render whatever services is necessary for my care and/or my dependents.

PHONE MESSAGES

I hereby authorize Health Quest Therapy, Inc. to leave messages regarding patient appointment times at the phone numbers given on the patient information sheet unless otherwise noted.

RELEASE OF INFORMATION

I give permission to Health Quest Therapy to release my medical records information to the following people when they are inquiring about me during my appointments.

____________________ ____________________ ____________________

PATIENT AGREEMENT

I, the undersigned have read, understand and agree with the sheet titled "INSURANCE BILLING AND COLLECTION GUIDELINES", that has been provided to me in this packet. I am responsible for all fees regardless of insurance coverage and that payment is due at time of service. I am responsible for furnishing all insurance information correctly to Health Quest Therapy, Inc. prior to treatment, unless other arrangements have been made in advance. If you have read the above policies and understand them to your satisfaction and agree with them in their entirety please sign and date below.

Signature____ Date________________________

Social History

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Occupation: ________________________ Who do you live with? _________________________

Tobacco Use: ☐ Yes ☐ No If Yes, packs/times per day? _________ #Years________

Alcohol Use: ☐ Yes ☐ No If Yes, type: ☐ Beer ☐ Wine ☐ Liquor

Number of drinks per week: _______________ If yes, do you drink daily? _________________

Marijuana/Cocaine/Other Drug Use: ☐ Yes ☐ No Type: __________ Frequency: _______

Current Medication List

Please list all medications that you are currently taking, including prescriptions, over the counter, herbals, vitamins, minerals & dietary supplements.

Medications	Dosage	Frequency	Route of Administration

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Name: ____ Date: _____________________

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More Than Half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping to much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself–or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite–being so fidgety of restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3

Add columns __________ + _________ + _________

Total: _________

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all_____ Some what difficult _____ Very difficult_____ Extremely Difficult_____

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Health Quest Therapy, Inc.
Physical, Occupational and Pediatric Therapy

Elder Abuse Suspicion Index® (EASI)

EASI Questions

Question one (1) through five (5) asked of patient; Question six (6) answered by medical services provider.

Responses should reflect activities and incidents within the last twelve (12) months

Question			
1. Have you relied on people for any of the following: Bathing, dressing, shopping banking, or meals?	Yes	No	Did not answer
2. Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you want to be with.	Yes	No	Did not answer
3. Have you been upset because someone talked to you in a way that made you feel shamed or threatened?	Yes	No	Did not answer
4. Has anyone tried to force you to sign papers or to use your money against your will?	Yes	No	Did not answer
5. Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?	Yes	No	Did not answer
6. Medical services provider: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last twelve (12) months?	Yes	No	Did not answer

Medical services provider____ Date:_______________

Health Quest Therapy, Inc.
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MEDICAL QUESTIONNAIRE

Please complete to the best of your knowledge.

1. Personal details.

Name____ DOB__________ Age____ M F

2. Do you suffer of have you ever suffered from?

Cancer?	Yes	No
Dizzy spells?	Yes	No
Heart trouble and /or blood pressure problems?	Yes	No
Asthma, bronchitis and/or shortness of breath?	Yes	No
Diabetes?	Yes	No
Seizures and/or fainting attacks?	Yes	No
Migraine?	Yes	No
Head injury?	Yes	No
Neck/Back problems?	Yes	No
Allergies (medication/latex)?	Yes	No
Fractures, tendon, ligament/cartilage damage?	Yes	No
Stroke?	Yes	No
Psychiatric or mental illness?	Yes	No
Are you suffering from or a carrier of any infectious diseases?	Yes	No
Are you pregnant?	Yes	No
Do you smoke?	Yes	No
Do you have any other conditions that are not stated above?	Yes	No
Do you have a pacemaker or defibrillator?	Yes	No

2. If you have answered yes to any of the above questions, please explain below.

____

____

____

____

Health Quest Therapy, Inc.

Physical, Occupational and Pediatric Therapy

BODY PAIN INDICATOR CHART

Use a pen or pencil to indicate the body area where you are experiencing pain or discomfort.

Front

Back

0 1 2 3 4 5 6 7 8 9 10

Assess your pain using the above scale, 0-no pain, 5-moderate pain, and 10-worst pain possible.

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