

SOUTHWEST ADVANCED NEUROLOGICAL REHABILITATION, LLC
PATIENT QUESTIONNAIRE

PATIENT INFORMATION

Name: _____ Date of birth _____ Age _____
Address: _____ City: _____ State _____ Zip _____
Phone: () _____ Email: _____

CAREGIVER INFORMATION

Name: _____ Phone: () _____
Address: _____ City: _____ State _____ Zip _____
Relationship to patient: _____ Email: _____

TYPE OF INJURY

- Stroke Side of body affected: Right Left Dominant Hand Prior to stroke: Right Left
Date of stroke: _____ Type of stroke _____
 Traumatic brain injury Date of brain injury _____
 Other: _____

WALKING AND BALANCE

Are you able to walk?	Yes	No	Do you use a wheelchair?	Yes	No
Do you use a walker?	Yes	No	Do you use a cane?	Yes	No
Do you use a leg brace?	Yes	No			
Have you fallen in the past year?	Yes	No	In the past month?	Yes	No

If so, when? _____

Have you stumbled recently or are you fearful of falling? Yes No

If yes, please explain: _____

OTHER INFORMATION

Do you need any help for the following activities?

Getting in/out of bed	No	Yes	How much	_____
Getting dressed / undressed	No	Yes	How much	_____
Toileting	No	Yes	How much	_____
Eating	No	Yes	How much	_____
Preparing food	No	Yes	How much	_____
Showering / bathing	No	Yes	How much	_____

Do you drive? Yes No If no, do you want to drive? Yes No

Do you use your affected arm for anything? Describe _____

Pre stroke recreation and hobbies _____

Medications:

_____	for what	_____
_____	for what	_____
_____	for what	_____
_____	for what	_____
_____	for what	_____
_____	for what	_____

HEALTH INFORMATION

Please mark if you have a history of any of the following conditions.

Heart Disease	Yes	No	Cancer	Yes	No
Hypertension	Yes	No	Depression	Yes	No
Pulmonary Disease	Yes	No	Diabetes	Yes	No
Head injury or surgery	Yes	No			
Thyroid Disease	Yes	No	Expressive Aphasia	Yes	No
Seizures	Yes	No	Receptive Aphasia	Yes	No
Allergies, Asthma	Yes	No	Anemia (blood problems)	Yes	No

Other: _____

If you answered yes to any of the above, please explain _____

WHAT ARE YOUR GOALS FOR THERAPY?

Walking and balance goals

_____	_____
_____	_____
_____	_____

Arm and Hand Goals

_____	_____
_____	_____
_____	_____

Signed: _____ Date _____

SOUTHWEST ADVANCED NEUROLOGICAL REHABILITATION, LLC
PATIENT DEMOGRAPHIC INFORMATION

Today's Date: _____

Patient Information

Patient Name _____
Last First Middle Initial

Gender: M _____ F _____ Date of Birth ____/____/____ Age _____

Social Security Number _____ - _____ - _____ Marital Status: S M W D Sep

Local Address _____

City _____ State _____ Zip Code _____ Local Phone (____) _____

Permanent Address _____

City _____ State _____ Zip Code _____ Permanent Phone (____) _____

Cell Phone _____ Email _____

Date of Stroke/Injury ____/____/____ Name of Spouse/Parent/Guardian (circle one) _____

How did you hear of us or who referred you? _____

EMERGENCY CONTACT: _____ Relationship _____

Phone(s) (____) _____ Cell Phone (____) _____

Physician Information

Referring Physician _____ Phone (____) _____

Fax (____) _____

Office Location: Street Address _____

City _____ State _____ Zip _____

Patient's Primary Physician _____ Phone (____) _____

Office Location: Street Address _____

City _____ State _____ Zip _____

Responsible Party Information

Name: _____

Employer: _____ Occupation _____

Street Address _____

City _____ State _____ Zip _____

Insurance Information

Primary Insurance Company: _____

Street _____ City _____ State _____ Zip Code _____

ID# _____ Policy # _____ Group # _____

Policy Holder's Name _____ Relationship to Patient _____

SS # _____ - _____ - _____ Date of birth _____

Policy Holder's Address (if other than patient's):

Street _____ City _____ State _____ Zip Code _____

Policy Holder's Employer:

Street _____ City _____ State _____ Zip Code _____

Secondary Insurance Company: _____

Street _____ City _____ State _____ Zip Code _____

ID# _____ Policy # _____ Group # _____

Policy Holder's Name _____ Relationship to Patient _____

SS # _____ - _____ - _____ Date of birth _____

Policy Holder's Address (if other than patient's):

Street _____ City _____ State _____ Zip Code _____

Policy Holder's Employer:

Street _____ City _____ State _____ Zip Code _____

Assignment of benefits/authorization to release information

I authorize payment of my insurance benefits directly to SWAN Rehab. I understand I am personally responsible for balances not paid by my insurance.

x _____ Date /_____/_____
Patient/Responsible Party

I authorize SWAN Rehab to release any medical records necessary to assist with the processing of my claim.

x _____ Date /_____/_____
Patient/Responsible Party

Stroke Impact Scale

VERSION 3.0

Name _____

Date: _____

The purpose of this questionnaire is to evaluate how stroke has impacted your health and life. We want to know from **YOUR POINT OF VIEW** how stroke has affected you. We will ask you questions about impairments and disabilities caused by your stroke, as well as how stroke has affected your quality of life. Finally, we will ask you to rate how much you think you have recovered from your stroke.

These questions are about the physical problems which may have occurred as a result of your stroke.

1. In the past week, how would you rate the strength of your....	A lot of strength	Quite a bit of strength	Some strength	A little strength	No strength at all
a. Arm that was <u>most affected</u> by your stroke?	5	4	3	2	1
b. Grip of your hand that was <u>most affected</u> by your stroke?	5	4	3	2	1
c. Leg that was <u>most affected</u> by your stroke?	5	4	3	2	1
d. Foot/ankle that was <u>most affected</u> by your stroke?	5	4	3	2	1

These questions are about your memory and thinking.

2. In the past week, how difficult was it for you to...	Not difficult at all	A little difficult	Somewhat difficult	Very difficult	Extremely difficult
a. Remember things that people just told you?	5	4	3	2	1
b. Remember things that happened the day before?	5	4	3	2	1
c. Remember to do things (e.g. keep scheduled appointments or take medication)?	5	4	3	2	1
d. Remember the day of the week?	5	4	3	2	1
e. Concentrate?	5	4	3	2	1
f. Think quickly?	5	4	3	2	1
g. Solve everyday problems?	5	4	3	2	1

These questions are about how you feel, about changes in your mood and about your ability to control your emotions since your stroke.

3. In the past week, how often did you...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Feel sad?	5	4	3	2	1
b. Feel that there is nobody you are close to?	5	4	3	2	1
c. Feel that you are a burden to others?	5	4	3	2	1
d. Feel that you have nothing to look forward to?	5	4	3	2	1
e. Blame yourself for mistakes that you made?	5	4	3	2	1
f. Enjoy things as much as ever?	5	4	3	2	1
g. Feel quite nervous?	5	4	3	2	1
h. Feel that life is worth living?	5	4	3	2	1
i. Smile and laugh at least once a day?	5	4	3	2	1

The following questions are about your ability to communicate with other people, as well as your ability to understand what you read and what you hear in a conversation.

4. In the past week, how difficult was it to...	Not difficult at all	A little difficult	Somewhat difficult	Very difficult	Extremely difficult
a. Say the name of someone who was in front of you?	5	4	3	2	1
b. Understand what was being said to you in a conversation?	5	4	3	2	1
c. Reply to questions?	5	4	3	2	1
d. Correctly name objects?	5	4	3	2	1
e. Participate in a conversation with a group of people?	5	4	3	2	1
f. Have a conversation on the telephone?	5	4	3	2	1
g. Call another person on the telephone, including selecting the correct phone number and dialing?	5	4	3	2	1

The following questions ask about activities you might do during a typical day.

5. In the past 2 weeks, how difficult was it to...	Not difficult at all	A little difficult	Somewhat difficult	Very difficult	Could not do at all
a. Cut your food with a knife and fork?	5	4	3	2	1
b. Dress the top part of your body?	5	4	3	2	1
c. Bathe yourself?	5	4	3	2	1
d. Clip your toenails?	5	4	3	2	1
e. Get to the toilet on time?	5	4	3	2	1
f. Control your bladder (not have an accident)?	5	4	3	2	1
g. Control your bowels (not have an accident)?	5	4	3	2	1
h. Do light household tasks/chores (e.g. dust, make a bed, take out garbage, do the dishes)?	5	4	3	2	1
i. Go shopping?	5	4	3	2	1
j. Do heavy household chores (e.g. vacuum, laundry or yard work)?	5	4	3	2	1

**The following questions are about your ability to be mobile,
at home and in the community.**

6. In the past 2 weeks, how difficult was it to...	Not difficult at all	A little difficult	Somewhat difficult	Very difficult	Could not do at all
a. Stay sitting without losing your balance?	5	4	3	2	1
b. Stay standing without losing your balance?	5	4	3	2	1
c. Walk without losing your balance?	5	4	3	2	1
d. Move from a bed to a chair?	5	4	3	2	1
e. Walk one block?	5	4	3	2	1
f. Walk fast?	5	4	3	2	1
g. Climb one flight of stairs?	5	4	3	2	1
h. Climb several flights of stairs?	5	4	3	2	1
i. Get in and out of a car?	5	4	3	2	1

**The following questions are about your ability to use your hand that was
MOST AFFECTED by your stroke.**

7. In the past 2 weeks, how difficult was it to use your hand that was most affected by your stroke to...	Not difficult at all	A little difficult	Somewhat difficult	Very difficult	Could not do at all
a. Carry heavy objects (e.g. bag of groceries)?	5	4	3	2	1
b. Turn a doorknob?	5	4	3	2	1
c. Open a can or jar?	5	4	3	2	1
d. Tie a shoe lace?	5	4	3	2	1
e. Pick up a dime?	5	4	3	2	1

The following questions are about how stroke has affected your ability to participate in the activities that you usually do, things that are meaningful to you and help you to find purpose in life.

8. During the past 4 weeks, how much of the time have you been limited in...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Your work (paid, voluntary or other)	5	4	3	2	1
b. Your social activities?	5	4	3	2	1
c. Quiet recreation (crafts, reading)?	5	4	3	2	1
d. Active recreation (sports, outings, travel)?	5	4	3	2	1
e. Your role as a family member and/or friend?	5	4	3	2	1
f. Your participation in spiritual or religious activities?	5	4	3	2	1
g. Your ability to control your life as you wish?	5	4	3	2	1
h. Your ability to help others?	5	4	3	2	1

9. Stroke Recovery

On a scale of 0 to 100, with 100 representing full recovery and 0 representing no recovery, how much have you recovered from your stroke?

_____ 100 Full Recovery

—
_____ 90

—
_____ 80

—
_____ 70

—
_____ 60

—
_____ 50

—
_____ 40

—
_____ 30

—
_____ 20

—
_____ 10

_____ 0 No Recovery

SWAN Rehab, LLC

Payment Policy

Welcome to SWAN Rehab! We are happy to further extend our services by filing your insurance for you. Please select from the following payment choices:

_____ Self-Pay – Please pay the balance in full at the time of service. In the event you are unable to pay the balance in full, please advise us prior to the time of service. Please be advised that we are not a credit grantor, and therefore, failure to maintain these agreements may result in the placement of your account with an agency or attorney for collection.

_____ Primary Insurance – We will bill your primary insurance. We assume payment of insurance benefits is not forthcoming on charges older than thirty (30) days. Charges outstanding for more than thirty (30) days from the date of filing will be due in full from you regardless of the type of insurance involved. Any overpayments will be refunded after all charges have been processed by your primary insurance.

IF YOUR INSURANCE CHANGES, YOU NEED TO NOTIFY US PRIOR TO ANY CHANGES TO YOUR NEW INSURANCE COMPANY. IF ANY CHARGES ARE DENIED BY YOUR NEW INSURANCE, YOU WILL BE RESPONSIBLE FOR THE FULL AMOUNT.

ALL SUPPLIES ARE PAYABLE AT THE TIME OF SERVICE AND CANNOT BE CHARGES. WE WILL FILE FOR ANY COVERED SUPPLIES ALLOWED BY YOUR INSURANCE CARRIER.

Please be aware that you will remain financially responsible for any and all services and supplies received regardless of the payment option selected above. In the event your account becomes delinquent and is therefore in default of payment, the patient, legal guardian, or admitting parent will be responsible for the principle amount owed and all reasonable costs associated with the collection of this debt, including, but not limited to, collection service fees, attorney's fees, all court costs, and additional legal expenses associated with recovery of the debt.

Thank you for allowing us the opportunity to service you. Please sign and date this form. If you have any questions, please ask for our assistance.

Signature _____ Date _____

Cancellation Policy

SWAN Rehab schedules a high ratio of therapist to patient. Therefore, it is imperative that if you are unable to make your scheduled appointment you provide the courtesy of a 48 your cancellation notice. Cancellations made with less than 48 hours notice will result in a \$50.00 service charge.

SWAN Rehab

1020 E. Missouri Ave. Suite 1, Phoenix, Arizona 85014, 602-393-0520 phone, 602-393-0523 fax

PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

In this document, “we” refers to Wing Neurological Rehabilitation, LLC. “You” or “yours” refers to individual patients. We are required by federal law to protect the privacy of your individual health information (referred to in this notice as “Protected Health Information” or PHI). We are also required to provide you with this notice regarding our legal duties and privacy practices with respect to your PHI, and to abide by the terms of this notice.

We maintain medical information about you in the course of providing health care services to you. We also hire business associates, such as a billing service and a transcription service, and bill third party payers, such as Medicare, in the process of providing and billing these services. These business associates also receive and maintain medical information about you.

Purposes for which we may use or disclose medical information about you without your consent or authorization.

We may use and disclose medical information about you for the following purposes:

- **Health Care Providers’ Treatment Purposes.** For example, to communicate with your doctor we may disclose medical information about you.
- **Payment.** For example, we may use or disclose medical information about you to pay claims for covered health care services or to provide eligibility information to your doctor when you receive treatment
- **Health Care Operations.** For example, we may use or disclose medical information about you for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of contracts.
- **Health Services.** For example, we may use medical information about you to contact you to give you information about treatment alternatives or other health-related benefits and services that may be of interest to you.
- **As Required By Law.** For example, we must allow the U.S. Department of Health and Human Services to audit our records. We may also disclose medical information about you as authorized by and to the extent necessary to comply with workers’ compensation or other similar laws.
- **To Business Associates.** We may disclose medical information about you to business associates we hire to assist us in your care. Each business associate must agree in writing to ensure the continuing confidentiality and security of medical information about you.

We may also use and disclose medical information about you as follows:

- To comply with legal proceedings, such as a court or administrative order or subpoena
- To law enforcement officials for limited law enforcement purposes.
- To your personal representatives appointed by you or designated by the applicable law.
- For research purposes, as long as certain privacy-related standards are satisfied.
- To a governmental agency authorized to oversee the health care system or government programs.
- We may disclose to one of your family members, to a relative, to a close personal friend, or to any other person identified by you, PHI that is directly relevant to the person’s involvement with your care or payment related to your care.

Authorizations: Uses and Disclosures with Your Permission

We will not use or disclose medical information about you for any other purposes unless you give us your written authorization to do so. If you give us written authorization to use or disclose medical information about you for a purpose that is not described in this notice, then, in most cases, you may revoke it in writing at any time. Your revocation will be effective for all medical information about you that we maintain, except for information we have already released based on your authorization.

Your Rights

You may make a written request to us to do one or more of the following concerning medical information about you:

- To put additional restrictions on our disclosure of medical information about you we do not have to agree to your request.
- To communicate with you in confidence about medical information about you by a different means or at a different location than we are currently doing you must do by a request in writing and must specify the alternative means or location.
- To see and get copies of medical information about you, we do not have to agree to your request.
- To amend medical information about you, in some cases we do not have to agree to your request.

Complaints

If you believe your privacy rights have been violated, you may complain to us in writing. Or the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

Conclusion

PHI use and disclosure by us is regulated by a federal law known as HIPAA. You may find these rules at 45 *Code of Federal Regulations* Parts 160 and 164. This Notice attempts to summarize the Privacy Standards. The Privacy Standards will supersede any discrepancy between the information in the Notice and the Privacy Standards.