



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 360.334.5290. 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,

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:

Init. 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.

Init. 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.**

Init. 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 for any given reason 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.

Commercial Insurance - Primary or Secondary

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

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 Compl 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? _____

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.

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 _____

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_____

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? _____

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

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.
