

Select Therapy & Fitness

Patient Information

1425 S Columbia Road Grand Forks ND - 3035 DeMers Ave Grand Forks ND- 404 4th St N Devils Lake ND

Name _____
Last First MI

Address _____

City _____ State _____ Zip _____

Sex: M or F SS#: _____ Date of Birth _____

Home Phone # _____ Work Phone # _____ Student: Yes or No

Cel Phone _____ Email address _____

Marital status D M S W Occupation _____

Employer _____

Hobbies _____

Responsible Party if other than patient: Name _____

Billing address _____

Sex: M or F DOB _____ Home Phone # _____ Work Phone # _____

Relationship to responsible party: self spouse parent other Employer _____

Insurance: Please present insurance cards and ID

Primary Insurance Company _____

Address _____ Insurance phone # _____

Insured Id #/Policy #/ Claim # _____

Group Name _____ Group # _____

Policy Holder Name _____

Policy Holder DOB _____ Sex: M or F Phone # _____

Patient Relationship to insured: self spouse parent other

Please see other side

Secondary Insurance Company or Medicare Supplement

Insurance Company _____

Address _____ Insurance phone # _____

Insured Id #/Policy #/ Claim # _____

Group Name _____ Group # _____

Policy Holder Name _____

Policy Holder DOB _____ Sex: M or F Phone # _____

Patient Relationship to insured: self spouse parent other

Referring Physician _____

Primary Physician _____

Accident/Injury/Onset Date: _____ **Accident type:** None W/C Auto Other

If auto accident state the accident occurred in: _____

Person to Contact in case of emergency _____

Phone # _____ Relationship to patient: Self Spouse Parent Other

If a work related injury:

Workers Compensation/Workforce Safety Information

Insurance Company Name _____

Billing Address _____

Claim # _____ Claim Contact Name _____

Phone # _____ Fax # _____

Date if Injury _____ State of injury _____

Have you had any previous Physical Therapy for this injury Yes or No

PATIENT MEDICAL HISTORY

Name: _____

Referring Physician: _____ Family Physician: _____

Date of first doctor visit for injury: _____ Is an Attorney involved in this case? Yes No

Have you had surgery for this injury? Yes No Number of surgeries: _____

Type of surgery: _____ took place at Hospital Surgery Center

Are you currently taking prescription or non-prescription medications? _____

Anti-Inflammatories _____ Muscle Relaxers _____ Pain Medication _____

Are you allergic to any medications: Yes No

List: _____

Have you had any of the following medical or rehabilitative services for this injury?

_____ Chiropractor	_____ Physical Therapy	_____ Massage Therapy
_____ Occupational Therapy	_____ General Practitioner	_____ Neurologist
_____ Emergency Room Care	_____ Orthopedist	_____ Podiatrist
_____ CT Scan	_____ MRI	_____ X-rays
_____ EMG/NCV	_____ Myelogram	

Other: _____

Do you now have or have you ever had any of the following:

_____ Asthma, Bronchitis or Emphysema	_____ Severe frequent headaches
_____ Shortness of breath/chest pain	_____ Vision or hearing difficulties
_____ Coronary Heart Disease or Angina	_____ Numbness or tingling
_____ Do you have a Pacemaker?	_____ Dizziness or fainting
_____ High blood pressure	_____ Bowel or bladder problems
_____ Heart attack or heart surgery	_____ Weakness
_____ Stroke TLA	_____ Weight loss/energy loss
_____ Congestive heart disease	_____ Hernia
_____ Blood clot/Emboli	_____ Varicose veins
_____ Epilepsy/seizures	_____ Allergies
_____ Thyroid Disease or Goiter	_____ Any pins or metal implants
_____ Anemia	_____ Joint replacement surgery
_____ Infectious diseases	_____ Neck injury/surgery
_____ Diabetes	_____ Shoulder injury/surgery
_____ Cancer or Chemotherapy/Radiation	_____ Elbow or hand injury/surgery
_____ Arthritis	_____ Back injury/surgery
_____ Osteoporosis	_____ Knee injury/surgery
_____ Gout	_____ Leg, ankle or foot injury/surgery
_____ Sleeping problems/difficulties	_____ Are you pregnant?
_____ Emotional/Psychological problems	_____ Do you use tobacco?

List any other information that would assist us in your care: _____

Patient/Guardian Signature

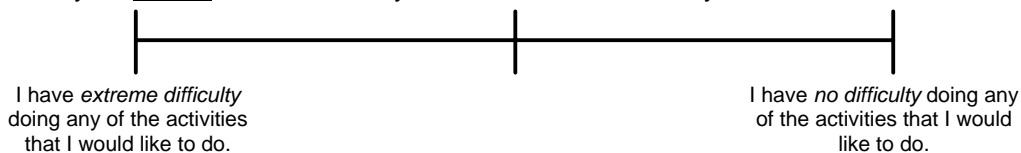
Date

OPTIMAL INSTRUMENT

Difficulty–Baseline

Instructions: Please circle the level of difficulty you have for each activity today.	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	9
2. Rolling over	1	2	3	4	5	9
3. Moving–lying to sitting	1	2	3	4	5	9
4. Sitting	1	2	3	4	5	9
5. Squatting	1	2	3	4	5	9
6. Bending/stooping	1	2	3	4	5	9
7. Balancing	1	2	3	4	5	9
8. Kneeling	1	2	3	4	5	9
9. Walking–short distance	1	2	3	4	5	9
10. Walking–long distance	1	2	3	4	5	9
11. Walking–outdoors	1	2	3	4	5	9
12. Climbing stairs	1	2	3	4	5	9
13. Hopping	1	2	3	4	5	9
14. Jumping	1	2	3	4	5	9
15. Running	1	2	3	4	5	9
16. Pushing	1	2	3	4	5	9
17. Pulling	1	2	3	4	5	9
18. Reaching	1	2	3	4	5	9
19. Grasping	1	2	3	4	5	9
20. Lifting	1	2	3	4	5	9
21. Carrying	1	2	3	4	5	9

22. Thinking about all of the activities you would like to do, please mark an “X” at the point on the line that best describes your overall level of difficulty with these activities today.



23. From the above list, choose the 3 activities you would most like to be able to do without any difficulty (for example, if you would most like to be able to *climb stairs*, *kneel*, and *hop* without any difficulty, you would choose: 1. 12 2. 8 3. 13)

1. ____ 2. ____ 3. ____

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Select Therapy

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for SELECT THERAPY to furnish medical care and treatment to _____ considered necessary and proper in diagnosing or treating his/her physical and mental condition.

Patient/Guardian _____ Date _____

BENEFIT ASSIGNMENT/RELEASE OF INFORMATION

I, hereby assign all medical and or/surgical benefits to include major medical benefits to which I am entitled, including Medicare, Medicaid, private insurance and third party payers to SELECT THERAPY. A photocopy of this assignment is to be considered as valid as the original. I, hereby authorize said assignee to release all information necessary, including Medical Records, to secure payment.

Patient/Guardian _____ Date _____

FINANCIAL POLICY STATEMENT

We bill your insurance carrier solely as a courtesy to you. You are responsible for the entire bill when the services are rendered. We require that arrangements for payment of your estimated share be made today. If your insurance carrier does not remit payment within 60 days, the balance will be due in full from you. In the event that your insurance company requests a refund of payments made, you will be responsible for the amount of money refunded to your insurance company. In the event your company establishes an internal usual and customary fee schedule, you will be responsible for the difference remaining.

If any payment is made directly to you for services billed by us, you recognize an obligation to promptly remit same to SELECT THERAPY.

The above does not apply for those patients that are considered Worker's Compensation. However, be advised if you claim W/C benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.

When you pay by check you expressly authorize SELECT THERAPY, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee of up to the state maximum legal limit (plus any applicable sales tax). Please Note: The above language authorizes an electronic debit to your account for the state-allowed recovery fee. In accordance with the rules of the National Automated Clearing House Association, you may call (888) 235-4635 to revoke the authorization for the electronic transaction. This does not, however mean that SELECT THERAPY cannot collect a returned check fee by other methods.

I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees and attorney fees.

ESTIMATED INSURANCE BENEFITS: _____

Estimated patient payment _____ Arrangements for payment of patient's share

NOTE: Estimated coverage information is provided as a courtesy to our patients, but is not intended to release them from total responsibility for their account balance.

The above information has been read and explained to me. I UNDERSTAND MY RESPONSIBILITY FOR THE PAYMENT OF MY ACCOUNT.

Patient/Guardian/Responsible Party

Clinic Representative/Witness

NOTICE OF PRIVACY POLICY-SELECT THERAPY

August 15, 2003

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

INDIVIDUAL RIGHTS REGARDING PROTECTED HEALTH INFORMATION - PHI

You have certain rights under federal privacy standards including:

- the right to receive a printed copy of this notice
- the right to inspect and receive copies of you PHI - Select Therapy may charge a reasonable fee for copying, postage, labor, and supplies.
- the right to amend or submit corrections to your PHI.
- the right to request restrictions on the use and disclosure of your PHI -we are not required to agree to your request.
- the right to receive and specify confidential communications concerning your PHI and treatment.
- the right to receive an accounting of certain disclosures of your PHI except disclosures made for treatment, payment, healthcare operations or with your written authorization.

USES OF DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION - PHI

TREATMENT: Your PHI may be used by Select Therapy staff or disclosed other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, providing treatment, and managing your health care and related services.

PAYMENT: Your PHI may be used by Select Therapy to bill and collect payment for treatment and services and to seek payment from your health plan, such as Medicare/Medicaid/Worker's Compensation/Blue Shield of ND or MN and other third party payers.

HEALTHCARE OPERATIONS: Your PHI may be used by Select Therapy and disclosed to other agencies to improve quality of care, reduce healthcare costs, provide training programs for students, healthcare providers -and non-healthcare professionals or for business planning, management and development.

COMMUNICATION: Your PHI may be used by Select Therapy to send you appointment reminders or other information about treatment options or health related benefits.

INDIVIDUALS INVOLVED IN YOUR CARE OR PAYMENT FOR YOUR CARE: Select Therapy may disclose PHI about you to your family members, close friend, or any other person identified by you if that information is directly relevant to that person's involvement in your care or payment for your care.

GOVERNMENT AGENCIES: your PHI may be disclosed by Select Therapy to Public Health Agencies, Coroner, Medical Examiner, Funeral Director, Government Agencies, or Law Enforcement Agencies as required by law to support government audits and inspections, to facilitate law enforcement investigations, to comply with government mandated reporting, or in the case of suspected domestic violence, abuse, or neglect.

Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you wish to revoke your authorization you may do so by submitting a written notice of revocation.

SELECT THERAPY RESPONSIBILITY: We are required by law to maintain the privacy of your Protected Health Information, to comply with the privacy policies outlined in this notice, and to provide you this notice of privacy practices. Select Therapy is permitted by law to reserve the right to amend or modify our privacy policies, our practices, and this document. You may review or receive copies of you PHI by submitting a written request. Select Therapy requires that request to review your PHI, receive copies of your PHI, or request to restrict disclosures of your PHI, be submitted in writing. Forms to request information may be obtained from the Privacy Officer.

CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT INFORMATION

This will authorize: *SELECT THERAPY LLC*
1425 S COLUMBIA ROAD
GRAND FORKS ND 58201

to release the following information: _____ Complete medical record
_____ Other (specify) _____

to: _____
Facility/Individual/Organization releasing information

Address

Address

for the following purpose:
_____ Disability determination
_____ Continued care by another physician/healthcare facility
_____ Insurance claim
_____ Other (specify) _____

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance hereon and if not revoked sooner in writing. This consent will expire 45 days from the date signed or date of discharge. I understand that I have the right to examine and copy the information to be disclosed, unless deemed that such disclosure is not in my best interest.

To the receiving party of this information:
This information has been disclosed to you for the sole purpose stated in this consent. Any other use of this information without the expressed written consent of the patient is prohibited. These records may be protected by Federal Regulation (42 CFR, Part 2).

Patient signature: _____ Date: _____

Parent/Guardian/Authorized Representative signature: _____

Witness signature: _____ Date: _____

Completed by: _____ Date: _____