COPC Physical Therapy

Patient Name: _____

Date: _____

CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

Compared to before you had COVID-19, what problems or symptoms bother you most?

_____
_____
_____

Are you able to perform the following activities at the level you expect?

Please answer yes or no

1. Vocational activities such as work, education, or other occupation? YES NO
2. Leisure activities (active or sedentary? YES NO
3. Shopping or other community activities, including driving? YES NO
4. Household and domestic activities? YES NO
5. Feeding yourself, swallowing safely? YES NO
6. Washing and dressing? YES NO
7. Moving around in your house (including stairs), getting around outdoors? YES NO

Do you have new problems with?

1. Fatigue, endurance, being overtired? YES NO
1. Pain? YES NO
2. Vision or your eyes? YES NO
3. Ears or your hearing? YES NO
4. Thinking or remembering? YES NO
5. Balance? YES NO
6. Dizziness? YES NO

What are your goals for physical therapy? What would you like to be able to do that you cannot currently do?

_____
_____
_____
_____
_____
_____

Patient Signature _____

Physical Therapist Signature _____

orthotoolkit

PROMIS Global--10 Score

Patient Name: _____ Patient MRN: _____

Date: _____

Please respond to each question or statement by marking on box per row.

	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is:	c +5	c +4	c +3	c +2	c +1
2. In general, would you say your quality of life is:	c +5	c +4	c +3	c +2	c +1
3. In general, how would you rate your physical health?	c +5	c +4	c +3	c +2	c +1
4. In general, how would you rate your mental health, including your mood and your ability to think?	c +5	c +4	c +3	c +2	c +1
5. In general, how would you rate your satisfaction with your social activities and relationships?	c +5	c +4	c +3	c +2	c +1
9r. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	c +5	c +4	c +3	c +2	c +1

	Completely	Mostly	Moderately	A little	Not at all
6. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	c +5	c +4	c +3	c +2	c +1

	Never	Rarely	Sometimes	Often	Always
10r. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	c +5	c +4	c +3	c +2	c +1

	None	Mild	Moderate	Severe	Very Severe
8r. How would you rate your fatigue on average?	c +5	c +4	c +3	c +2	c +1

	No pain									Worst pain imaginable
7rc. How would you rate your pain on average?	c +0	c +1	c +2	c +3	c +4	c +5	c +6	c +7	c +8	c+9 c+10

Valued COPC Physical Therapy Patient:

At Central Ohio Primary Care, it is our goal to give you the best care possible. In order to best serve all of our patients, we request the following:

- If you cannot keep your scheduled appointment, please call us at the number above to cancel the appointment at least 24 hours prior to the visit.
- If you miss an appointment, and fail to call to re-schedule or cancel, you may be assessed a No Show/Late Cancelation fee of $50.00 for an initial evaluation or $25.00 for an established follow-up visit.
- If you have 3 cancellations within a consecutive 3 week period, the Physical Therapist will be notified and will determine if your therapy should resume, or be discontinued.
- If you will be more than 10 minutes late, we may ask you to re-schedule your appointment. This will assure that we are giving you the full time you deserve to address all of your needs during treatment.

Thank you for helping us to provide our patients with the most convenient scheduling possible!

I have read this physical therapy policy and agree to the above.

Today's Date: _____

Printed Name: _____

Signature: _____

CENTRAL OHIO PRIMARY CARE
THE BEST FOR PRIMARY CARE

Patient Name: _____ DOB: _____ Acct. #_____

Agreement of Financial Responsibility

Thank you for choosing ***Central Ohio Primary Care Physicians, Inc.*** (***COPC***) as your health care provider. COPC is committed to providing quality care and service to all of our patients. The following is a statement of COPC's financial policy, which we require that you read and agree to prior to receiving any treatment from COPC.

Payment of your bill is considered part of your treatment. Fees are due and payable when services are rendered. COPC accepts cash, check, credit cards, and pre-approved insurance for which COPC is a contracted provider.

It is your responsibility to know your own insurance benefits, including:

- whether COPC is a contracted provider with your insurance company;
- your covered benefits and any exclusions in your insurance policy; and
- any pre-authorization requirements of your insurance company.

COPC will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information to COPC, including any updates or changes in your insurance coverage. Should you fail to provide this information, you will be financially responsible for the costs of the services rendered by COPC.

If COPC has a contract with your insurance company, COPC will bill your insurance company first, less any co-payment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.

If COPC does not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. COPC will provide you with a statement that you can submit to your insurance company for reimbursement.

Proof of insurance and photo ID are required for all patients. COPC will ask to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

Some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services that are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policy stated above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I acknowledge that if my insurance company denies coverage and/or payment for services provided, I will be financially responsible and will pay all such charges due and owing in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient