

Patient Registration



Patient Information

Office use only

Last Name _____ First Name _____ MI _____ Nickname _____ Social Security Number _____

Chart Number

Street Address _____ Apt. # _____ Month / Day / Year _____ Weight (lbs.) _____
(Birthdate)

City _____ State _____ Zip Code _____ Month / Day / Year _____
(New Patient Date)

Male Female

Home Phone _____ Email Address _____

Cell Phone _____ Relationship to Primary Insurance Holder _____

Work Phone _____ Relationship to Secondary Insurance Holder _____

Employment Type (Check One Box)	
<input type="checkbox"/> Full Time Student	<input type="checkbox"/> Self Employed
<input type="checkbox"/> Part Time Student	<input type="checkbox"/> Retired
<input type="checkbox"/> Employed	<input type="checkbox"/> Active Military
<input type="checkbox"/> Not Employed	<input type="checkbox"/> Unknown

Marital Status (Check One Box)	
<input type="checkbox"/> Single	<input type="checkbox"/> Widowed
<input type="checkbox"/> Married	<input type="checkbox"/> Unknown
<input type="checkbox"/> Legally Separated	<input type="checkbox"/> Partner

Office use only
<u>Mark Netzinger</u> Provider
<u>Physical Therapy Consultants</u> Office
<u>Initial Fee Schedule</u> Fee Schedule

Diagnosis _____ Diagnosis Codes _____

Referring Physician Information

Last Name _____ First Name _____ Title _____ Suffix _____

Office/Company _____ Dept. _____

Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone Number _____

Fax Number _____

Referral Type _____ Specialty _____

Primary Care Physician Information

Last Name _____ First Name _____ Title _____ Suffix _____

Office/Company _____ Dept. _____

Street Address _____ Suite _____

City _____ State _____ Zip Code _____

Phone Number _____

Fax Number _____

Referral Type _____ Specialty _____

Emergency Contact Information

Last Name _____ First Name _____ Phone Number _____ Relationship to the Patient _____



Primary Insurance Information

Last Name (guarantor) _____ First Name _____ Middle Initial _____ Nickname _____ Social Security Number _____

Street Address _____ Apt. # _____ Month / Day / Year
(Birthdate)

City _____ State _____ Zip Code _____ Male

Home Phone _____ Email Address _____ Female

Cell Phone _____ Auto Liability Month / Day / Year Claim Number Policy Number
(Injury Date)

Work Phone _____ Workers Comp. Adjustor's Name Adjustor's Phone Number

Employer Name _____ Phone Number _____

Street Address _____ Ste. # _____ City _____ State _____ Zip _____

Insurance Carrier's Name _____ Subscriber Number (ID Number) _____ Group Number _____

Street Address _____ Ste. # _____ City _____ State _____ Zip _____

Secondary Insurance Information

Last Name (guarantor) _____ First Name _____ Middle Initial _____ Nickname _____ Social Security Number _____

Street Address _____ Apt. # _____ Month / Day / Year
(Birthdate)

City _____ State _____ Zip Code _____ Male

Home Phone _____ Email Address _____ Female

Cell Phone _____ Auto Liability Month / Day / Year Claim Number Policy Number
(Injury Date)

Work Phone _____ Workers Comp. Adjustor's Name Adjustor's Phone Number

Employer Name _____ Phone Number _____

Street Address _____ Ste. # _____ City _____ State _____ Zip _____

Insurance Carrier's Name _____ Subscriber Number (ID Number) _____ Group Number _____

Street Address _____ Ste. # _____ City _____ State _____ Zip _____

How did you hear about us? _____

Patient Signature _____

Date _____ / _____ / _____



SUMMARY OF OUR NOTICE OF PRIVACY PRACTICES



Pg. 1 of 2

Physical Therapy *Consultants, Inc.*

EFFECTIVE DATE: APRIL 14, 2003

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

Please review the full Notice of Privacy Practices (NPP) which is attached. If you have any questions about this notice, please contact Beth Johnson, Privacy Official at (763) 413-0880.

WHO WILL FOLLOW THIS NOTICE

- PHYSICAL THERAPY CONSULTANTS, INC.
- Andover Physical Therapy
- St. Francis Physical Therapy
- Isanti Physical Therapy
- Ham Lake Physical Therapy

This notice describes our privacy practices. We are affiliated with and in some circumstances may operate under the policies and practices of:

- Anodyne, Inc.
- Empi, Inc.
- Thera Tech, Inc.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION

We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal physical therapist or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose health information. By coming for care, you give us the right to use your information for treatment, to get reimbursed for your care, and to operate our organization.

There are also various other ways in which we may use or disclose your information:

- **To allow oversight of the quality of the healthcare we provide**
- **To allow workers' compensations claims**
- **As required by subpoena in lawsuits and disputes**
- **Various uses as required by law or to avert a serious threat to health or safety**

The full details for all these uses are contained in the full NPP.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to inspect and copy**
- **Right to amend**
- **Right to an accounting of disclosures**
- **Right to request restrictions**
- **Right to request confidential communications**
- **Right to a paper copy of this notice**

Information on how to exercise these rights can be seen in the NPP or can be obtained from Beth Johnson, Privacy Official at (763) 413-0880.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact Beth Johnson, Privacy Official. All complaints must be submitted in writing. **You will not be penalized for filing a complaint.**

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.



NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT



Physical Therapy
Consultants, Inc.

18415 NE Hwy 65
Cedar, MN 55011

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

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I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE _____ INITIALS _____ REASON _____



PATIENT COMPLIANCE FORM

Welcome to Physical Therapy Consultants, Inc.! We look forward to assisting you in your recovery process. In order to allow for a smooth process the staff has a few expectations.

To maximize the effects of your treatment, you need to:

1. **Show up on time.** We schedule adequate amount of time for us to successfully complete each visit. If you show up late, the therapist reserves the right to shorten your treatment session or even cancel your visit altogether if you are late by 15 minutes or more. Showing up late may negatively impact someone else's treatment as well.

Patient Initials:_____

2. **Avoid cancellations.** Failure to attend each session, by canceling or not showing up compromises your therapist's ability to help you get better. If your are unable to attend your scheduled appointment, please give 24 hour notice, or we reserve the right to charge \$15 to your account. If treatments are canceled 3 times, or if there are 3 no-shows, your therapist may reserve the right to discontinue your care. Please be aware that this may negatively impact your benefits with some insurance plans as well.

Patient Initials:_____

3. **Follow the directions provided by your therapist.** As part of your care your therapist may give you a number of exercises to do at home. Your therapist may also give you additional instructions that you need to follow through with. Not complying with all these instructions may negatively affect the outcome of your treatments and/or benefits.

Patient Initials:_____

If you are able to fully comply with these guidelines your therapist will be able to better assist you in returning to your previous level of function. Your therapist will do everything possible to try to greet you at your scheduled appointment time, however, we may be a few minutes behind due to other patient's treatment sessions that may overlap. Please be patient as your therapist is committed to giving you the necessary time and attention that has been given to the patients that were scheduled before you.

Thank you so much for complying with these guidelines. As stated, these guidelines have been put in place to ensure effective and timely care for you and other patients.

I have read, understand, and agree to comply with this policy,

Signature:_____

Date:_____

(Witness):_____

(Please give form to patient and place a copy in the chart)



Physical Therapy
Consultants, Inc.



PATIENT QUESTIONNAIRE

As a rehabilitation agency, Physical Therapy Consultants, Inc. is required to evaluate the social and vocational needs of each of our patients. Please answer the following questions to the best of your ability.

- | | | |
|--|-----|----|
| 1. Has your injury or illness produced a financial hardship for you or other members of your family? | YES | NO |
| 2. Has your injury or illness isolated you from your friends or family? | YES | NO |
| 3. Has your injury or illness caused you to receive assistance? | YES | NO |
| 4. If not, do you need assistance? | YES | NO |
| 5. Would you like information on finding assistance? | YES | NO |
| 6. As a consequence of your injury or illness, do you feel vulnerable or threatened by friends, family members, or others? | YES | NO |
| 7. As a result of your injury or illness, do you have thoughts of harming yourself or others? | YES | NO |
| 8. If you answered yes to any of the above questions, would you be Interested in meeting with a member of Social Services or Vocational Rehabilitation Services? | YES | NO |
| 9. Are there any other issues we haven't addressed? (if yes, please explain below) | YES | NO |

Patient Signature

Date

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_____ Patient will be referred to Minnesota Workforce Center for Vocational Rehabilitation Services.

_____ Patient will be referred to Anoka County Social Services.

_____ Patient does not require either Vocational Rehabilitation nor Social Services assessment.

Physical Therapist, License Number

Date

Signature of Social Worker/Psychologist

Date



Physical Therapy
Consultants, Inc.



FINANCIAL AGREEMENT

Thank you for choosing Physical Therapy Consultants, Inc. as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

All patients must complete our Information and Insurance forms before seeing a physical therapist.

Regarding Insurance: We cannot bill your insurance company unless you give us the correct insurance information. Your insurance is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. All co-pays are due on the date of treatment.

_____ (patient's initials) **ASSIGNMENT OF BENEFITS:** I hereby authorize and direct any insurance company to pay the proceeds of any benefits due me for services rendered by Physical Therapy Consultants, Inc. Clinics directly to the provider. A copy of this can be considered as an original for insurance purposes.

_____ (patient's initials) **KNOWLEDGE AND RELEASE OF INFORMATION:** I understand the diagnosis of my problem and consent to Physical Therapy Consultants, Inc. Clinics to render appropriate treatment as prescribed by my physician. Furthermore, I authorize Physical Therapy Consultants, Inc. Clinics to release to my referring physician and insurance company any information including my diagnosis and records of treatment, concerning my past medical history and physical therapy.

_____ (patient's initials) **RESPONSIBILITY AGREEMENT:** I acknowledge and understand that I am responsible for all the charges for all services rendered to me or a member of my family. Although I have requested that my bill be submitted to my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the bill is paid in a reasonable amount of time. If for any reason a portion of my bill is not paid by my insurance company, I further agree to make arrangements for prompt payment of the bill. I also understand and acknowledge that I am responsible for any and all additional charges incurred due to any collection efforts. I also understand that obtaining required authorization for physical therapy (and/or supplies) is my responsibility, as is any unpaid balance if this is not done. I waive any right to claim the charges for the services are unreasonable or unnecessary, as to the amount charged or the treatment rendered. I have read this entire agreement and understand it and agree to fully pay all sums charged.

_____ (patient's initials) **THERAPY PRODUCTS FOR HOME USE:** Products that are purchased for patients through Physical Therapy Consultants, Inc. must be paid for upon receipt. If the product is eligible for insurance coverage, it is the responsibility of the patient to negotiate reimbursement with their insurance company.

_____ (patient's initials) **CANCELATION AND "NO SHOW" POLICY:** Appointments must be canceled 24 hours in advance. If you fail to arrive for your appointment or do not cancel 24 hours in advance, a \$15.00 fee will be added to your account per appointment. This fee is the responsibility of the patient and will not be submitted to the insurance company.

SIGNATURE: _____ **DATE:** _____



Andover Physical Therapy
 13831 Round Lake Blvd.
 Andover, MN 55030
 P: (763) 433-8108
 F: (763) 433-8134

Health History Questionnaire

Name: _____ DOB: ____/____/____ Date: ____/____/____

Have you or a family member ever had...	You	Family		You	Famil
Angina/Chest pain	Y/N	Y/N	Osteoarthritis	Y/N	Y/N
Broken Bones	Y/N	Y/N	Osteoporosis or Osteopenia	Y/N	Y/N
Cancer	Y/N	Y/N	Rheumatoid Arthritis	Y/N	Y/N
Diabetes	Y/N	Y/N	Stroke	Y/N	Y/N
Heart disease/Heart attack	Y/N	Y/N	Multiple Sclerosis	Y/N	Y/N
High blood pressure	Y/N	Y/N	Other	Y/N	Y/N
Do you have history of?	Yes	No	Do you have history of?	Yes	No
Allergies/ Asthma			Depression		
Are you pregnant			Bronchitis		
Dizziness/Balance problems			Headaches		
Hernia			Kidney disease or problems		
Metal implants			Nervous disorders		
Rheumatic fever			Pacemaker		
Seizures			Sensitive to heat/ice		
STD's			Ulcers		
In the past few months have you had...	Yes	No	Have you had...	Yes	No
A change in your health			Changes in appetite		
Changes in bowel or bladder functions			Difficulty swallowing		
Dizziness			Fever/Chills/Sweats		
Nausea/Vomiting			Numbness or tingling		
Shortness of breath			Unexplained weight changes		
Upper respiratory infection			Urinary tract infection		
Are you under stress?	Yes	No			
Are your symptoms getting	Worse	Same	Better		
Describe your level of activity	Not Active	Active	Very Active		
Do you have a problem with	Vision	Speech	Hearing		
Do you smoke	No	Yes	___Packs/ day		
How are your able to sleep?	Poor	Fair	Medicated		
How do you most effectively learn?	Audio	Visual	Hands-on		
How often do you drink alcohol?	Never	Once/week	___Times/week		

I have completed the above information to the best of my ability.

Patient Signature: _____ Date: _____



Authorization To Release Medical Information

This will authorize _____ to release to Andover Physical Therapy information from the medical record(s) maintained regarding all injuries, medical history, and physical condition.

The information to be disclosed is:

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Operative Reports |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Pathology Reports |
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> X-ray Reports |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Doctors Progress Notes |
| <input type="checkbox"/> EEG's, EMG's, EKG's, MRI's, CT Scans | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Occupational Therapy Notes | <input type="checkbox"/> Doctor Statements |
| <input type="checkbox"/> All Medical Records | <input type="checkbox"/> Other (Specify) |

The information is needed to assist in development of a physical therapy plan of care.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose this consent will automatically expire without my express revocation.

A photocopy or fax copy of this authorization shall be considered as valid as the original.

(Signature of Patient/Guardian)

Date: _____

Patient Name: _____

Date of Birth: _____

SS#: _____