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

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 Alaska Billing Services. Questions concerning your bill should be addressed directly to Alaska Billing Services, contact by phone toll free at 888.783.1777. 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, 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,

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

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 and 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

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_____

Phone #_____ Cell Phone#_____

Emergency contact name_____ Phone#_____

Employer name_____ Phone#_____

Email_____

Responsible Party (if different than patient)

Last name_____ First_____ MI_____

Mailing address_____

City/State_____ Zip_____

Phone #_____ Cell phone#_____

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

Primary Insurance Information

Last name_____ First_____ MI_____

SSN#_____ DOB_____ Relationship to patient_____

Employer name_____

Insurance Co. name_____ Policy#_____ Group#_____

Do you have a Co-pay?_____ Co-pay amount $_____ Have you met your deductible?_____

Deductible amount $_____ What is your insurance coverage? (Example 20/80)_____

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

Last name_____ First_____ MI_____

SSN#_____ DOB_____ Relationship to patient_____

Employer name_____

Insurance Co. name_____ Policy#_____ Group#_____

Do you have a Co-pay?_____ Co-pay amount $_____ Have you met your deductible?_____

Deductible amount $_____ What is your insurance coverage? (Example 20/80)_____

Doctor & Referral Source

Doctor name_____ Phone#_____

Whom may we thank for your visit today?_____

Are you currently being seen by another Physical/Occupation/Speech Therapist? Yes____ No____

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

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_____

Wasilla Clinic - 650 North Shoreline Drive, Wasilla, AK 99654 | phone 907.376.6363 fax 907.376.6366
Eagle River Clinic - 11432 Business Blvd., Suite 18, Eagle River, AK 99577 | phone 907.622.6363 fax 907.622.6366
www.healthquesttherapy.com

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

HIPAA 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_____

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

PEDIATRIC QUESTIONNAIRE

Name of Patient: _____ Date: _____
Date of Birth: _____

1. What is your child's social status? (primary custodian, number of siblings, school etc.):_____
   _____
2. Please expand on your child's medical history (pregnancy, birth, surgeries, previous/current therapies, clinics and or doctors following etc.): _____
   _____
   _____
3. Is your child currently on Medications? If so please list them: _____
   _____
4. Please list any Precautions/Allergies: _____
   _____
5. Please list approximate age of developmental milestones:
   - Rolling over: _____
   - Sitting: _____
   - Crawling/creeping_____
   - Pulling to stand: _____
   - Walking: _____
6. Self-help skills:
   - Feeding
   - Dressing
   - Toileting
7. Please list any sensory issues your child may have (vision, hearing, sensitivities etc.): _____
   _____
8. What are your parental goals for therapy? _____

_____

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

AUTHORIZATION TO TREAT A MINOR

Childs Name: _____Date of Birth: _____

Home Address: _____Home Phone Number: _____

City, State, Zip Code: _____

Parental Contact: _____

Caregivers Name: _____
The above named caregiver shall be authorized to consent for medical treatment and /or other medical procedures, for the above named child, which may be required during absence.

Please attempt to contact me at the following telephone number: _____

This consent serves as permission for treatment by Health Quest Therapy, Inc. I agree to pay for all services provided to my child in my absence. This authorization shall be effective until: (select one)
a)_____(Month, Day Year) b) Unless earlier revoked by me.

Signatures:

_____
Parent/Guardian (circle one) Date

_____
Parent/Guardian (circle one) Date

_____
Witness Date

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

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.

_____

_____

_____

_____

Wasilla Clinic - 650 North Shoreline Drive, Wasilla, AK 99654 | phone 907.376.6363 fax 907.376.6366
Eagle River Clinic - 11432 Business Blvd., Suite 18, Eagle River, AK 99577 | phone 907.622.6363 fax 907.622.6366
www.healthquesttherapy.com

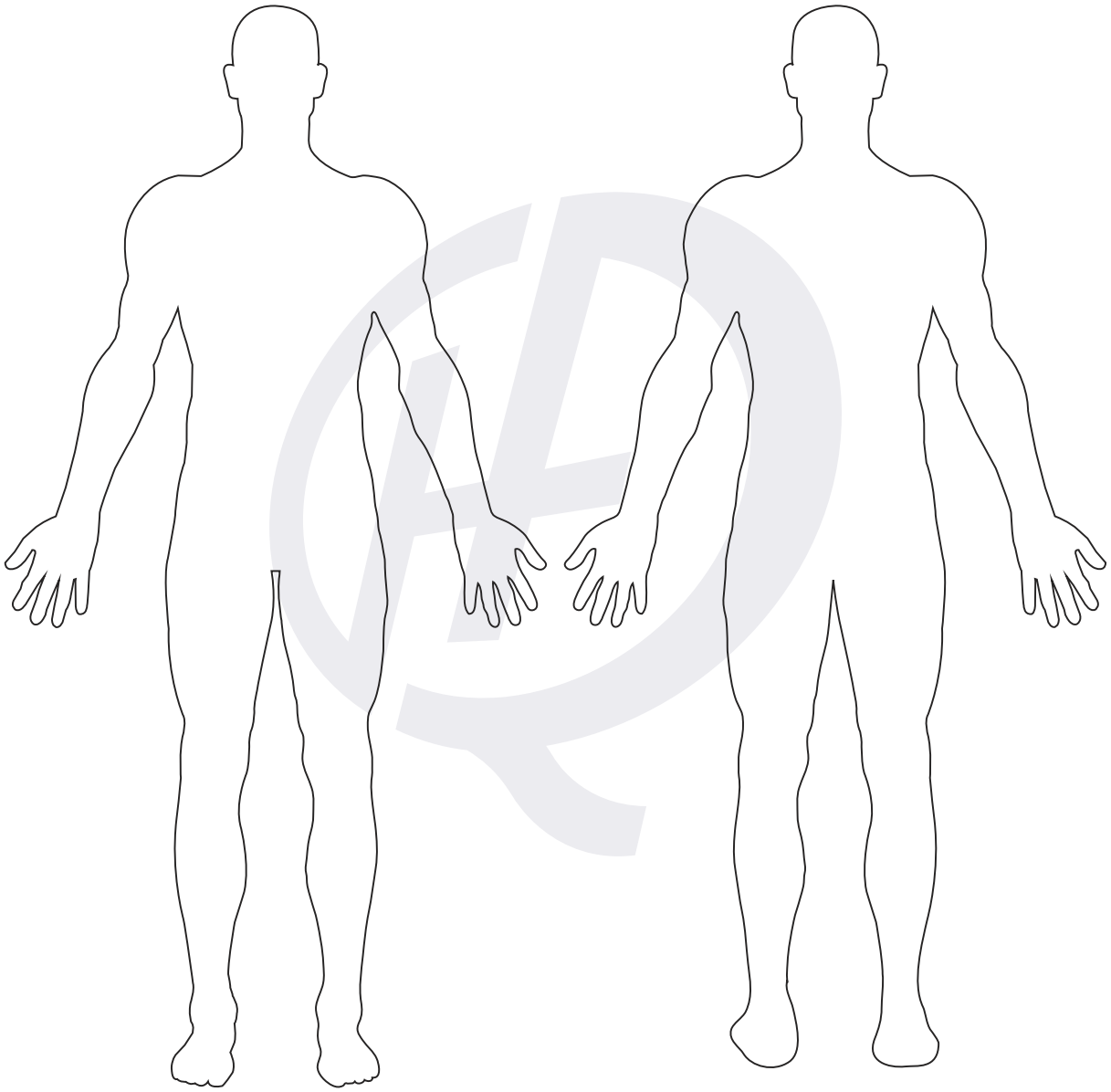
Health Quest Therapy, Inc.
Physical, Occupational and Pediatric Therapy

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.

Wasilla Clinic - 650 North Shoreline Drive, Wasilla, AK 99654 | phone 907.376.6363 fax 907.376.6366
Eagle River Clinic - 11432 Business Blvd., Suite 18, Eagle River, AK 99577 | phone 907.622.6363 fax 907.622.6366
www.healthquesttherapy.com