MEDICARE SECONDARY PAYER QUESTIONNAIRE

Patient Name:_____

Today's Date: _____

First Choice Physical Therapy, Inc.

1. Are you currently on Medicare based on (please check all that apply):
   ___Age
   ___Disability
   ___End-Stage Renal Disease (Transplant Date: _____ Dialysis Date: _____)

2. Are you receiving Black Lung Benefits? ___Yes ___ No
   If YES, Date benefits began _____

3. Are the services to be paid by a government research program? ___Yes ___ No

4. Has the Department of Veterans Affairs authorized and agreed to pay for your care at our facility? ___Yes ___ No

5. Was the illness or injury due to a **work-related** accident? ___Yes ___ No

6. Was the illness or injury due to a **non-work related** accident or other liability accident? ___Yes ___ No

7. Are you or your spouse currently employed? ___Yes ___ No

8. Other health plan coverage besides Medicare & your supplement? ___Yes ___ No

SECTION B: (ONLY complete this section if you have insurance ABOVE & BEYOND your Medicare and the supplement.)

Type of Insurance:

___Workers Compensation ___No-fault, Auto or Liability ___Group Health Plan (GHP)

If GHP, approximate number of employees: ___1-19 ___20-99 ___100 or more

Name of Policy Holder _____ Relationship to Patient _____

Insurance Name_____

Street Address _____ City, State, Zip _____

Phone Number _____ Policy/Group Number _____

Name and Address of Employer (if applicable) _____

_____

Date of accident (if applicable) _____

I understand that federal law requires completion of this form for all Medicare patients as there may be situations where Medicare is not the primary payer or Medicare coverage varies. I certify that all of the information provided herein is true and correct.

Signature of Patient/Representative _____

MEDICATION LOG SHEET

NAME: _____ DATE: _____

Be sure to include ALL prescription drugs, over-the-counter medications, vitamins, and herbal supplements.

	MEDICINE, VITAMIN, OR SUPPLEMENT	FORM (pill, injection, liquid, patch, etc)	DOSAGE	HOW MUCH & WHEN	USE (regularly or occasionally)	START/STOP DATE (1/15/17-3/5/17 or 1/5/17-ongoing)	NOTES, SPECIAL DIRECTIONS OR REASONS FOR USE
1							
2							
3							
4							
5							
6							
7							
8							
9							
10							
11							
12							
13							
14							
15							
16							

First Choice
Physical Therapy, Inc.

FUNCTIONAL ASSESSMENT OF DIFFICULTY (OPTIMAL INSTRUMENT) BASELINE OR FOLLOW-UP

NAME: _____ TODAY'S DATE: _____

INSTRUCTIONS: Please circle the level of difficulty you have for each activity today. If the activity does not apply to you circle the 0 under "Not Applicable".

ACTIVITY	ABLE TO DO WITHOUT ANY DIFFICULTY	ABLE TO DO WITH LITTLE DIFFICULTY	ABLE TO DO WITH MODERATE DIFFICULTY	ABLE TO DO WITH MUCH DIFFICULTY	UNABLE TO DO	NOT APPLICABLE
1. Lying flat	1	2	3	4	5	0
2. Rolling over	1	2	3	4	5	0
3. Moving – Lying to Sitting	1	2	3	4	5	0
4. Sitting	1	2	3	4	5	0
5. Squatting	1	2	3	4	5	0
6. Bending/stooping	1	2	3	4	5	0
7. Balancing	1	2	3	4	5	0
8. Kneeling	1	2	3	4	5	0
9. Standing	1	2	3	4	5	0
10. Walking – short distances	1	2	3	4	5	0
11. Walking – long distances	1	2	3	4	5	0
12. Walking – outdoors	1	2	3	4	5	0
13. Climbing stairs	1	2	3	4	5	0
14. Hopping	1	2	3	4	5	0
15. Jumping	1	2	3	4	5	0
16. Running	1	2	3	4	5	0
17. Pushing	1	2	3	4	5	0
18. Pulling	1	2	3	4	5	0
19. Reaching	1	2	3	4	5	0
20. Grasping	1	2	3	4	5	0
21. Lifting	1	2	3	4	5	0
22. Carrying	1	2	3	4	5	0

From the list above, list the 3 activities you would most like to be able to do without any difficulty:

1. _____ 2. _____ 3. _____

From the 3 activities, you just listed, write down the one activity you would most like to be able to do without any difficulty:

PRIMARY GOAL: _____

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