UNITED THERAPY ASSOCIATES, P.A.

6714-I RITCHIE HIGHWAY • GLEN BURNIE, MARYLAND 21061

410-787-2229 • FAX 410-787-0141

DR. LAWRENCE S. SAEZ, DC, MUAC

MONICA L. SAEZ, OTR/L

NEW PATIENT QUESTIONNAIRE

Last Name________________________First________________________Middle__________

Address: ____
Street City State Zip Code

Who may we thank for referring you to our office? ______________________________

Social Security # ___-__-____ Age ______ Date of Birth __-__-__ [ ] Male [ ] Female

Phone: Home ________________ Cell ______________ E-Mail ________________

[ ] Single [ ] Married [ ] Separated [ ] Divorced Spouse's Name ________________

Spouse's Date of Birth __-__-__ Spouse's Social Security # ___-__-____

Your Employer ____
Company name Phone Number

What is your occupation? ____

Spouse's Employer ____
Company name Phone Number

Family Physician____
Name Address Phone Number

Please describe your main complaint.____________________________________

When did you first experience this complaint? ____________________________

What seems to help it? ____

What makes it worse? ____

Describe the pain: Is it [ ] sharp [ ] dull [ ] achy [ ] burning [ ] stiff
[ ] sore [ ] stabbing [ ] numb [ ] tingling

Does it radiate/shoot or travel anywhere? ________________________________

Where exactly is the pain located? ______________________________________

Is the pain [ ] constant [ ] frequent [ ] intermittent [ ] occasional [ ] rare
How often do you experience it? ______________________________________

Are there any other areas that are bothersome for you? ______________________

******* OVER PLEASE *******

Please describe what treatment, if any, you have received in the past for these complaints________

____
____
____

MEDICAL HISTORY

Have you ever experienced any significant physical trauma or injuries? ____________________

____
____

Do you *now* or have you *ever* had:

Gastro-Intestinal System

___ Poor appetite
___ Excessive hunger
___ Difficulty chewing
___ Difficulty swallowing
___ Excessive thirst
___ Nausea
___ Vomiting food
___ Vomiting blood
___ Abdominal pain
___ Diarrhea
___ Black or Bloody stool
___ Hemorrhoids
___ Liver or Gallbladder problems
___ Weight problems

Cardio-Vascular-Respiratory System

___ Chest pain
___ Pain over heart
___ Difficulty breathing
___ Coughing phlegm
___ Rapid heartbeat
___ Coughing blood
___ High Blood Pressure
___ Heart problems
___ Lung problems
___ Varicose veins

Female

___ Vaginal bleeding
___ Vaginal discharge
___ Breast pain

Eye, Ear, Nose and Throat

___ Eye strain
___ Eye inflammation
___ Vision problems
___ Ear pain or noises
___ Hearing loss
___ Ear discharge
___ Nose pain or bleeding
___ Sore gums
___ Dental problems
___ Sore mouth
___ Sore throat
___ Hoarseness
___ Difficult speech

Nervous System

___ Numbness
___ Loss of feeling
___ Paralysis
___ Stroke
___ Dizziness
___ Fainting
___ Headaches
___ Cancer
___ Muscle jerking
___ Convulsions
___ Forgetfulness
___ Pacemaker
___ Confusion
___ Depression
___ Vertigo
___ HIV/AIDS

List all medications you are currently taking ______________________________

____
____
____

Is there any other information you would like to tell the doctor? ____________________

____
____
____

FEMALES

Are you pregnant? [ ] yes – how many months ______ [ ] no [ ] maybe

Patient's Signature ______________________________ Date ______________

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ACTIVITIES OF DAILY LIVING

Rate the level of difficulty that you are having with the following activities
From 1-5 (1=minimum difficulty, 5=unable to perform)
{Leave blank if no difficulty}

Living:
_____Bending over
_____Sitting for greater than _____
_____Standing for greater than _____
_____Walking for greater than _____
_____Reaching overhead
_____Driving a car
_____Looking over your shoulder
_____Sleeping for greater than _____
How long can you sleep undisturbed?
____
_____Lying on back
_____Lying on side {R or L}
_____Lying on stomach

Dressing:
_____Putting on a blouse/shirt
_____Fastening buttons/zippers in back
_____Putting on a coat
_____Putting on a pullover shirt/sweater
_____Putting on shoes/socks
_____Putting on pants/slacks

Work:
_____Lifting
_____Carrying objects
_____Using a computer
_____Using the phone
_____Other: __________

Describe physical demands of daily work or activities:
____
____
____
____

_____Ascending stairs
_____Descending stairs
_____Buckling seatbelt
_____Sweeping/Mopping
_____Child care activities
_____Cooking
_____Doing yard work
_____Shoveling
_____Getting out of a chair
_____Getting out of bed
_____Other: __________

Hygiene:
_____Washing your hair
_____Washing your feet
_____Washing your back
_____Putting on deodorant
_____Shaving face/legs
_____Other: __________

Leisure:
______Reading
______Watching TV
______Other: __________

Have you experienced any of the following since the onset of your symptoms?
_____Headaches
_____Irritability
_____Loss of attention
_____Fatigue
_____Bowel or bladder dysfunction
_____Dizziness or nausea

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NON-PREGNANCY VERIFICATION

Name ______________________________ Date of Birth ______________

I, ____________________________________ hereby notify all concerned, that I neither suspect nor know positively at this time that I may be or am pregnant. I release United Therapy Associates from any and all damages arising from any and all procedures, of a diagnostic or treatment nature with reference to the possibility of pregnancy.

Signature of Patient ____

Date _________________________________

Witness _______________________________

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ACKNOWLEDGEMENT OF HEALTH INFORMATON PRIVACY PRACTICES

I, ____________________________, acknowledge that by signing this form, I have received notice of the Health Information Privacy Practices from United Therapy Associates, P.A.

Patient's Signature:____________________________Date______________

Witness ______________________________Date__________________

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AUTHORIZATION TO PAY PROVIDER

I hereby authorize the ______________________________ Insurance Company to pay by check made out and mailed directly To: UNITED THERAPYASSOCIATES, P.A. 6714-1 Ritchie Highway Suite I, Glen Burnie, MD 21061, the medical and surgical expense benefits allowable and otherwise payable to me under my current insurance policy, as payment towards the total charges for Professional Services rendered. This payment will not exceed my indebtedness to the above-mentioned assignee, and I agree to pay, in a current manner, any balance of said Professional Service over and above the insurance payment.

If my current policy prohibits direct payment of provider, then I hereby authorize you to make the check to me and mail it as follows: c/o United Therapy Associates, P.A. 6714 Ritchie Highway Suite I, Glen Burnie MD 21061. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. A photocopy of this Assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertaining to my case to any insurance company, adjuster or attorney.

CONSENT TO TREAT A MINOR

I hereby authorize United Therapy Associates, P.A. and whomever it may designate, as its therapists/assistants to administer treatment as it deems necessary to
Child's Name: ______________________________ Birth Date: ______________

______________________ ______________________
Signature of Parent or Guardian Relationship to Child

MEDICAL RELEASE AUTHORIZATION

I, ___________________________, Hereby authorize any hospital, physician, health care provider or facility to furnish United Therapy Associates, P.A. with any and all information pertaining to any illness, disease, injury, history or treatment and a copy of all records.

Date: ______________________________________

Patient Name: ______________________________

Signature of Patient: _________________________

Witness: ___________________________________

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OFFICE FINANCIAL POLICY

Our office policy is to extend to you the courtesy of allowing you to assign your insurance benefits directly to us in order to reduce your out-of-pocket expenses.

If you have health insurance, all deductibles and co-payments are expected at the time of service or by an authorized payment plan. Your co-insurance balance may not exceed $150 or care may be terminated. Our payment plans make care an affordable part of your budget.

You are considered a self-pay patient until you bring completed insurance forms, insurance card, and we verify and accept your insurance coverage.

If your carrier has not paid a claim within sixty (60) days of submission, you agree to take an active part in the recovery of your claim. If your insurance carrier has not paid within ninety (90) days of submission, you accept responsibility for payment in full.

Our fees are considered usual, customary and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Patient's Printed Name: ______________________________

Signature: ______________________________________ Date: ____________

Front Desk Staff: ________________________________ Date: ____________

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MISSED APPOINTMENT POLICY

Please be advised of our missed appointment policy. This office requires **24 hours notice** for a missed appointment. If 24 hours notice is not received, a $25.00 fee will be charged that is not payable by your insurance company. In order to avoid this charge; please notify our office accordingly in the event an appointment must be rescheduled.

Date: ______________________________

Patient Name: ______________________________

Signature of Patient: ______________________________

Witness: ______________________________