FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

Tel: 610.241.2685
Fax: 877.732.7311
WWW.FULLRANGEHEALTH.ORG

Welcome to Full Range Health Services.

Thank you for trusting us with your care!

Contact Information:

My name is: _____

I am your: _____

If at any time during your care, or after your care is finished, you have any questions, concerns, or feedback, you can reach the following ways:

My Number: _____

Office Number: 610-241-2685

Email: support@fullrangehealth.org

Website: www.fullrangehealth.org

Services Offered:

Home Health- Part A ◆ Therapy House Calls - Part B ◆ Outpatient Clinics

Nursing • Physical Therapy • Occupational Therapy • Speech Therapy • Social Work

Outpatient Clinics Locations:

Drexel Hill	-	4302 Woodland Ave. Drexel Hill, PA 19026
West Chester	-	307 W. Boot Rd. West Chester PA 19380

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Patient/POA Consent and Financial Responsibility

Please read and discuss this document with your therapist, sign, and date it to confirm your understanding of, and your agreement to its content.
Full Range Health Services, LLC has been asked by your physician or healthcare provider team to provide physical, occupational, and/or speech therapy evaluation and treatment services. Please read and discuss this document with your therapist, sign, and date it to confirm your understanding of, and your agreement to, its content.

Informed Consent

My physician has prescribed, and Full Range Health Services, LLC has designed a plan of care to provide physical therapy, speech language pathology, and/or occupational therapy to address one or more of my medical conditions. I agree to receive the services of Full Range Health Services, LLC as recommended in the plan of care designed by my therapist and prescribed by my physician.

Statement of Financial Responsibility

I authorize direct payment to Full Range Health Services, LLC from my primary insurance carrier and well as from my secondary and/or supplemental insurance carrier (if any), if my primary insurance does not cover my full bill. I will be billed for any uncovered portion, and I acknowledge my personal responsibility for that balance, to the extent permitted by law. Any uncovered portion may include primary and secondary insurance deductibles, co-payments, coinsurances, and any other out of pocket expenses due to my insurance policies. I agree to forward any insurance payments that I receive from my insurance carriers directly to Full Range Health Services, LLC. I am obligated to inform Full Range Health Services, LLC of any changes in my insurance coverage.

Open Home Healthcare Episode

I authorize that I am not engaged in services through a home health agency at this time. I further acknowledge that if I am engaged in services through a home health agency, the services provided by Full Range Health Services, LLC may be denied by my insurance company, in which case, the services will be billed directly.

Cancellation Policy

Please provide our team with 24- hour notice to change or cancel an appointment. Patients who do not maintain a scheduled appointment and do not provide 24-hour notice to change or cancel an appointment may be responsible for a $15.00 cancelled visit charge. This charge cannot be billed to insurance and must be paid on or before the next scheduled appointment.

Financial Services

Full Range Health Services, LLC will make every attempt to obtain all proper insurance information for all admissions. It is recommended for our patients to contact their insurance companies to fully understand their covered benefits for rehabilitation services.
In the event that a patient's insurance benefit does not cover the full cost of the provided services, Full Range Health Services, LLC is required to send balance bill to the patient or their assigned financially responsible party. If you require additional information or assistance, please contact Full Range Health Services, LLC at (P) 610-241-2685 or visit our website at www.FULLRANGEHEALTH.org

HIPAA Acknowledgment

I acknowledge receipt of the Notice of Privacy Practices for Full Range Health Services, LLC and had the opportunity to review it with my therapist, prior to signing this document.

Services: Physical Therapy_____ Occupational Therapy _____ Speech Therapy:_____

Other: _____

Consent: By my signature below I acknowledge that I have read, understand, and agree to the terms and conditions contained in the Informed Consent and the Statement of Financial Responsibility to release all information necessary to secure payment.

Print: _____ **Date:** _____

Signature: _____

Please Check: Patient:_____ Guardian:_____

Financially Responsible Party (Please Specify) _____

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Name: _____ **Date**: _____

Date of Birth: _____ Personal Email Address: _____

Primary Care Physician: _____ **Occupation:**_____

Emergency Contact: _____ Emergency Contact Phone Number: _____

Please document your height and weight: Height: _____ Weight: _____

Falls How many times have you fallen in the past year? _____ Were you injured? Yes ☐ No ☐

Check off below what has prompted today's visit.

Head	☐ Right	☐ Left	**Neck**	☐ Right	☐ Left
Upper back	☐ Right	☐ Left	**Low back**	☐ Right	☐ Left
Buttock	☐ Right	☐ Left	**Shoulder**	☐ Right	☐ Left
Elbow	☐ Right	☐ Left	**Forearm**	☐ Right	☐ Left
Wrist	☐ Right	☐ Left	**Hand/fingers**	☐ Right	☐ Left
Hip	☐ Right	☐ Left	**Thigh**	☐ Right	☐ Left
Knee	☐ Right	☐ Left	**Shin/calf**	☐ Right	☐ Left
Ankle	☐ Right	☐ Left	**Feet/toes**	☐ Right	☐ Left
Chest	☐ Right	☐ Left	☐ **CRPS**	☐ **Vertigo/balance**	

Is this a reoccurrence of a prior injury?

☐ Yes ☐ No If yes, what year was the prior injury? _____

Have you received surgery for this injury?

☐ Yes ☐ No If yes, what was the date of your surgery? _____

Describe what type of pain you feel:

☐ Aching	☐ Dull	☐ Heavy	☐ Pins and needles	
☐ Cramping	☐ Variable	☐ Burning	☐ Stabbing	
☐ Weak	☐ Numb	☐ Deep	☐ Constant	☐ Throbbing

Rate your pain on a scale of 0-10 (0= no pain, 10= worst pain I have ever felt)

What was the level of your pain when the injury first occurred? _____

What is your pain: Currently:_____ At best:_____ At worst:_____

What makes your pain feel worse?_____

_____

What relieves your pain?

☐ Ice	☐ Lying flat	☐ Exercise	☐ Pain medication	☐ Stretching
☐ Nothing	☐ Heat	☐ Rest	☐ Avoiding activity	

Medical History: Check each of the area of the body that relates to your medical history.

Ankles:	☐ Right	☐ Left	**Elbows**:	☐ Right	☐ Left
Hips:	☐ Right	☐ Left	**Knees**:	☐ Right	☐ Left
Legs:	☐ Right	☐ Left	**Shoulders**:	☐ Right	☐ Left
Wrists:	☐ Right	☐ Left			

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Medical History: Check each of the items that relate to your medical history:

☐ Anemia	☐ Pacemaker	☐ Allergies
☐ Back Pain	☐ Angina	☐ Asthma
☐ Bronchitis	☐ Blot clot/Emboli	☐ Bowel/bladder problems
☐ Coronary Heart Disease	☐ Drink Alcohol	☐ Dizziness or fainting
☐ Gout	☐ Emphysema	☐ Epilepsy/Seizures
☐ Hernia	☐ Hearing difficulties	☐ Heart attack
☐ Parkinson's	☐ High blood pressure	☐ Kidney Disease
☐ Severe/frequent headaches	☐ Pneumonia	☐ Pregnant
☐ Stroke/TA	☐ Sleeping problems	☐ Cigarettes/Other Tob Use
☐ Vision difficulties	☐ Thyroid problems	☐ Varicose Veins
☐ Women's health issues	☐ Weakness	☐ Weight loss/energy loss
☐ Cancer:_____	☐ Diabetes: ☐ Type 1 (or) ☐Type 2	

Medical History: Check each of the topics that relate to your medical history.

☐ Joint replacement If yes, location: _____
☐ Arthritis If yes, location: _____
☐ Pins or metal implant If yes, location: _____
☐ Numbness/tingling/neuropathy If yes, location: _____

Medical History: Circle each of the topics that relate to your medical history.

I use the following equipment: ☐ cane ☐ walker ☐ wheelchair ☐ Other: _____
☐ I live alone ☐ I received nursing at home ☐ I received P.T.
☐ I am caregiver for someone else ☐ Other important issues:_____

How often do you exercise?

☐ Never
☐ Usually 1 time (weekly)
☐ Usually 2 times (weekly)
☐ Usually 3 times (weekly)
☐ 4 or more times (weekly)

Does your daily routine, or work, aggravate your injury?

☐ No
☐ I am unable to participate in my normal routines or work
☐ My routine/work usually impacts my injury 1 day per week
☐ My routine/work aggravates my injury about 2 days per week
☐ My routine/work aggravates my injury 3 or more days per week
☐ My routine/work aggravates my injury every day, but I try to cope

Does your diagnosis impact your ability to do your job?

☐ I am retired
☐ I can only work part time
☐ I can work, but with minor difficulty
☐ Not applicable
☐ The diagnosis prevents me from working.
☐ I can work, but with great difficulty.
☐ The diagnosis does not impact my ability to work.

Please list current medications, including dosage and route: **Ex: Tylenol 2 tabs 325 every 6 Hrs as needed orally*

1. _____
2. _____
3. _____
4. _____
5. _____

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ALLERGIES: _____

Are you latex sensitive? ☐Yes ☐ No

Please list any surgeries or other conditions for which you have been hospitalized, including dates:

1. _____
2. _____
3. _____
4. _____
5. _____

Is this a work-related injury?

☐ Yes ☐ No

If you answered yes to the previous question, please answer the following questions:

Please list your current Employer: _____

Please list your current Job Title: _____

Is there an attorney assigned to your case?

☐ Yes, Name: _____ ☐ No

Is there a case manager associated with your case?

☐ Yes, Name: _____ ☐ No

What is your current employment status?

☐ Full-Duty ☐Partial/Light Duty ☐ Not working

If you answered not working, when was the last day you were employed? _____

Please define any lifting or other restrictions you have related to your employment

_____

_____

_____

_____

Patient Signature _____ **Date**: _____

(For Office Use Only)

Clinician Initials: _____ **Date:** _____

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Therapy Care Management ™

Facts:

- More than 1 out of 4 older people all each year.
- 1 out of 5 falls cause a serious injury such as broken bones or a head injury.
- More than 95% of hip fractures are caused by falling, usually by falling sideways.
- Falling 1 time doubles your chance of falling again.
- The direct medical costs for fall injuries are more than $31 billion annually.

What is Therapy Care Management?

Therapy Care Management™ is our unique screening program designed to identify issues before they become a life changing problem. Additionally, it is designed to recommend therapeutic care and durable medical needs, and advocate on behalf of those who have chronic conditions, such as osteoarthritis, COPD, Parkinson's Disease, ALS, Multiple Sclerosis, and more…

Why Do I need It?

Medicare Part B is a great insurance that provides for its beneficiaries; however, like most things, has its limitations.

- Each year the therapy benefit for outpatient services has a cap that may limit your access to certain services.
- Medicare Part B only covers 80% of your therapy Services.
- Therapy services after a major life changing event can be needed for an extended time.
- Some services may be denied after being rendered.

Contact Us Today to Learn More:

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Satisfaction Survey

We are interested in receiving your feedback about the care provided by our team. Please take a few minutes to complete this survey and return it to us. Your responses help us to provide the best care possible.

5: Extremely Satisfied **4**: Very Satisfied **3**: Satisfied **2**: Very Dissatisfied **1**: Extremely Dissatisfied

Did you hear from your therapist in a timely manner? Yes ☐ No ☐

Were your appointments scheduled at a convenient time?

5 4 3 2 1

Did your therapist act in a professional and respectful manner to you during your appointments?

5 4 3 2 1

Did you therapist answer your questions and explain things in a way that you could understand?

5 4 3 2 1

Did your therapist demonstrate knowledge about your diagnosis and the treatment protocol/plan?

5 4 3 2 1

Were therapy goals and the role of therapy discussed with you during your visits?

5 4 3 2 1

Were you satisfied with your treatment time, thoroughness of the treatment, and the overall attentiveness of your therapist? 5 4 3 2 1

Do you have any specific comments about your therapy that you wish to share with us? We appreciate your feedback! _____

_____

_____

_____

_____

Ways of submitting your Satisfaction Survey:

Email to: support@fullrangehealth.org Fax to: 877-732-7311

Mail to: 319 N. Pottstown Pike Suite 101, Exton PA 19341