## HIGH PLAINS PHYSICAL THERAPY ASSOCIATES, INC.

# WELCOME TO OUR CLINIC

Please fill out this form completely. If you have questions or need help, please ask. We are happy to assist you.

### Patient Information

Name: Last_____ First_____ MI_____

Preferred Name (Nickname) _____ DOB_____ □ Male □ Female

Address_____ City_____ State_____ Zip_____

Employer_____ □ Single □ Married □ Other

Phone: H_____ C_____ W_____

SSN: _____ E-mail Address_____

Preferred method of appointment reminders: □ Phone call to home □ Phone call to cell □ Text □ Email

Referring Doctor_____ Phone #_____

Primary Care Doctor_____ Phone #_____

### Insurance Policy Information

Primary Insurance Company _____ ID_____ Plan/Group_____

Policyholder's Name: Last_____ First_____ MI_____

Policyholder's DOB:_____ Policyholder's Relationship to Patient_____

Address of Policyholder (if different than above)

Street_____ City_____ State_____ Zip_____

Is the patient covered by additional insurance? □ Yes □ No

Secondary Insurance Company_____ ID_____ Plan/Group_____

Policyholder's Name: Last_____ First_____ MI_____

Policyholder's DOB:_____ Policyholder's Relationship to Patient_____

# HIGH PLAINS PHYSICAL THERAPY ASSOCIATES, INC.

## CURRENT COMPLAINTS & MEDICAL HISTORY

**Patient Name: _____ Today's Date: _____**

The information requested below is intended for treatment purposes only and will remain a part of your confidential medical record.

**PAIN/INJURY/SURGERY**
Area(s) of Pain/Injury_____

Have you had Surgery related to your pain or injury? □ Yes □ No
If yes, date of surgery? _____ Surgeon_____

**DIAGNOSTIC TESTS**
Please check any tests or procedures that have been done for your **current** condition.

□ X-rays □ MRI □ CT Scan □ Bone Scan □ Bone density □ Ultrasound

If your injury the result of an accident? □ Auto □ Work Comp □ Other
If yes, date of Injury_____
Is there an attorney or adjuster we need to contact? □ Yes □ No
If yes, please give the claim number _____ and name and phone number of the attorney or adjuster: _____

**MEDICAL HISTORY**
Are you currently experiencing or have you ever had any of the following conditions? Check all that apply.

□ Diabetes
□ Chest Pain/Angina
□ High Blood Pressure
□ Heart Disease
□ Heart Attack
□ Heart Palpitations
□ Nervous Disorders
□ Pacemaker
□ Chronic Headaches
□ Numbness in Toes
□ Allergies to Heat
□ Poor tolerance to Cold
□ Asthma/Respiratory Problems
□ Metal Implants
□ Osteoporosis
□ Neck Pain
□ Pins & Needles in Legs
□ Neck Stiffness
□ Numbness in hands/fingers
□ Bowel Abnormalities
□ Bladder Abnormalities
□ Urine leakage
□ Kidney Problems
□ Liver/Gallbladder Problems
□ Ringing in your ears
□ Lightheadedness
□ Low Back Pain
□ TMJ
□ Hernia
□ Cancer
□ Allergies
□ Seizures
□ Sleeping Problems
□ Heavy Head
□ Irritability
□ Stroke/CVA
□ Nausea/Vomiting
□ Shortness of Breath
□ Joint Pain
□ Dizziness/Fainting
□ Previous Surgeries

Are you currently pregnant? □Yes □ No

If you answered yes on any of the above, please briefly explain and give approximate dates:

_____

_____

Please list any medications you are currently taking (or provide our office staff with a list of medications to attach to your permanent medical record): _____

_____

Do you participate in sports, exercise programs or activities on a regular basis? □ Yes □ No

If yes, what sports/programs/activities? _____

If you are currently having pain, please rate the intensity of your pain on a scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible: 0 1 2 3 4 5 6 7 8 9 10

In the rare instance of an emergency, who should we notify?
Name_____ Phone_____

## PATIENT AUTHORIZATION & FINANCIAL POLICY

As a courtesy, High Plains Physical Therapy (HPPT) will verify your insurance benefits; however, it is ultimately your responsibility to be aware of your specific coverage. We will also bill your insurer on your behalf. If your insurer designates that a copayment, deductible and/or co-insurance is your responsibility, we are obligated to collect it. The ultimate payment responsibility is yours and you will be billed for any balance not paid by your insurance.

**ASSIGNMENT OF BENEFITS/RELEASE OF INFORMATION/FINANCIAL RESPONSBILITY**
I authorize my insurer to pay benefits directly to HPPT. I authorize HPPT to release all information necessary to secure payment including documentation on the medical record which may include present or past history. I understand that I am financially responsible for all charges incurred by HPPT. Any portion of these charges not covered by my insurer must be paid by me. I further understand that copayments are due at the time of my HPPT visit and that payment of any deductibles and coinsurance are my responsibility as stated by my contract with my insurer.

**HIPAA NOTICE OF PRIVACY PRACTICES**
I understand that HPPT and its staff will make every effort to keep my protected health information confidential and private. My signature below acknowledges that I understand that HPPT may use and disclose my protected health information for treatment, for billing or to obtain payment, and for related health care reasons. I have been offered a copy of, read, or received HPPT's Notice of Privacy Practices and I may obtain a copy of the Privacy Notice at the HPPT office.

I have read and agree to the terms and information stated above.

_____ _____
Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient: _____

**CONSENT FOR TREATMENT OF MINOR PATIENT**
I give my consent to HPPT to render physical therapy treatment for my minor son/daughter. In the event that I am unable to accompany my minor child (under 18 years of age) to his/her HPPT appointments, I permit HPPT to render treatment to my child when I am not present.

_____ _____
Signature of Patient or Patient Representative or Parent/Legal Guardian of Minor Date

If signed by patient representative or parent/legal guardian, indicate relationship to patient: _____

# HIPAA Notice of Privacy Practices

Effective, January 1, 2016, we understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us, which we need in order 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 **High Plains Physical Therapy Associates, Inc.**, whether made by your physical therapists or any employee of High Plains Physical Therapy Associates, Inc. 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 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:**

- For treatment
- For payment
- For health care operations
- As required by law
- To avert a serious threat to health and safety
- As required by the Military or Veterans and Workers Compensation
- Public health risk
- Health oversight activities
- Lawsuits and disputes
- Law enforcement
- Coroners, health examiners and funeral directors
- National Security and Intelligence activities
- Protective Service for the President and others

**Your rights regarding Health Information about you:**

- Right to inspect and copy
- Right to amend
- Right to accounting of disclosures
- Right to request restrictions
- Right to request confidential communications
- Right to a paper copy of this Notice.

**Changes to this Notice:**
We reserve the right to change this Notice. We will retain a copy of the current Notice in our facility.

**Complaints:**
If you believe that your privacy rights have been violated you may file a complaint with us. All complaints must be in writing. Please contact Cody or Katherine Young at 614 East Boulevard, Rapid City, South Dakota or at highplains614@gmail.com.

**Acknowledgement of Receipt of this Notice:**
We will request that you sign a separate form acknowledging you have received a copy of this Notice. The acknowledgement will become part of your records.

HIGH PLAINS PHYSICAL THERAPY ASSOCIATES, INC.

# AUTHORIZATION TO ACCESS MEDICAL RECORDS

PATIENT: _____ DOB: _____

Please list any family members or others who you give permission to view the information found in your medical record.

| NAME | RELATIONSHIP TO PATIENT | EXPIRATION |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

I understand that my medical record may include a wide variety of information on diagnosis, treatment and procedures.

High Plains Physical Therapy will continue to rely on the information on this form unless you request changes. It is your responsibility to immediately notify High Plains Physical Therapy of any change that may alter this authorization.

To revoke or alter this authorization, please send a written request to the address below:

High Plains Physical Therapy Associates, Inc.
614 East Blvd
Rapid City SD 57701

Signature of Patient: _____ Date: _____

## HIGH PLAINS PHYSICAL THERAPY ASSOCIATES, INC.

# CANCELLATION AND NO SHOW POLICY

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule. For these reasons, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $35.00 fee; this fee will not be covered by your insurance company and will be your responsibility.

By signing this form, you acknowledge you have read and understand the Cancellation and No Show Policy of High Plains Physical Therapy and agree to give 24 hour notice in the event you cannot make a scheduled appointment and to be responsible for the $35.00 fee otherwise.

_____ _____

Patient Signature Date