PER INSURANCE GUIDELINES:
"Must include ALL prescriptions, over-the-counters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration"

During the course of your care we will need to be informed immediately if there are any changes to any of the medications on this list.

NAME of MEDICATION	DOSAGE (mg.)	FREQUENCY (x/day)	ROUTE OF ADMINISTRATION (i.e. by mouth)

Check the boxes that apply to your medical history

☐ Knee	☐ Liver	☐ Ears	☐ Intestinal	☐ Arthritis
☐ Shoulder	☐ Kidney	☐ Eyes	☐ Bladder	☐ Asthma

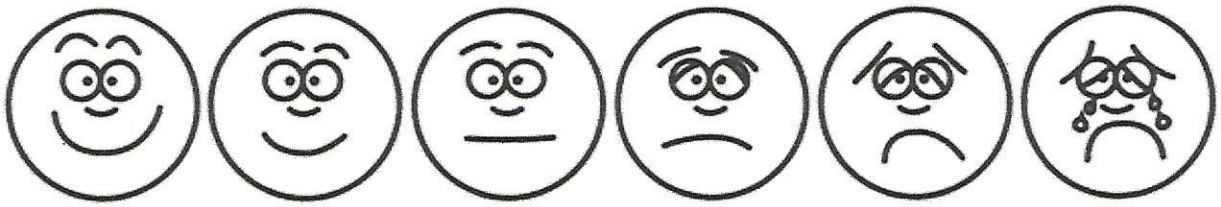
PERSONAL HEALTH HISTORY

Referring Physician:_____ Date of next appointment with referring physician:_____

Reason for physical therapy referral:_____

Related to an Injury or Accident? ☐ No ☐ Yes,_____ Date of Injury or Onset:_____

☐ Ankle	☐ Heart	☐ Nose	☐ Bowel	☐ Dizziness
☐ Neck	☐ High Blood Pressure	☐ Throat	☐ Diabetes	☐ Seizures
☐ Back	☐ Pacemaker	☐ Lungs	☐ Circulation	☐ Hernia
☐ Hip	☐ Cancer	☐ Skin	☐ Stroke	☐ Headaches



0	2	4	6	8	10
No Pain	Little Pain	Mild Pain	Moderate Pain	Severe Pain	Worst Pain

Additional Information or Explanation of Above:

_____

_____

_____

_____

Any known allergies:

MEDICATION LIST:

→→→→SEE BACK OF PAGE →→→→

*****REQUIRED INFO FOR ALL MEDICARE PATIENTS*****

HEALTH HABITS AND PERSONAL SAFETY

Health Info:	**Weight:**	**Height:**		
Personal Safety:	Do you live alone?		☐ Yes	☐ No
	Do you have frequent falls?		☐ Yes	☐ No
	Have you sustained an injury in 12 months due to a fall?		☐ Yes	☐ No
	Do you have vision or hearing loss?		☐ Yes	☐ No

How did you hear about Compass Therapeutic services?

☐ Physician ☐ Friend ☐ Previous Patient ☐ High School Function ☐ Facebook ☐ Web Search ☐ Saw Location

SIGNATURE:_____ ***DATE:***_____

MEDICATION LIST

COMPASS THERAPEUTIC, INC

1945 42nd Ave

Vero Beach, FL 32960

772-999-3129 Fax 772-564-0380

PLEASE READ THE FOLLOWING AND ACKNOWLEDGE BY SIGNING BELOW.

I hereby authorize Compass Therapeutic, to furnish rehabilitation therapy/treatment by a licensed healthcare practitioner as indicated by my referring physician.

Patient Signature

As you know, Medicare usually will pay 80% of the charges we submit regarding your account. If you have a secondary insurance, they usually pay most of the 20% balance that is left.

In some cases we have to re-submit these bills. After 90 days, the charges that have not been paid by your insurance companies become your responsibility.

You can contact your insurance company on your own to see why payment has not been made. If payment cannot be made in full, you may contact our office to set up a payment plan if needed. We will be happy to work with you.

I, the undersigned patient, authorize my insurance company to make payment directly to Compass Therapeutic for services or supplies rendered to me.

Patient Signature

Date

PATIENT QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

NAME:		**DOB:**	**SSN:**
Complete Address:			
Contact Info:	**Home #:**	**Cell #:**	**Email:**
Employer:			**Work #:**
Emergency Contact: Name & Phone #			

GUARANTOR INFORMATION FOR INSURANCE POLICY:

Guarantor/ Responsible Party Information:	☐ **Self** ☐ **Spouse: Name**_____ **DOB:**_____ ☐ **Parent/Guardian: : Name**_____ **DOB:**_____ ☐ **Employer:**_____

INSURANCE INFO /COVERAGE:

Your insurance policy is a contract between you and your insurance company. We are not a part of that contract.

We do not set the deductible, co-insurance, or copay amounts.

The following information is a quote based on the benefits provided by your insurance carrier.

Insurance Company_____

Policy #_____ Group #_____

Amount remaining on deductible: $_____ Co-Insurance Amount: _____ % Copay Amount: $ _____

Are you currently receiving any type of home health? ☐ No ☐ Yes

Have you received any occupational, speech or physical therapy this year? ☐ No ☐ Yes – how many visits? ____

SIGNATURE:_____ **DATE:**_____