# WELCOME TO

SIOUX CITY PHYSICAL THERAPY

## Patient Information - Please complete the following form COMPLETELY

**Today's Date**____/____/____

**How did you hear about us? Family/Friend** □ **Physician** □ **Other** _____

**Patient Name**_____ **Date of Birth**____/____/_____
(First) (MI) (Last)

**Gender:** □ Male □ Female **Marital Status:** □ Married □ Divorced □ Single □ Not Applicable

**Home Address**_____ **City**_____ **State** ___ **Zip** _____

**Primary Phone# (**____)_____ **Secondary Phone# (**____)_____

**Email Address**_____

**Emergency Contact**_____ (____)_____ _____
(First and Last Name) Phone # (Relationship to Patient)

**Referring Physician**_____ **Follow-up Appt. Date/Time**_____

**********

**Work Status:** □ FT □ PT □ Retired □ N/A **Student:** □ FT □ PT □ N/A

**Current Employer:** _____

**Employer Address**:_____ SS#_____(needed for billing purposes)

**Employer Phone#: (**____)_____

**Is today's visit due to a**
**Work related accident/injury?** □ Yes □ No **State where accident occurred**_____
**Date of Injury**___/___/_____

**Auto Accident:** □ Yes □ No

**Attorney's Info (if applicable):** Name_____ Phone (____)_____

**********

**Primary Insurance Information**

**Ins. Carrier**_____

**Policy ID#**_____

**Group#**_____

**Policy Holder Info:**

_____ ___/___/___
**Name** **DOB**

**Relationship to Patient:** □ Self □Spouse □Parent

**Secondary Insurance Information**

**Ins. Carrier**_____

**Policy ID#**_____

**Group#**_____

**Policy Holder Info:**

_____ ___/___/___
**Name** **DOB**

**Relationship to Patient:** □ Self □Spouse □Parent

**********

**Minor Information (Address needed only if different from patient's)**

**Mother's Name**_____

**Mother's Address**_____

**City**_____ **State**___ **Zip**_____

**Father's Name**_____

**Father's Address**_____

**City**_____ **State**___ **Zip**_____

SIOUX CITY PHYSICAL THERAPY

Patient Name: _____ Age: _____ Weight: _____ Height: _____

What are your functional therapy goals? _____

Surgeries and dates:_____

_____

_____

Recent Hospitalization and dates:_____

_____

_____

Have you had previous treatments for this condition?

☐ Physician ☐ Chiropractic ☐ Podiatrist ☐ Surgery
☐ Massage ☐ Medication ☐ Neurologist ☐ PT
☐ Orthopedic Surgeon ☐ None

Additional info:_____

Have you had any of the following diagnostic tests?

X-Rays: Yes No Results:_____

MRI: Yes No Results:_____

CT Scan: Yes No Results:_____

Are you currently taking medication? Yes No

| Medication: | For what condition: |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Primary Complaint:_____

_____

_____

How did your injury happen:_____

_____

_____

Using the 1-10 Pain Scale: (Best) 1 2 3 4 5 6 7 8 9 10 (Worst)

Rate your Pain Level: Best:_____ Current:_____ Worst:_____

Please indicate what makes pain *better*: ☐ Sitting ☐ Standing
☐ Walking ☐ Laying flat ☐ Bending ☐ Other_____

Please indicate what makes pain *worse*: ☐ Sitting ☐ Standing
☐ Walking ☐ Laying flat ☐ Bending ☐ Stairs Up ☐ Stairs Down
☐ Coughing/Sneezing ☐ Voiding ☐ Reaching ☐ Lifting
☐ Other:_____

_____

## Medical History - Check all that apply:

| | |
|---|---|
| ☐ Alzheimer's | ☐ Asthma |
| ☐ Muscular Dystrophy | ☐ Cancer |
| ☐ Fibromyalgia | ☐ Diabetes Type I |
| ☐ Osteoporosis | ☐ Diabetes Type II |
| ☐ Rheumatoid Arthritis | ☐ Epilepsy |
| ☐ Fracture or Suspected Fracture | ☐ Parkinson's |
| ☐ Current infection | ☐ Hypertension |
| ☐ Depression/Anxiety | ☐ Seizure Disorder |
| | ☐ Emphysema/COPD |

Present Activity Level:

☐ Sedentary ☐ Light ☐ Heavy ☐ Very Heavy

History of Falls: YES or NO
Currently Pregnant?: YES or NO
Do you wear orthotics? YES or NO

Please check all that apply:

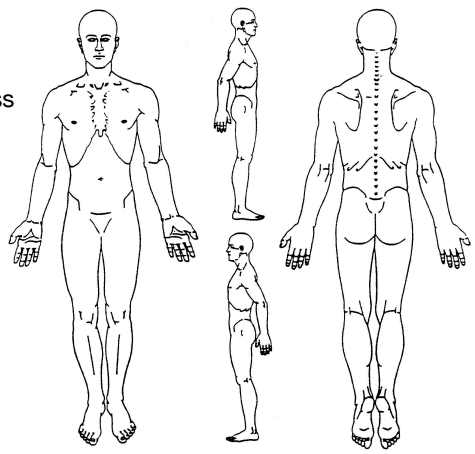
| | |
|---|---|
| ☐ Fatigue | ☐ Significant Weightloss |
| ☐ Dizziness | ☐ Balance Problems |
| ☐ Fainting | ☐ Incontinence |
| ☐ Headaches | ☐ Bowel/Bladder Problems |
| ☐ Pacemaker | ☐ Metal Implants |

☐ Allergies: _____

## Body Chart:

Please mark the location of pain and type on the chart.

Key:
- ☐ A = Ache
- ☐ B = Burning
- ☐ N = Numbness
- ☐ S = Stabbing
- ☐ O = Other



## PATIENT CONSENT FORM (HIPPA)

The Department of Health and Human Services has established a **"Privacy Rule"** to help ensure that personal health care information is protected for privacy. The **"Privacy Rule"** was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information about treatment, payment, or health care operations, order to provide health care that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your health information, but this **must be in writing**. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name_____Signature:_____Date: _____

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## COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem, causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers, and therapists continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPPA) with particular emphasis on the **"Privacy Rule"**. We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

# CONSENT FOR CARE, TREATMENT, MEDICAL RECORDS RELEASE, AND ASSIGNMENT OF BENEFITS

I, the undersigned, do herby agree and give my consent for Sioux City Physical Therapy to furnish medical care and treatment to _____ considered necessary and proper in diagnosing and/or treating
(Patient Name)
their physical and mental condition. I also understand that my medical records will be released to my **referring physician** for the continuity of my care. If I want my medical records to be released to another physician or entity then I will need to sign an additional release stating to whom these records need to be released. I also understand that Sioux City Physical Therapy may charge a fee for the copying and mailing of these records.

By my signature, I hereby assign all medical benefits to include major medical benefits to which I am entitled, including Medicare, private insurance and any other health plans to Sioux City Physical 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. I understand that I am responsible for the entire bill when services are rendered and that Sioux City Physical Therapy will bill my insurance carrier as a courtesy. I also understand that I must pay my **CO-PAY AND/OR COINSURANCE** at the time of service. If any payment is subsequently made by you or your insurance carrier in excess of the balance due, Sioux City Physical Therapy will promptly refund the credit. In addition, I understand that if I receive any direct payment from my insurance carrier I have an obligation to promptly remit same to Sioux City Physical Therapy.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, after such default and upon referral to a collection agency or attorney by Sioux City Physical Therapy, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees. **A fee of 1.5 % will be added to your account for each billing period past 60 days. Also a fee of $35.00 for a returned check fee will be added to your account for any checks returned by the bank.**

**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 does not apply to those patients who are considered **Worker's Compensation**. However, be advised that as a **Compensation patient**, you **may be held responsible for your charges in the event that your claim is denied.**

Sioux City Physical Therapy will do their best to work with your insurance carrier to receive payment.

I have read and understand the above. I have also received a copy of the collection process and understand that **I am responsible for the payment of my account.**

_____ _____
Patient or Responsible Party Signature Date

_____ _____
Staff Member Signature Date


# CANCELLATION POLICY

Sioux City Physical Therapy will be providing you with the highest quality of care and will attempt to arrange your therapy sessions to accommodate your schedule as much as possible. During your first visit we will reserve a specific time for each of your therapy sessions in accordance with your prescription. Please note that you should allow 1 (one) full hour for each session.

You, the patient, are responsible for attending all your scheduled appointments at the times reserved for you. If you are unable to attend your scheduled appointment, you must notify us AS SOON AS POSSIBLE, preferably 24 hours in advance. This will allow us to reschedule your appointment and offer this reserved time to another patient. Also, if you know that you will be MORE THAN 15 minutes late for your reserved time, please call the office to notify us and we will tell you if you can still be seen or if you need to reschedule. Please know that if you do show up late for your appointment it is highly probable that you will not be seen, as there are other patients scheduled also.

We feel that this policy is necessary for the benefit of each patient and will enable us to better serve you.

I have read and understand the above cancellation policy, and will do my best to adhere to it.

Patient Signature:_____ Date:_____

***Please Note: We reserve the right to cancel any further appoints if there are 3 unexcused absences in order to prioritize and encourage patient compliance/attendance.